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Health Equity

Health Equity and Community Engagement Report





HEALTH EQUITY AND COMMUNITY ENGAGEMENT REPORT

BEST PRACTICES, CHALLENGES AND RECOMMENDATIONS FOR LOCAL HEALTH DEPARTMENTS

BAY AREA REGIONAL SUMMARY

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Project Description

The Bay Area Regional Health Inequities Initiative (BARHII) is a collaboration of public health directors, health officers, senior managers and staff from eleven of the San Francisco Bay Area local health departments (LHDs). BARHII formed to collectively address the factors that contribute to egregious differences in life expectancy and health outcomes between different racial and socio-economic groups in the region. The mission of BARHII is to: *Transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities.* BARHII focuses its work on how public health departments can address

upstream, structural and social factors that perpetuate health inequities. The BARHII Framework below describes the problem areas addressed by a continuum of public health practice ranging from cataloguing disproportionate causes of mortality and disease management on the right side to addressing more upstream social inequalities such as racism and class inequality on the left side (Figure 1).

One area of BARHII’s work is developing LHD capacity to effectively partner with community representatives to address health inequities. BARHII supports member health departments as they attempt to forge new strategies for community engagement and capacity building to address the broad range of conditions that contribute to poor health, and to

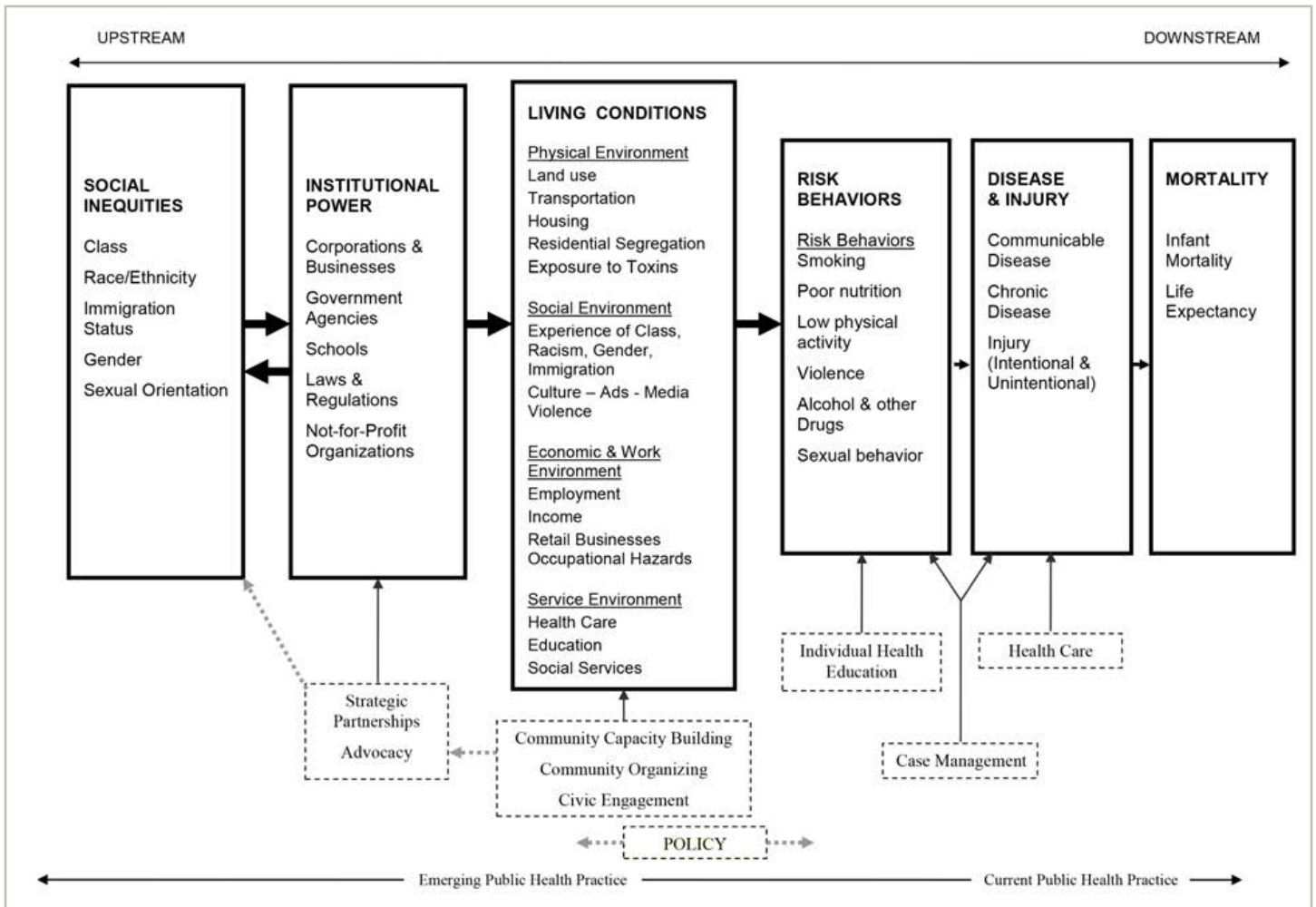


FIGURE 1: BARHII’s Public Health Framework for Reducing Health Inequities

establish relationships that can be sustained over time. From 2009-2011, BARHII conducted qualitative assessments in seven local health jurisdictions (LHJs) consisting of a total of 39 focus groups with staff at both LHDs and LHD-selected community agencies that have experience working with public health. Separate LHJ reports were generated for participating health jurisdictions to reflect in more detail the qualitative data results for each LHJ.

This Bay Area Regional Summary report combines the data from all LHJ reports and describes perspectives of both LHD and community agency staff on key themes that emerged in discussions from the focus groups conducted. The data results presented show local priorities in health inequities and social conditions as well as highlight best practices and lessons learned related to (1) public health and community agency collaborations and (2) how health inequity concerns are being addressed by both LHDs and community agencies in the Bay Area.

Social Determinants of Health Inequities in the Bay Area

Health Disparities and Health Inequities

Focus group discussions revealed a significant difference in how LHD staff and community participants view health inequities. Most public health departments collect data and design targeted programming based on the disparities in health seen between different racial and socio-economic groups in the population. Not surprisingly, most LHD staff spoke to inequities in terms of health outcomes – such as diabetes rates among Latinos or HIV rates among African Americans. Community-based participants responded by speaking to the systemic inequities in the social determinants of health, some of which are highlighted below.

Cost of Living, the Wealth Gap and Cultural Divides

When asked to describe the greatest inequities they see and experience in their areas, health department and community agency participants across the region spoke to common, disparate realities between the “haves” and the “have-nots”. A few of the Bay Area jurisdictions were described as having “two worlds” – one being what the tourists, affluent residents or successful industry professionals are exposed to and the other being what the underserved and lower-income workers and indigent residents experience. Desirable geographic locations produce extremely high costs of living due to the success of local industries such as high-tech, tourism, food and wine and academia – which can increase housing displacement as well as the inaccessibility of affordable goods and services for lower-income residents.

Whether it be due to historical, local industry shifts, current successful businesses and/or the wider economic downturn, the gap in employment, housing and wealth was described as leading to separate social and physical spaces where different members of the community work and live. Several of the health jurisdictions have clear, geographical distinctions or other names for areas of the jurisdictions which delineate not only the physical divides but also the socio-economic and even cultural divisions that exist among its residents. One Napa County community agency staff member describes this dynamic: “*There is a huge disparity between families that are very, very wealthy and then families [that] are struggling to make ends meet...it seems like right now there’s no kind of coming together...they’re very separate communities.*” (Napa County community agency representative) Many lower-income residents, often times also immigrants and/or people of color, end up isolated in areas plagued by violence and crime with few economic opportunities leading to more police presence and higher incarceration rates.

In addition, participants spoke to how these low-income neighborhoods have fewer important resources such as reliable transportation, good schools, public

health and health care services, and safe, healthy, living environments. Economically underdeveloped neighborhoods also provide poorer choices for affordable, healthy food – and include an abundance of fast food restaurants and liquor stores – as well as very few safe, clean places to socialize and exercise. Even service workers employed in the various agricultural and food industries ironically have very little access to affordable, healthy fruits and vegetables. Many participants mentioned how certain, inequitable housing conditions – such as gentrification leading to displacement, foreclosures, overcrowding in substandard housing, and homelessness – also result from this place-based, wealth gap dynamic. Focus group participants spoke to how government leaders and businesses tend to cater more to tourists, high-income residents and industries out of concern for the local economy and focus less on the social and economic development of lower-income areas of need, hence, creating a sense of “two worlds” that continues to be perpetuated by local policies and decision-making.

Root Causes of Health Inequities

Some of the underlying root causes for these social, economic and health inequities were highlighted in participant discussions as key issues to address for healthier and more equitable communities. The discrimination (e.g. racism, classism, sexism, homophobia) that is observed and experienced among different subgroups of the population influences mental and physical health as well as the quality of people’s living environments. For example, the discrimination experienced by low-income immigrants and non-white racial/ethnic groups manifest themselves in a direct lack of access to culturally appropriate and affordable goods and

services, including public health and health care. In addition, discrimination leads to an increase in racial tension, stress and mental health issues, a lack of knowledge of how to navigate the systems and continual fear, discomfort and other barriers to achieving equitable services and conditions. At the same time that these predominantly no- and low-income communities of color have less access to resources and healthy opportunities, they also have less meaningful representation and political power to improve these conditions and to influence policies that directly affect their quality of life, health and livelihood.

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Best Practices and Challenges in Health Equity and Community Engagement

The following topical themes emerged throughout the Bay Area focus group data and highlighted the subtle nuances of each of these strategic concepts. Like many complex efforts, it is not only what you are doing (i.e. building partnerships) but how you are doing it (i.e. with respect and transparency) that make the difference in success. Discussed below are common and consistent challenges and best practices – some of which emerged from previous lessons learned – as described by LHD and community agency participants:

- Relationship building
- Community engagement
- Community capacity-building

- Data collection and sharing
- Partnership and collaboration development
- Accessible community-based services
- Upstream practices and policy change
- Role of public health
- Leadership support for health equity efforts

Relationship Building

Relationships are a key first step in establishing more formal agency partnerships and are fundamental to meaningful community engagement in public health practice. Some LHDs do not have strong relationships with community agencies, community groups, or individual community members. In some cases, there is also a disconnect between LHD and community agency perceptions of what it means to have a community relationship. Some LHDs exclusively have relationships with community-based agency staff rather than also having relationships directly with individual community members or key stakeholders who are not connected to a local organization. Under these circumstances, the community agencies act as a proxy, which may or may not be representative of or a gateway to individual community members and their experiences.

Both LHD and community agency staff spoke to the strength found in individual, personal connections which lead to meaningful working relationships that are built on trust. The more that LHD staff can advocate for community-driven change and maintain a consistent presence in the community by attending meetings beyond strictly public health concerns (e.g. school events, non-health community forums and celebrations, etc.), the more they will be recognized by community members as professionals who share

common goals with residents and have genuine concern for their overall well-being. Participants emphasized that not only is it important to have decision-makers and program representatives come to the community, it is also important to have approachable and accessible LHD staff contacts who are known liaisons that help communities understand institutional information and who then help institutions understand what is going on in communities and how to best proceed. These strong personal connections based on listening and transparent information-sharing also help engage community partners and residents, as needed, when LHDs are working on community-based strategic planning efforts or public health events. The

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perspective of one community agency member on this topic was: *"The [public health] folks that I have relationships with,...folks that we sat in meetings with and I've been able to see their heart, it's like you're serious about your work, you're not just punching a paycheck or just trying to meet some arbitrary goal...you're really serious about the people and about the work...when you can identify those folks, then those folks become your entry point."* (City of Berkeley community agency representative)

Approaching these ongoing relationships with an open heart, an open-door policy, cultural humility¹ and an understanding of both the history and current

¹ Definition of cultural humility: "A lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. An institution committed to cultural humility would be characterized by training, established recruitment and retention processes, identifiable and funded personnel to facilitate the meeting of program goals and dynamic feedback loops between the institution and its employees and between the institution and patients and/or other members from the surrounding community" (Source: Melanie Tervalon and Jann Murray-Garcia; Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education, Journal of Health Care for the Poor and Underserved; May 1998; 9, 2; Research Library; pg. 117)

issues of local neighborhoods were also noted as important characteristics which support meaningful community relationship-building. Meeting people “where they are” and not judging them for past mistakes, for example with individuals who were formally incarcerated, was mentioned as a community agency best practice and an important step in making meaningful connections that will help support lasting community change. Site visits to community agencies where LHD staff meet the people served is seen as respectful and embracing of individual and community experience. In addition, success in building trust and meaningful relationships has been shown when community agency Boards of Directors and LHD community advisory groups genuinely represent the community and give meaningful power in decision-making to the neighborhoods they serve.

From the community perspective, grassroots organizers are sometimes resistant to building relationships with government agencies because they do not want to be a part of a system which may have failed them in the past. In addition, bureaucratic barriers that sometimes accompany these governmental relationships may pose limits to the community’s preferred strategies and approaches – especially when their goal is to be part of systemic change and community-driven transformation. Community participants also spoke to some LHDs being difficult to navigate in order to find the right person to whom they can provide input on needs or feedback on programs where they will get a response that can influence change. Generally speaking, the LHD staff who have more direct contacts and on-going working relationships in community also have less power in decision-making within their departments. Some of the most impactful ways for LHDs to improve community relationships – as well as create effective and sustainable public health programming – is to keep a pulse on community needs and to connect consistently with community members via genuine, community engagement strategies and capacity-building efforts.

Community Engagement

When relationships between government agencies and the community do exist, community agencies emphasize the importance of an ongoing and mutual-exchange dialogue with LHDs needing to listen to the community to identify key issues and strategies for successful health equity work. Both LHDs and community agencies mention how the government sometimes may miss opportunities and waste resources, by starting and then stopping projects due to funding or a shift in priorities, creating repetitive programs in-house that overlap with other community efforts, and not utilizing the expertise of community members. It was recommended by participants that community members be continually engaged and utilized as a resource to ensure public health materials, programs and services are culturally and linguistically appropriate and that they address the current needs of the community.

In order to conduct truly meaningful community engagement, LHDs should acknowledge community members as experts in their own needs. Participants stressed how essential it is that LHDs maintain an ongoing presence in community meetings and partner with the community to assess and understand changing needs. Currently, many community agency representatives believe that LHDs are not genuinely considering what the community is saying and assumptions are then made about what the community needs. In some cases, the LHD may involve the community in a superficial way, for example, asking the community for input when most decisions have already been made, or providing an unrealistic timeline for participation which excludes the community from decision-making and eliminates community-driven work.

Some of the barriers to meaningful community engagement mentioned by LHD and community participants include rigid, organizational structures of LHDs, restrictions in categorical public health programming, and limited LHD staff locations and “9-5” business hours which can discourage community involvement. Participants expressed that institutional funding silos and separate programming lead to less

internal and external collaboration on communitywide efforts to address health equity and community engagement. The tendency to become disillusioned with LHDs due to this truncated programming can lead to LHD staff repeatedly coming in and out of the community, seemingly asking for the same information. Gaps in communication between the LHD and the community may also lead to less community participation, fewer successful programs and more mistrust of government agencies by the community.

Some best practices in community engagement done by community agencies – which may or may not involve LHDs as partners – include bringing members together socially and for organized efforts to increase community cohesion, community organization, and information sharing. These also involve developing direct-service programs such as health screenings, school-linked services and food distribution in the highest need areas of the community. Community agencies see themselves as allies to LHDs in community engagement efforts due to their long-term relationships with the same residents that LHDs are serving. Community agencies can also help to engage community members in specific public health efforts such as recruitment of Community Health Workers (CHWs) and Promotoros/as, collection of community health and/or equity assessments, health campaign messaging, as well as identification and prioritization of community needs which could contribute to the creation of new or additional non-health services, such as after school youth development programs. Participants shared that engaging youth to develop their own leadership skills has also increased youth

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involvement in personal and community transformation within political, economic and social change arenas. These youth have also worked to bring other youth to the social equity discussions and efforts to reduce the negative impacts of the social determinants of health. An Alameda County community agency representative commented on their approach to working with youth in the context of systems change: “Personal transformation

plus systems change equals community transformation that we are not in the business of simply just helping young people. We get expectation that in helping young people that they somehow magically are going to transform the space around them, that it must be the system that changes and the young people who are able to change it.” (Alameda County community agency representative)

Community Capacity-Building

A shared value by all groups in this assessment was to increase community members’ ability and opportunity to directly engage in strengthening their own communities in culturally appropriate ways. Engaging existing community leaders and health promoters such as CHWs and Promotores/as has worked well in many local communities. LHD training of Promotores/as on health topics to educate their peers is a community strategy that can also work to promote the bridging of information from the community back to LHDs in a language that is understandable to both groups. CHW training programs, as well as LHD hiring practices that prioritize recruitment from the community, have also been successful in building local capacity and

public health program sustainability. Training CHWs is also seen as a strategy toward general community leadership development. Although most CHWs do this work because the issues are of personal value, it was emphasized that it is important to acknowledge the monetary value of community educators with stipends, incentives or other forms of reimbursement, as this helps to show added appreciation for their work and promotes continued engagement.

Another best practice mentioned across the region by participants was the technical assistance and capacity-building conducted by various public health divisions with community agency staff in order to improve their community-based program planning and fundraising efforts. One Marin County community agency representative stated that: *“Community’s relationship with Health and Human Services (HHS) is that they rely on HHS for support in terms of training, direct services, funding, logic models and these are particularly helpful to the degree they help CBOs get funding.”* (Marin County community agency representative)

Leadership development of community members for local policy advocacy was also seen as a successful strategy to increase community efforts as well as to offer more equitable arenas for community voices to be heard in civic engagement processes. Some LHD and community participants mentioned the strategy of hosting public forums with local leaders to discuss health inequities and upstream approaches as successful in leading to both increased cross-sector collaboration and joint funding opportunities .

Successful youth capacity-building programming done by both LHDs and community agencies emphasized increasing knowledge and skill-building in literacy, educational attainment, managing finances, and job

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training. By helping to increase leadership and employment opportunities for all youth, LHDs and community agencies can promote future institutional practices that are more equitable. Additionally, engaging youth in decision-making arenas encourages policy changes that are already inclusive of their needs, rather than relying on what adults think is important for youth.

Data Collection and Sharing

Analyzing and using morbidity and mortality data to inform public health programming was mentioned by LHDs as a vital part of their work and by community leaders as a valued resource of LHDs. In addition, having community partners share in the collection of the data, as well as in the analysis and reporting, allows communities to provide more qualitative, community-level data that may not have originally been captured by the LHD and helps people interpret the data from a community lens. Sharing of local data also helps communities understand health issues in their area and can improve the success of community agencies applying for funding with local data. Data sharing and in-depth discussions around results interpretation can assist both LHDs and community agencies to communicate effectively in regards to prioritizing efforts in local health and social conditions. GIS mapping has also been helpful in incorporating some social determinants of health in community assessments by geographic location, for example, liquor store density and life expectancy by zip code.

Participants report that due to a lack of community relationships and the siloed approach of categorical funding, many times LHDs and other government and academic agencies sample high-need communities repeatedly, do not engage the community in the assessments or research, and do not share the results

back with community participants. When more meaningful, ongoing partnerships in data collection, interpretation and usage are formed, there is a mutually beneficial dynamic, as information is transferred in both directions and different data resources can be used to prioritize and drive both community efforts and LHD public health work.

In Santa Cruz County, the health department partners with local foundations to collect a local data set similar to the California Health Interview Survey (CHIS)², as described by a community agency participant: “[The Community Assessment] developed over time, it involves a lot of people beyond just healthcare people. It involves environmental people, it involves issues around education and public safety, and so it brought a lot of people together and it...is now done every two years...it’s like a CHIS for Santa Cruz, and we have 16 years of reports and about 10 surveys that we’ve done so we can really look at points over time.” (Santa Cruz County community agency representative)

Partnership and Collaboration Development

Partnership with other agencies and collaboratives were seen by both LHDs and community agencies as mutually beneficial, especially when it leads to concrete action and new programs or services. The LHD’s role as a public health subject matter expert is complemented by partnering with existing coalitions which bring more concrete and historical knowledge of the community culture and dynamics. Collaborations with LHD and

² The California Health Interview Survey (CHIS) is the largest state health survey in the nation. It is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California’s large and diverse population. A full data cycle takes two years to complete, with over 50,000 Californians surveyed. Continuous data collection allows CHIS to generate timely one-year estimates. (Source: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>)

community have resulted in a variety of community resources, including health access for the underserved by opening health care clinics in high-need areas, building strong and reliable referral systems, and strategizing for better access to care and services overall. Additionally, partnering with faith-based organizations, schools, and other agencies have led to a better system for

ongoing public health events, consistent messaging, efficient information dissemination, a stronger sense of community, and accountability to the quality of shared efforts. Using existing coalitions was mentioned as an efficient way to also gain information about community-led efforts, as well as engaging community member expertise and direction from community in decision-making. Community agencies can serve as important bridge-builders between residents and government agencies by helping to navigate systems and foster dialogue – one example being between police and youth residents.

Another benefit of on-going community engagement, relationship-building and meaningful partnerships can result in an increase in information-sharing during emergency situations (such as the H1N1 virus prevention efforts). When health-related messages need to be shared quickly with communities, LHDs and their local partner organizations can work together to pass on information to clients. Community agencies also spoke to successes in working with LHDs, foundations and other institutions to apply for shared funding through these cross-sector, collaborative efforts.

One of the main challenges raised by focus group participants in working with partnerships is when collaborative efforts simply stop at discussions in coalition meetings and do not lead to action. The more that community members and trusted local agencies

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are involved in public health and wider community planning efforts from the beginning, and each partner has clear roles in carrying out specific actions, the more flexible, long-lasting and successful these partnerships can be.

As one San Mateo County community agency participant noted, *“To experience the collaboration with the health department has been really, really humbling for me because other than really this work, it’s really hard to find agencies that can or have the capability or the capacity to really concentrate on my community. And so with this has really opened up a lot of doors.”* (San Mateo County community agency representative)

In addition, addressing inequities as a community was described by participants as more successful than approaching issues via isolated programs or agencies. Community agencies which are strong in connecting families together and mobilizing for a common cause are necessary leaders in community-centered work. Communities that felt more cohesive in their efforts mentioned that they had more alternative and relevant choices for health care, they were more empowered to take action on improving their social determinants of health, and they had more opportunities to have an effect on their own health outcomes.

Accessible Community-Based Services

Accessible, community-based services are important to both LHDs who prioritize access as well as community representatives advocating for issues unique to their communities. “Accessibility” of services can mean many things including but not limited to:

- Free or low cost
- Physical/geographical location in close proximity to high-need residents
- Accessible by public transportation
- Available to undocumented or underinsured clients
- Providing care in client’s native language
- Providing culturally appropriate care

To some, physically locating county-sponsored services, including clinics in high-need geographic areas, was viewed as a priority. In one county, it was seen as easier to engage the community in LHD sponsored programs when there is an identifiable, community-oriented space for gatherings where people feel at home, which increases their willingness to participate regularly. Another LHD partnered with local agencies and community members to conduct neighborhood, door-to-door outreach for cardiovascular disease, which helped with community engagement, capacity building and the quality of information that was both shared with and gathered from community members.

Beyond geographical access, participants additionally valued characteristics such as a cultural understanding of these communities and *“speaking the same language”* regarding a shared vision of cultural needs and expectations as a part of their care and treatment planning.

Upstream Practices and Policy Change

LHDs face the challenge of finding balance between providing direct public health services to meet basic community needs – which are necessary and may be urgent – and focusing resources on upstream policy work to influence the social determinants of health and health equity – which have the potential to prevent poor health outcomes in the wider community and improve the health of future generations. Some LHD staff mentioned being caught between community members trying to have their current needs met and LHD leadership or elected officials with different goals for public health services directing them otherwise. It is recommended that LHDs critically examine and challenge current public health practices in the face of continued health disparities in parallel with the crucial efforts of traditional programs. One example raised is that poor birth outcomes are determined by a lifetime of inequity of the parents, not just the mother’s condition during the perinatal period where the traditional maternal and child health program (MCH) is focused. This means that LHDs should continue to support direct MCH services while working to address broader

policy issues that could improve both birth and social outcomes.

Policy work as an upstream practice is seen as having the greatest potential for large scale change to improve health equity. From this broader perspective, best practices in policy were described as cross-departmental collaborations within and between county institutions that are currently addressing health inequities. Examples mentioned in the focus groups include LHDs working with:

- Planning departments to develop appropriate zoning restrictions to limit liquor outlets
- Public works to address mobility and road conditions in low-income areas
- Housing authorities to address insufficient affordable housing and inequities in public housing
- Transit agencies to increase access to public transportation in isolated and low-income areas
- Educational agencies to improve school-linked services

In one county, the LHD worked with the planning department to build senior housing near public transportation. In another county, the LHD played a major role in saving an affordable housing establishment.

Even with the struggle to balance upstream and downstream work, the intention to eliminate health inequities was a shared value by LHDs and community agencies. A few LHDs were part of the creation of formal, internal and/or countywide, health equity groups – some which have since been inactive or disbanded due to budget cuts or the lack of a local champion to keep making its efforts a priority. The importance of these health equity work groups are to provide venues for challenging discussions regarding race/ethnicity, language access, physical and mental abilities, gender, sexuality, poverty, place-based health, and other issues of societal discrimination that contribute to health outcomes. The California

Newsreel series titled *Unnatural Causes* (<http://www.unnaturalcauses.org>) was also used in several counties to help promote these types of intentional dialogues with LHD staff, key stakeholders and policy makers about the inequities in social determinants seen in their jurisdictions. As more in-depth information-sharing such as this happens between communities and the LHD, and parallel community-organizing efforts are made to increase civic engagement, healthy policy advocacy efforts can be enhanced.

One community agency representative in Santa Clara County posed some poignant questions to consider related to upstream approaches, *“They never give you enough (money) and they never give it to you long enough, and so then you’re in this constant cycle of trying to fix a problem...And so in my mind it’s really trying to say how would we get upstream and really look at what does the vision look like? And then what is the framework for action that will get us to that vision? Not what is the strategic plan that will do it, but what’s even higher than that, what’s the framework? What do you have to do to move a movement to be able to capture this vision? And then how do you articulate that plan into advocacy steps that a community can actually do?”* (Santa Clara County community agency representative)

Role of Public Health

The role of public health in creating health equity remains unclear and varies between jurisdictions. At the heart of this issue is finding balance between traditional public health charges along with direct public health services to meet basic community needs and upstream policy work to influence the social determinants of health and health equity. One of the main challenges in LHDs addressing these upstream factors is the limited funding structure of categorical programs in public health. Not only have many LHDs lost significant funding overall in the recent economic downturn, but they also have restrictions on how staff time and budgets are used based on existing, condition-specific programming. Funds received by LHDs from government and foundations alike are generally linked

to specific categorical program activities and outcome measures vs. being able to use these resources to develop or build upon broader social determinant and health equity work across sectors.

The ability of LHDs to improve health equity is further limited in scope due to a lack of integration and partnerships with different county sectors, insufficient public-private partnerships and geographic boundaries. Some community agencies perceived that one role of LHDs is to provide technical assistance to community agencies in order to procure funding and adhere to those funding requirements, as these agencies saw themselves as partners that contribute to the LHD connections with community and the ultimate outcomes of LHDs. Although not all LHDs have the resources to provide this level of technical assistance to partnering community agencies, these partners may still expect and/or rely on LHD expertise to be successful.

Participants also mentioned the challenge that public health has of being somewhat invisible in regards to the breadth of services it provides and the general lack of understanding in the community about all the programs and policies that LHDs develop and implement. One Santa Clara County public health staff member stated, *“People don’t know what public health is, and you ask anybody on the street, they probably will tell you their restaurant inspections is actually what they do.”* (Santa Clara County local health department staff)

Lastly, due to the overwhelming nature of multiple inequities in the social determinants of health, the issue

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of a desensitization of some inequities was mentioned across the region. For example, both community agency and LHD participants shared their concerns with a *“business as usual”* approach to public health that ignores consistent and pervasive issues related to violence, poverty and discriminatory policies that contribute to health inequities.

Leadership Support for Health Equity Efforts

The level of leadership support in LHDs for health equity varies widely and often fluctuates when there are changes in personnel. Consistent champions for health equity and community engagement among LHD staff leadership, especially senior managers, are essential to ensure health equity work is sustainable, supported by general funds, and remains a priority. When lacking leadership support, LHD staff can feel pressure to work *“under the radar”* and outside of the official role of public health in order to work in collaboration with communities for their needs. LHD staff may be limited to typical working week hours (i.e. 8 a.m. to 5 p.m. Monday through Friday) or face other limitations – from unions or other institutional structures – which can create barriers to community engagement. Even when leadership support exists, there may be no departmental infrastructure or resources for joint health and wellness efforts working to address the social determinants of health and increase health equity. In addition, LHDs often lack systematic, professional development opportunities for public health staff to create understanding of health equity and cultural humility.

Best practices in leadership support in this area include:

- community-friendly, flexible work schedules
- educating funders about the importance of non-categorical funding
- incorporating health equity into formal LHD documents and strategic plans
- using general funds for health equity work
- providing ongoing opportunities for dialogues (i.e. brown bags) on the roots of social inequities
- requiring training for staff on the relationship between inequities and public health outcomes
- supporting cross-sector, collaborative efforts in increasing equity in the social determinants

- Engage partner to include health considerations in all policies (i.e. land use zoning, transportation, criminal justice)
- Institutionalize professional development for staff regarding SDOH and health equity
- Partner with communities to mobilize and create more cohesion
- Prioritize community capacity-building and leadership development
- Prioritize health equity work in LHD strategic planning
- Provide community-based, culturally appropriate services
- Provide flexibility in staff time and priorities to allow for effective community and health equity work
- Provide technical assistance to community agencies
- Support more flexible funding with categorical program funders to address the social determinants of health and health equity
- Work across City/County departments and disciplines to address health inequities

Summary of Results and Recommendations

The following list of recommendations consists of the highlights from the data provided in this report. Local health departments are encouraged to critically look at their current practices and strategic plans to incorporate as much of these upstream, community-building and health equity focused strategies as possible in order to address the underlying conditions that affect the common disparate health outcomes seen in our communities (listed in alphabetical order):

- Assist community agencies to work with and within government systems
- Build meaningful, on-going relationships with community partners
- Create collaborations and partnerships with LHD and community agencies
- Elevate and foster champions of health equity work
- Engage community partners in all steps of the program planning

The results summarized in this BARHII report are based purely on the qualitative data from 39 focus groups held in 2009-2011. In order to more completely assess the strengths and areas for improvement in the efforts of LHDs to increase health equity and community engagement, BARHII recommends the implementation of the Organizational Self-Assessment for Addressing Health Inequities Toolkit. This toolkit, available as a free PDF download (<http://www.barhii.org/resources/toolkit.html>), includes information on how to assess and work to improve both the organizational and staff capacity to better address health inequities. In addition, the community survey template provided in this toolkit is a great resource for incorporating more health equity and social determinant measures into mandated hospital community assessments and public health department

accreditation processes.

One final recommendation BARHII has for the usage of these data is to share this Regional Summary Report and/or your own local health jurisdiction's individual BARHII Health Equity and Community Engagement Report with the community agencies who participated in the assessment and additional, key community partners. By coming together and sharing this information, health department and community agency staff can discuss how far along they have come since these data were collected a few years ago and where crucial gaps remain in local community engagement and social determinants of health efforts. Together, the LHD and partnering community agencies can develop a plan for improving on these strategies to meet their common goals to improve health equity and improve the quality of life of all their residents.

Participating Public Health Departments and Community Agencies

ALAMEDA COUNTY

Alameda County Public Health Department

<http://www.acphd.org/>

East Bay Asian Youth Center

<http://www.ebayc.org/>

Healthy Oakland

<http://www.healthycommunities.us>

Youth Uprising

<http://www.youthuprising.org/>

CITY OF BERKELEY

City of Berkeley Department of Health Services, Public Health Division

<http://www.ci.berkeley.ca.us/publichealth/>

Berkeley Alliance

<http://berkeleyalliance.org/>

Berkeley Organizing Congregations for Action

<http://www.berkeleyboca.org/>

Berkeley Youth Alternatives

<http://www.byaonline.org/>

Life Long Medical Care

<http://lifelongmedical.org/>

MARIN COUNTY

Canal Alliance

<http://canalalliance.org/>

Canal Welcome Center

<http://www.cwcenter.org/>

Marin City Health and Wellness Clinic

<http://www.marincityclinic.com/>

Marin Community Clinics-Novato

<http://www.marinclinic.org/>

Marin County Health and Human Services

<http://www.co.marin.ca.us/depts/HH/Main/index.cfm>

Marin County Health and Wellness Campus

<http://www.co.marin.ca.us/campus/>

Novato Youth Center

<http://www.novatoyouthcenter.org/>

San Geronimo Valley Community Center

<http://www.sgvcc.org/>

NAPA COUNTY

American Canyon Family Resource Center

<http://americancanyonfrc.org/>

Calistoga Family Center

<http://www.calistogafamilycenter.org/>

Napa County Health and Human Services, Public Health Division

<http://www.countyofnapa.org/publichealth/>

On the Move

<http://www.onthemovebayarea.org/>

SAN MATEO COUNTY

African American Community Health Advisory Committee

<http://aachac.org/index.html>

El Granada Mobile Home Park

<https://www.facebook.com/pages/El-Granada-Mobile-Home-Park-California/106554439377970>

One East Palo Alto

<http://www.onepa.org/>

Pacific Islander Initiative and Mana

<http://smchealth.org/PI>

<http://smchealth.org/Mana>

Puente del la Costa Sur

<http://puentedelacostasur.org/>

Redwood City 2020

<http://www.rwc2020.org/>

San Mateo County Health System

<http://smchealth.org/>

SANTA CLARA COUNTY

Health Trust

<http://www.healthtrust.org/>

South County Collaborative Gilroy

277 Loof Avenue, Room 1, Gilroy, CA 95020

(408) 776-6228

Asian Americans for Community Involvement

<http://aaci.org/>

Santa Clara County Public Health Department

<http://www.sccgov.org/sites/sccphd/en-us/Pages/phd.aspx>

SANTA CRUZ COUNTY

Health Improvement Partnership

<http://www.hipsc.org/>

Pajaro Valley Community Health Trust

<http://www.pvhealthtrust.org/>

Santa Cruz County Community Foundation

<http://www.cfsc.org/>

**Santa Cruz County Health Services Agency, Public Health
Department**

<http://www.santacruzhealth.org/phealth/2pht.htm>