# Advancing Health Equity Awards 2017 Application

As you answer the questions below, please describe the strategies you used, including, for example, research and data, evaluation, advocacy, leadership and capacity building, and communications.

Note that while we expect that some award recipients will have strong answers to all the application questions below, we also expect that other award recipients will have strong answers to only a subset of the questions.

Please respond to each question in no more than 500 words.

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## Profile of Candidate Public Health Department

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## Practice

These questions are intended to:

1. Provide the reader with a brief overview of the practice specifically through a health equity lens.

2. Draw out examples of health equity practice that attempt to use public health resources, expertise and perspectives to directly address social inequalities and not just their consequences (for example, equity in economic development, gentrification and displacement, wages, structural racism in education, gender pay equity, etc.). While much of contemporary public health practice helps to improve daily living conditions in low-income areas, significant differences in life expectancy persist between communities. We are looking for practices that explicitly link to the social inequalities that produce and perpetuate such great differences.

3. Provide the reader with an understanding of how and why the process was prioritized. For example, community residents may have been asked what issues, policies, and/or plans are affecting their lives and health, or data analysis within the health department may have led to the genesis of the work.

Briefly describe the practice for which your public health department is submitting. * How does the practice* attempt to address: a) The Social Determinants of Health (e.g., housing, transportation, employment, education, criminal justice, physical environment); and/or b) The Social Determinants of Health Equity (e.g., power relations and social inequalities – economic inequalities, racism, gender inequity, disenfranchisement, etc.)? What innovative quantitative or qualitative data or approaches informed the decision to prioritize this practice? If your submission is based on one project, please describe how this project is connected to other projects and programs across your department. *Practice refers to a set of programs, projects, policies, strategies, tactics, or initiatives implemented by the public health department.

One of Monterey County's key strategic initiatives listed in its 2017-2018 Legislative Platform states, in part, that "promoting access to equitable opportunities for healthy choices and healthy environments in collaboration with communities" is a priority. This statement by the governing body of our County and the underlying values it communicates represents over five years of hard work spearheaded by the Monterey County Health Department (MCHD). In fact, MCHD has been working towards achieving health equity – where everyone has the opportunity to attain their highest level of health -- for some time now, as exemplified by an ever-increasing number of the programs, projects, policies, strategies, tactics, and initiatives hawse have implemented and championed
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The primary way in which MCHD has supported its mission to improve the health of all residents is by intentionally expanding upstream work on the social determinants of health through adopting a Health in All Policies (HiAP) framework. Since 2012, MCHD

has been using HiAP with a Collective Impact approach to further this work, including staffing and funding support for a department 'backbone'. MCHD developed a stronger county-wide commitment to health equity both within the department and outside with stakeholders by using five key HiAP elements: (1) Promoting incorporation of HiAP into policies, programs, and processes and embedding HIAP into government decision making; (2) Fostering intersectoral collaboration; (3) Creating co-benefits; (4) Engaging stakeholders; and (5) Creating structural change.

MCHD incorporated health equity throughout the department and with partners using planning documents required for national public health accreditation, including the MCHD Strategic Plan (2011), the Community Health Assessment (CHA, 2014), and the Community Health Improvement Plan (CHIP, 2014). The Strategic Plan, approved by the Board of Supervisors in December 2011, presented HiAP as the strategy to work on upstream processes with stakeholders. The CHA demonstrated statistically significant county health inequities and disparities while the CHIP provides alignment of many major county health-related initiatives around health equity.

One program that particularly exemplifies MCHD's focus on promoting health equity, and specifically on social determinants of health equity such as power relations and social inequities like disenfranchisement, is the enLACE Leadership and Civic Engagement Academy. enLACE is offered by MCHD to community residents interested in exploring the importance of civic engagement and its relationship to the health and well-being of the community. enLACE, which means "to link or connect" in Spanish, provides community members an opportunity to learn more about leadership and provides the tools to encourage participants to engage in the processes needed to make positive and healthy changes in their communities. The 8-week program was started based on research that an engaged community is a healthy community, and it addresses topics such as local government decision-making and budget processes, and prevention and safety issues.

In choosing locations in which to offer the enLACE Academies, MCHD has focused on communities which have typically been underserved in our county, such as the primarily Latino neighborhood of East Salinas, the more rurally located King City, and Seaside, where living close to the beach has unfortunately not provided protection from the encroachment of gangs. In choosing the primary language in which to deliver these classes, MCHD chose to offer six out of eight sessions in Spanish, as almost 58% of our county is of Latino origin and over 53% of households speak a language other than English at home. (See US Census, QuickFacts for Monterey County, California)

enLACE is a relatively new program for MCHD, but we are hopeful that enLACE participants will not only go on to become more actively engaged in their individual neighborhoods but will also join some of the local community coalitions and collaboratives with which MCHD presently works and upon which MCHD relies for help and input when making programmatic and policy-oriented decisions.

## Community

The question is trying to draw out:

1. Who in the community is authentically engaged and the ways in which the public health department is working with communities to advance strategies external to the health department, as compared to strategies focused within the health department, that can greatly influence the policies and practices that affect health equity.

2. How the leadership of the health equity practice is being carried out and how that got decided. Is the work being used, for example, to build community leadership capacity and power through shared decision making?

3. Whether the practice is building a base for potential future work that might not be directly related to the current example.

How is the community involved in this practice? *

a) With whom in the community – residents, community-based organizations, community advocates, leaders , etc. – are you working? b) When and how did community members become involved in the project or practice? What roles are community members playing? c) How has the practice led to the development or strengthening of substantive, trusting relationships with the community? What steps are being taken to institutionalize these relationships? d) How is decision making shared with community members? Is the public health department in the lead, is it shared leadership or does the public health department participate under the leadership of others? How were the decisions about leadership made?

MCHD works with a remarkable number of different community coalitions and collaboratives. For example, we regularly work with Impact Monterey County, Community Alliance for Safety and Peace, and the Coalition for the Prevention of Senior Homelessness. Each of these different groups contain representatives from a cross section of the community, such as seasoned, research-oriented university administrators, social workers versed in dealing with the chronic challenges faced by people who are homeless, and electeds, who are often more conscious of the sensitivities of their constituents than their rhetoric may claim.

Frankly, MCHD has long realized the benefit of partnering with outside organizations and individuals to gain additional perspectives. As a result, when we approach these different groups with requests for data or support on a grant application, we receive enthusiastic, forthcoming responses more often than not.

MCHD decides to use and/or suggests using different leadership models depending on the characteristics of the given group we are working with at the time. For example, after conducting a series of listening sessions throughout the county in 2014, it became clear to the staff of our Behavioral Health Bureau that one of the biggest gaps in service

we faced was the lack of mental health and substance abuse treatment for residents of south Monterey County. Once the need was clearly identified, a grassroots group of nonprofit providers, government officials, and community members formed and has been meeting regularly ever since to share information and work on solution-oriented ideas. In an effort to enhance the reach and effectiveness of this group, MCHD took on the administrative duties of this group but left the governance to the discretion of the group members themselves. We are excited that this group recently agreed to become the oversight board for any work we will take on should we be awarded a $6 million grant we recently requested, aimed at providing diversion and prevention services to vulnerable individuals embroiled in the justice system.

## Power Building

Building community power can include increasing community influence over decisions being made and building stronger alliances between organizations that can help inform and set the political agenda. How does your practice build community power? For example, it might include specific examples of: community members taking action; leadership training you did for members of communities facing inequities or how you built their skills to analyze the power, policy, and historical context of decisions; changes in agency oversight [e.g., a new Community Advisory Board) that resulted from the work; shifts in the culture within institutions so that they consider community knowledge as evidence; alliances between organizations that are addressing inequities in their work that were built; or social justice movements that you supported that may not have originated as health promoting strategies (e.g., minimum wage increases, anti-displacement campaigns)].

How are you using this practice to build power in communities facing inequities so they have more control over the decisions that affect their lives? What steps were or are being taken to develop cross-organization alliances with social justice organizations and/or to support social justice movements? *

As has already been mentioned in the answers to the previous questions, MCHD made a focused commitment several years ago to furthering the influence and level of engagement of communities facing inequities in our county. Our enLACE Leadership and Civic Engagement Academies teach people previously unfamiliar with leadership and organizing principles about how to be effective changemakers. We have strategically placed representatives from MCHD on a wide range of local coalitions and collaboratives working to move the needle on inequities. We have also made sure that our MCHD representatives take on different roles in these coalitions and collaboratives, as best suits the needs of the group.

One example, again, as mentioned in our answer to Question 2 above, is how MCHD has worked with the members of the South County grassroots group dedicated to addressing the lack of mental health and substance abuse treatment in their region. In assessing the dynamics of this group, it became clear that the most useful services

MCHD could provide would be administrative in nature so as to alleviate the obligations on other members and free them up to take on more robust leadership roles.

Another example of our adaptability and intentionality when dealing with other agencies and organizations occurred this past year as part of the response efforts to AB82 and SB18, aimed at enhancing outreach to and enrollment and retention of those eligible for Medi-Cal. MCHD made a point of facilitating meetings between and engaging with community leaders and several well-established groups known for having gained the trust of local residents, including California Rural Legal Assistance (CRLA), Central Coast Center for Independent Living (CCCIL) and Communities Organizing for Relational Power in Action (COPA). We knew that our strengths lay in helping to move processes forward, but that the grassroots efforts would be critical to making any true change. Together with these advocates we worked to have the Board of Supervisors approve and fund a $500K pilot project to provide critical medical services to the uninsured, including those who happen to be undocumented.

## Collaboration

Since much of health equity practice involves working in areas beyond the normal purview of public health departments, this question is trying to draw out ways in which health departments have been able to influence policies and practices in other public agencies or private institutions. Some of that influence may come from new or strengthened relationships and collaborations that can be leveraged to advance health equity. The answer could describe a discrete change in a policy or practice, or a change in the way decisions are made so they include considerations of health equity.
What public or private cross-sector collaboration are you building as part of this practice? How does that collaboration advance SDOH-related policy change or changes in public or private policies and practices? *

Health in All Policies (HiAP), which MCHD has been using since 2012, has been a catalyzing force for partnership development for numerous initiatives across Monterey County, as well as within the Health Department itself. Strategic partnerships have been developed with community-based organizations in the areas of public works, housing, transportation, and community empowerment. Community residents have been engaged with the aforementioned enLACE program, which is creating a growing cadre of alumni who are trained in how to be community change agents.

In the County, HiAP has: supported the work on social equity by the Non Profit Alliance of Monterey County, representing over 100 non-profit agencies, through several co-sponsored trainings; brought consultants to the table for several policy-related initiatives; supported staff who facilitated positive relationship-building around social determinants of health for the Economic Development Element and for juvenile justice issues in the City of Salinas; developed a collaborative process to build transportation infrastructure in five cities near schools in low income neighborhoods; created bridges for MCHD to provide health equity-related comments on county Planning Agency documents; and provided an avenue for creating more alignment of county goals

around equity by adding equity concepts to the county strategic initiatives and Legislative Platform. Due to this latter work at the county level, the County Administrative Officer recently approved the development of a county cohort to participate in the 2017 Governing for Racial Equity program.

Within MCHD, stronger collaborative relationships around policy development have been supported by the use of HiAP principles. As an example, MCHD coordinated a regional grant to CalTrans with all five Salinas Valley cities with the proposal to regionalize HiAP efforts through the advancement of active transportation in the cities of Salinas, Gonzales, Soledad, Greenfield and King City.

The institutionalization of HiAP within county and MCHD initiatives underscores the strong commitment from the County's governance team and the Director of MCHD as well as the governing bodies of partnering jurisdictions to continue developing HiAP principles and to use it for policy development within and throughout the County.

## Transformation

Advancing health equity can lead to significant change in the way a health department carries out its work, including its practices and policies. It can also lead to an increase in capacity – more staff understanding health equity and how to advance it in their work, leadership development, skill building, etc. These internal changes will primarily lead to further advances in health equity when they are used to create or leverage external change – change in the conditions that lead to health and health equity in the community.

How has working on this practice contributed to transforming your public health department or building internal capacity to address equity? How is this new internal capacity being used to initiate, influence, and drive changes external to the department that impact communities facing inequities? *

Since 2012, MCHD has been using HiAP with a Collective Impact approach to further its health equity efforts, including staffing and funding support for a department 'backbone'. MCHD developed a stronger county-wide commitment to health equity both within the department and outside with stakeholders by using five key HiAP elements: 1. Promoting incorporation of HiAP into policies, programs, and processes and embedding HIAP into government decision-making; 2. Fostering intersectoral collaboration; 3. Engaging stakeholders; and 4. Creating structural change.

MCHD incorporated health equity throughout the Department and with partners using planning documents required for national public health accreditation, including the MCHD Strategic Plan (2011), the Community Health Assessment (CHA, 2014), and the Community Health Improvement Plan (CHIP, 2014). The Strategic Plan, approved by the Board of Supervisors in December 2011, presented HiAP as the strategy to work on upstream processes with stakeholders. The CHA demonstrated statistically significant county-wide health inequities and disparities while the CHIP provides alignment of many

major county health-related initiatives around health equity, including cradle to career and early childhood development initiatives, a gang violence reduction plan, and a network focusing on alignments between partners to support a healthy, safe, and thriving Monterey County. Health Department staff work intentionally as part of these initiatives to ensure enhanced focus on communities facing inequities.

An opportunity to incorporate health more intentionally into a local city's general plan presented itself in 2013. With Building Healthy Communities (BHC) East Salinas as a partner, MCHD played a critical role in advocating for the incorporation of a "Quality of Life" section into the City of Salinas' General Plan Economic Development element. This FY 2013-2015 intersectoral collaborative process leveraged existing partnerships and created a more robust community participatory process resulting in a win-win for all partners. The success of this process has led to partnership in 2016 with Gonzales, another city in the county, to develop a Health Element Toolkit as part of creating a health element for the city's general plan. This is being accomplished through a shared health equity fellowship.

MCHD recognized HiAP and health equity education was required, both within county government and with community partners, to assure long-lasting partner engagement. From early 2012 to today, MCHD created and offers multiple internal and external intensive trainings and opportunities for engagement in health equity: all-staff meetings, health equity forums, a Health Equity Scholars Academy for MCHD staff, and a community social equity academy (a Leadership And Community Empowerment Academy or EnLACE). As part of the process for authentic and effective community engagement, MCHD supports multiple discussion opportunities for community and partner change regarding institutional racialization, implicit bias, and "re-authoring the narrative". These trainings and engagement opportunities have reached over 2,000 county staff and resident participants.

Because of HiAP trainings MCHD promoted among nontraditional stakeholders, MCHD was able to develop a collaborative process to incorporate health equity assessments in county Planning Department land use reviews. Projects for which health equity have been considered include alcohol outlet permit requests, wind energy health impacts, ground water extraction, and housing and transportation-related projects.

## Addressing Barriers

Advancing equity typically requires directly or indirectly addressing systems of power and privilege, which inherently requires overcoming constraints and taking strategic risks. It can also involve navigating complex political environments and conflicting agendas in order to build the will to tackle inequities. Strategic health equity practice includes understanding potential barriers and intentionally addressing them.*

*It is critical to hear honest feedback on the challenges of doing this work, in order to maintain the credibility of the most promising practices and the award itself. Applicants

are strongly encouraged to discuss the difficulties and any failures that can inform future practice.

Within your own local jurisdiction, what challenges, constraints, or risks have you and/or your health department had to navigate to advance a health equity perspective in your practice? What strategies are you using to address or overcome those constraints and/or conflicting agendas? *

MCHD has spent the last five years steadily working at educating the community about the importance of health equity and at incorporating more practices into our own internal processes to foster the growth of health equity principles and outcomes. We have definitely made some significant strides so far: (1) our County Board of Supervisors have made the achievement of health equity a strategic initiative/priority; (2) we have started our enLACE and ACOMI programs, creating dozens of community leaders each year who are versed in health equity practices; and (3) we have increased the involvement of MCHD in a variety of community collaboratives, leading to numerous opportunities to educate a broader spectrum of County residents in why health equity is important how to work more effectively towards achieving it.

We have been especially fortunate that all throughout our shift to a HiAP framework we have had the ardent support and encouragement from County electeds and our executives. This has allowed us to make strides in ways that some of our sister counties which have less supportive, if not obstructive, leaders, have not. We are also a relatively small County and so have benefitted from the ability to capitalize on the power of face-to-face communication, an invalable aid in influencing individuals.

But our efforts have not been without challenges. Namely, getting diverse stakeholders to understand their role in health, keeping them engaged, obtaining consensus on what to work on collectively, ensuring that diverse perspectives and experiences are respected and appreciated, identifying priority areas in spite of there being so much need and varying interests, and finding funding to sustain the work have all proved to be difficult to deal with at times.

Our critical take aways when facing any of these issues have been the need to start as early as possible on whatever is at hand and to get awfully comfortable seeing things from other people's/sector's perspectives. Both of those tips were learned somewhat the hard way back in 2013, when MCHD had the opportunity to work with other community partners in advocating for the incorporation of a "Quality of Life" section into the City of Salinas' General Plan Economic Development element. Learning how to have city planners start to see the benefits of including diverse perspectives as opposed to feeling that the inclusion of such viewpoints was unhelpful and simply added extra work was a true victory for all of us involved in this effort, including the planners and the City itself.

## Expanding Understanding

Disease, healthcare, the biomedical model, and individual behavioral change dominate people's current understanding of what public health is and does. Public health departments can actively work to expand the understanding of what creates health and health equity – the social determinants of health and health equity – both within the department and with community, agency, and elected partners. This work can involve harnessing the power of popular culture (e.g., using art, music, or videos), running a series of related community organizing campaigns, using mass or social media, and/or developing communications plans and messages.

In the context of this practice, how have you been working to change the understanding and discussion of what creates health and health equity among people in your community? What innovative communications strategies are you using to do so? *

HiAP was not generally known or understood by our non-traditional partners prior to our HiAP presentations to our County Board of Supervisors. Having HiAP as a Board of Supervisors' approved initiative, set the stage for MCHD to work more strategically to engage non-traditional partners in health equity. Although HiAP was a new concept, within two years it has influenced several key county policies and practices, including (1) incorporating health equity language in numerous county comment letters on environmental impact reports and the county's strategic initiatives, (2) incorporating a health Quality of Life section in the City of Salinas' General Plan Economic Development element, and (3) developing a deeper county commitment to community engagement principles among some county agencies, in particular those working in the justice domain. This was possible because MCHD created a strategic approach using best practices established by early HiAP practitioners and as referenced in the HiAP Guide for State & Local Governments including incorporating an educational and engagement component to the timeline. Having backbone staff and a mix of appropriations budget and grant funding support for the staff and the trainings they needed to hold was key to creating the dedicated staff time to do this work.

Another strategy MCHD employed was linked its HiAP work with the development of pre-requisites required for National Public Health Accreditation. At every opportunity during our accreditation pre-requisite development process we educated our health system partners about HiAP the power and influence it has on gaining health equity. HiAP was incorporated into the Mobilizing for Action through Planning and Partnerships process components of a Local Public Health Systems Assessment, the Community Health Assessment, and the Forces of Change Assessment enabling staff to use this framework to reinforce HiAP education efforts across many partners and other agencies.

MCHD created a HiAP Advisory Committee to provide oversight and momentum for engaging non-traditional partners. Committee members include representatives from the Association of Monterey Bay Area Governments, city and county planning staff, and the housing, transportation, and early childhood development nonprofit organizations.

The HiAP Advisory Committee meets monthly and hasprioritized needs and goals in four domains: housing, park & open space, economic development and civic infrastructure, and identified strategies to accelerate and track HiAP progress.

As far as what innovative communications strategies we are using, there are several which come to mind most immediately. We have added several aspects of telemedicine to our Clinic Services practices in recognition of rural patient transportation constraints. Second, we are in the process of adding regular Spanish language content to our social media communications. As mentioned in our response to Question 1, 58% of our county is of Latino origin and over 53% of households here speak a language other than English at home. (See US Census, QuickFacts for Monterey County, California). A scan of Spanish-language social media offerings showed limited Spanish-language social media offerings by other Health Departments in California That means that our Department intentionally providing content in Spanish is critical for us to be able to reach the widest audience possible, and in particular to those who have not typically been kept in the fold of decision-making and civic engagement efforts.

It has also been shown that lower income residents do not have access to computers in their homes with the same frequency as higher income people. But, cell phone usage is almost ubiquitous now, and the majority of cellphone users are using some version of a smartphone which is capable of accessing the Internet. Therefore, we have realized that it behooves us greatly to ensure that whatever content we put out is optimized for use on a mobile platform. We have recently invested, therefore, in Constant Contact, an online marketing program which provides pre-made templates and guides for creating “customer” communications that are optimized for use across a multitude of platforms, including a particular focus on mobile compatibility. We believe that the combination of educating our staff who create communications content about customer relations together with the technological streamlining capabilities will not only make our communications stand out and be that much more appealing and memorable, but be more usable by communities experiencing inequities.

## Lessons Learned

The purpose of the health equity award process is to recognize examples of practices that can be adapted by other public health departments. This question is asking the nominees to reflect on how their experience might inform others who are interested in doing similar work. We recognize that some of the best lessons are learned from our mistakes and we encourage incorporation of those here. For example, what did you learn about core internal capacity building needs, building external partnerships, or how to make institutional policy and practice changes? What would you do differently or warn others about?

What lessons does your experience provide for your and other public health departments? *

The lessons we have learned about the challenges of making progress through a group process as well as of communicating effectively with vastly different audiences have taught us quite a few things. First of all, the adages to “take a breath and then speak” and “you catch more flies with honey than with vinegar” have proven invaluable. We believe that taking an approach of teaching our representatives to be patient and humble when communicating with diverse groups has led to MCHD being received more favorably and perceived as having more gravitas than if we came in insisting on being the sole authority in the room.

In addition, paying close attention to our demographics has taught us the importance of adjusting our communication strategies accordingly. Technology is changing rapidly, so we have been incorporating the use of additional social media platforms as they gain in popularity. We also have recognized the utility of providing bilingual content in our social media campaigns. We are confident that investing in the quality and variety of the communications that come out of our office will reap rewards in terms of how we are perceived and therefore in our ability to spread the word about the importance of health equity and how to work together to achieve it.
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