COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

2015

HEALTH EQUITY PLAN

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
DIVISION OF PUBLIC HEALTH SERVICES

This icon indicates that the plan being read is the County of San Diego's Health and Human Services Agency, Division of Public Health Services Health Equity Plan.

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This Health Equity Plan was developed under the Public Health Services Strategic Plan of the County of San Diego, and in support of the *Live Well San Diego* initiative. This plan was developed with support of the National Public Health Improvement Initiative.

LETTER TO READER

Dear Reader:

On behalf of the Division of Public Health Services (PHS) in the County of San Diego Health and Human Services Agency (HHSA), it gives me great pleasure to present the first Public Health Services Health Equity Strategic Plan 2014-2019. This document compiles the goals, strategies, and objectives taken by the PHS Division of HHSA to achieve health equity in San Diego County. Activities embodied in this document are reflective of the commitment and dedication to address disproportionality of health status and mortality rates in San Diego County by the staff of PHS Administration and its six branches that include Emergency Medical Services; Epidemiology and Immunization Services; HIV, STD, and Hepatitis; Maternal, Child, and Family Health Services; Public Health Nursing Administration; and Tuberculosis Control and Refugee Health.

As with all strategic plans, this is a living document that will be implemented, monitored, and updated annually to ensure that the Division is making progress, while supporting the vision and mission of the County of San Diego and the *Live Well San Diego* initiative. Our plan also aligns with the World Health Organization recommendations, Healthy People 2020, Office of Minority Health National Stakeholder Strategy to Achieve Health Equity, the National Association of County and City Health Officials Guidelines for Achieving Health Equity in Public Health Practice, the California Conference of Local Health Officials Framework for Local Health Departments Introduction to Health Equity Practice, and the *Live Well San Diego* Community Health Improvement Plan.

Additionally, it is anticipated that this document will be useful to local community partners and stakeholders that are striving to achieve health equity for all San Diegans. It is with this sense of duty and responsibility that we are indeed committed to the vision of health equity for all San Diego County residents.

Please take the time to review this plan and feel free to provide comments to my office.

All the best to you,

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER
DIRECTOR, PUBLIC HEALTH SERVICES

*Any word(s) that are in blue **and** underlined link to websites when the County of San Diego's Health and Human Services Agency, Division of Public Health Services Health Equity Plan is being viewed digitally.*
Example: Public Health Services

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INTRODUCTION

The Institute of Medicine defines public health as "what we as a society do to collectively assure the conditions in which people can be healthy".[1] In order to realize these conditions, health departments must address the root causes of health inequities, which can also be attributed to the social determinants of health. The Centers for Disease Control and Prevention (CDC) defines the social determinants of health as "the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world".[2] Addressing the social determinants of health has become an initiative at the global, national, federal, state, and local levels of healthcare and public health organizations.

EFFORTS AT THE GLOBAL LEVEL

At the global level, the World Health Organization's (WHO) Commission on Social Determinants of Health has set forth three overarching recommendations in it's final report launched in August 2008:

- Improve the conditions of daily life—the circumstances in which people are born, grow up, live, work, and age;
- Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally; and
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health[3].

Each recommendation is accompanied with actions to ensure an impact and sustainability over time.

EFFORTS AT THE FEDERAL LEVEL

At the federal level, the U.S. Department of Health and Human Services developed national guidelines, Healthy People 2020 (HP 2020), to address health issues, in addition to health disparities, across the nation. HP 2020's vision is "a society in which all people live long, healthy lives" and is directed towards achieving four goals: (1) Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) Achieve health equity, eliminate disparities, and improve the health of all groups; (3) Create social and physical environments that promote good heath for all; (4) Promote quality of life, healthy development, and healthy behaviors across all life stages[4]. HP 2020 includes a new topic, Health-Related Quality of Life and Well-Being, with a goal set forth to improve health-related quality of life and well-being for all individuals[5].

The Office of Minority Health (OMH) National Stakeholder Strategy to Achieve Health Equity[6] provides a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities achieve their full health potential. The National Stakeholder Strategy was based on the process of community and stakeholder collaboration. The plan includes five goals: (1) Awareness; (2) Leadership; (3) Health System and Life Experience; (4) Cultural and Linguistic Competency; and (5) Data, Research, and Evaluation. Along with the five goals, the plan includes 20 strategies for action to end health disparities (Appendix A).

EFFORTS AT THE STATE LEVEL

The California Department of Public Health (CDPH) Office of Health Equity (OHE)[9] was established by Section 121019.[5] of the California Health and Safety Code, to provide a key leadership role to reduce health and mental health disparities within vulnerable communities and is comprised of three units: (1) Community Development; (2) Policy Unit; and (3) Health Research and Statistics Unit. The office provides support to maintain and improve partnerships across sectors, consulting with community-based organizations and local governmental agencies. OHE is responsible for the following:

- Achieve the highest level of health and mental health for all people.
- Work collaboratively with the Health in All Policies Task Force.
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

The California Conference of Local Health Officials (CCLHO) Framework for Local Health Departments Introduction to Health Equity Practice[9] was developed in 2010 by the former President, Wilma J. Wooten, M.D., M.P.H (Appendix C). The framework identifies four domain areas: (1) Organization; (2) Workforce; (3) Community; and (4) Data, Evaluation, and Dissemination. These are categorized as internal transformation and/or external transformation efforts (Appendix C). Each domain area is aligned with the WHO Commission on Social Determinants of Health, the OMH National Stakeholder Strategy to Achieve Health Equity, and the NACCHO *Guidelines for Achieving Health Equity in Public Health Practice*. The CCLHO framework served as a guide when developing the Public Health Services (PHS) Health Equity Strategic Plan.

EFFORTS AT THE LOCAL LEVEL

Alameda County has made great strides to address the root causes of health inequities. In 2008, Alameda County Public Health Department implemented the 2008–2013 Health Equity Strategic Plan to eliminate health inequities, which addresses six strategic directions:

1. Transform organizational culture and align daily work to achieve health equity;
2. Enhance public health communications internally and externally;
3. Ensure organizational accountability through measurable outcomes and community involvement;
4. Support the development of a productive, creative, and accountable workforce;
5. Advocate for policies that address social conditions impacting health; and
6. Cultivate and expand partnerships that are community-driven and innovative.

The Alameda County health department launched the Place Matters and City County Neighborhood initiatives, developed a Public Health 101 Training Curriculum, dedicated a health equity website, and created a Health Inequities Report.

The Bay Area Regional Health Inequities Initiative (BARHII) is a national leader in transforming public practice to advance health equity to create healthier communities. BARHII is a collaborative of public health directors, officers, senior managers and staff from the eleven San Francisco Bay Area health departments and the California Department of Public Health. BARHII shares lessons learned and developed strategies and resources and established committees focused on data, community engagement, built environment, social determinants of health, structural racism and building health departments' capacity.

COUNTY OF SAN DIEGO

In 2001, recognizing health inequities across specific populations, the County of San Diego PHS developed the Reduce and Eliminate Health Disparities with Information Initiative (REHDII). This initiative's goal was to document local gaps, and develop strategies, to address the following six federal health priority areas: 1) cancer screening and management; 2) heart disease and stroke; 3) diabetes; 4) HIV and AIDS information; 5) Immunizations; and 6) infant mortality.

In the Spring of 2004, PHS formed a Chronic Disease and Health Equity Unit devoted to the promotion of wellness and prevention of illness, disability and premature death due to chronic diseases and health disparities. The unit focuses on encouraging county residents to make healthful lifestyle choices that will lead to increased healthy eating and physical activity; increased safe behaviors and environments; reduced tobacco use and exposure; increased use of recommended preventive health care and quality health care treatment; and collaboration with community partners to reduce health disparities. The unit partners with state and local stakeholders to address chronic disease and health equity, including, but not limited to, California Department of Public Health, Childhood Obesity Initiative, local cities, First 5 San Diego, Tobacco Control Resource Program, San Diego Association of Governments, and schools.

In 2010, the County of San Diego Board of Supervisors adopted *Live Well San Diego*, a long-term initiative (Appendix D). *Live Well San Diego* includes three components: Building Better Health, Living Safely, and Thriving. The Building Better Health component was designed based on the 3-4-50 concept, signifying that three behaviors contribute to four diseases – cancer, heart disease and stroke, type 2 diabetes, and respiratory conditions – which result in more than 50 percent of all deaths in San Diego.

The Building Better Health component was approved by the San Diego County Board of Supervisors and launched in October 2010. The four goals for this component calls for:

- Building a better service delivery system through partnerships with hospitals, clinics and other health care providers;
- Supporting positive choices, so that residents take action and responsibility for their own health;
- Pursuing policy changes for a healthy environment by creating environments that support health so that the healthy choice is the easy choice; and
- Changing the culture from within, encouraging County employees to become role models.

In 2010, PHS staff participated in the Public Health Institute (PHI) second cohort of the California/Hawaii Public Health Leadership Institute (CHPHLI), focused on health equity. In 2011 and 2012, PHS staff attended the CHPHLI second and third annual statewide health equity conferences.

In 2012, PHS was able to assess the County of San Diego Health and Human Services Agency (HHSA) 5,400 plus staff members on skills and organization practices and infrastructure needed to address health equity. The Health Equity Assessment was separated into three parts to provide information on which areas to target in order to ensure that staff is able to address health equity. The organizational self-assessment was based on a best practice from BARHII. In preparation for the national public health accreditation application to the Public Health Accreditation Board (PHAB), PHS utilized the Health Equity Assessment tool to direct the Division to develop a Health Equity Strategic Plan. BARHII states that the self-assessment is intended to serve the health department in the following ways:

- Serve as the baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities;
- Inventory the presence of a set of research-based organizational and individual traits that support the ability to perform effective health equity-focused work;

- Provide information to guide strategic planning processes and/or the process of developing and implementing strategies that improve capacities; and
- Serve as an ongoing tool to assess progress towards identified goals developed though the assessment process.

The BARHII Local Health Departments Organizational Self-Assessment for Addressing Health Inequities Toolkit and Guide to Implementation includes the staff survey questions that were utilized for the HHSA assessment. The toolkit can be found on the following link: http://www.barhii.org/resources/toolkit.html

In August 2012, following the CHPHLI third annual state-wide health equity conference, PHS formed the Health Equity Committee to develop a Health Equity Strategic Plan and further thread health equity activities throughout the six Branches. Since 2012, the committee has continued to meet on a monthly basis. In December 2012, the PHS Epidemiology and Immunization Services Branch (EISB) piloted the National Association of County and City Health Officials (NACCHO) Roots of Health Inequities online training. The training is comprised of five units: 1) Where Do We Start, 2) Perspectives on Framing, 3) Public Health History, 4) Root Causes, and 5) Social Justice. More than 40 EISB staff was randomly assigned to workgroups with an intention to discuss ideas together as they progressed through the training over the course of six months.

In July 2013, the PHS Health Equity Committee implemented a Team Charter to track activities for five priority areas.

In December 2013, PHS launched the Health Equity initiative with the support of the Health Equity Committee at the Annual All-Staff meeting with nearly 500 staff in attendance. PHS invited guest speaker, Dr. Anthony Iton, to provide an overview of health equity and the accomplishments of Alameda County Public Health Department since the implementation of their Health Equity Strategic Plan. PHS Branch Chiefs provided an overview of their program accomplishments in regards to health equity to highlight how staff has contributed to the initiative.

In October 2014, the County of San Diego Board of Supervisors adopted the third component of *Live Well San Diego*, Thriving, which encompasses a broad range of areas that are interconnected and foundational to the quality-of-life for everyone in the region. The third component of *Live Well San Diego*, Thriving, requires a high degree of partnership between government, stakeholders and the community to work together in effective and creative ways to achieve success. The Thriving initiative focuses on cultivating opportunities for all people and communities to grow, connect, and enjoy the highest quality of life. Ultimately, thriving is when our residents are engaging, connecting, and flourishing. A Thriving plan was created to outline a multi-year strategy focusing on Built and Natural Environment, Enrichment, and Prosperity, Economy and Education. Within these broad focus areas, the County and community stakeholders have developed goals and strategies to work on transportation, built environment and neighborhoods, housing, natural environment, civic life, community activities, workforce and economic development. The Thriving plan promotes stronger collaboration and coordination throughout the region among all stakeholders. It embodies a stakeholder-driven approach from start to finish including planning, prioritizing and implementing. Implementation requires leadership, participation and action from all sectors of the community including public, private, philanthropic, and non-profit organizations.

HEALTH EQUITY DEFINITIONS

What Are Health Disparities?
Although the term "disparities" often is interpreted to mean racial or ethnic disparities, many dimensions of disproportionality exists in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

What Are Health Inequities?
Health Inequities are differences in health status and death rates across population groups that are systematic, avoidable, unfair, and unjust.

What Is Health Equity?
Health Equity is when all groups in a population have equal, fair, and just opportunities to attain their full health and well-being potential and quality of life.

What are Social Determinants of Health?
Social determinants of health are the conditions in which people are born, grow, live, work, and age (i.e., poverty, air quality, schools, parks, jobs, and housing conditions). Poverty and education are two social determinants of health that have the greatest impact on health.

What Is Built Environment?
Built Environment refers to physical settings for activity, ranging in scale from buildings and parks to neighborhoods and cities.

What Is Social Justice?
Social Justice refers to social, economic, and democratic fairness and equality. When there is social justice, all people are able to participate fully in society; have equal access to resources, public goods and life opportunities; and are free from discrimination on the basis of race, gender, class, sexual orientation, and other factors.

HEALTH EQUITY DATA

The health of most Americans has improved in the past century; however, some groups continue to experience a disproportionately higher burden of morbidity and mortality.

Nationally, there are differences in rates of disease, death, and lifestyle behaviors that ultimately contribute to the development or prevention of disease. These differences, or health disparities, exist between genders, among racial/ethnic and age groups, geographic location, socioeconomic status, disability, and sexual orientation.[10]

In the United States:

- The rate of death due to coronary heart disease was 44.7% higher among males compared to females in 2009.[10]
- The rate of suicide was significantly higher for persons living in the western United States in 2010.[11]
- The prevalence of diabetes among adults was significantly higher among blacks and Hispanics in 2010.[10]
- The prevalence of asthma was higher among children compared to adults in 2010.[10]

Health equity is a key component of the *Live Well San Diego* vision. Addressing health disparities is essential in increasing and ultimately achieving health equity. Locally, health disparities exist among San Diego County residents. For example, in 2011, life expectancy was higher among females, Asians and Pacific Islanders, and residents living in suburban communities of the county.[12]

In San Diego County:

- Non-communicable (chronic) disease was higher among black and white residents, those aged 65 years and over, residents in very urban and rural communities of the county, and slightly higher among females.[13]
- Communicable disease was higher among females, black residents, those aged 15-24 years, and residents in very urban communities of the county.[13]
- Poor maternal and child health outcomes were higher among black and Hispanic residents, and residents in rural and very urban communities of the county.[13]
- Injury, overall, was higher among males, white and black residents, those aged 0-14 and 65 years and over, and residents in rural and very urban communities of the county.[13]
- Poor behavioral health outcomes were higher among black and white residents, those aged 45-64 years, and residents living in very urban communities of the county.[13]

HEALTH DISPARITIES AND INEQUITIES IN SAN DIEGO COUNTY

In developing the document, Identifying Health Disparities to Achieve Health Equity in San Diego County, all available data were analyzed through the lenses of age, gender, geography, race/ethnicity, and socioeconomic status to denote disproportionalities. Data available to analyze included reports, rates of death, hospitalization, emergency department discharge, incidence, and prevalence for 2011 were analyzed for non-communicable (chronic) disease, communicable disease, maternal and child health, injury, and behavioral health.

MEASURING PROGRESS TO ADDRESS HEALTH EQUITY

The County of San Diego Health and Human Services Agency (HHSA) developed a measurement tool, the *Live Well San Diego* Indicators[1], to evaluate whether the collective efforts under *Live Well San Diego* are truly improving the well-being of the region (Appendix D). The indicators are essential to measure progress to achieve health equity in San Diego County. The *Live Well San Diego* Indicators are part of a framework that can be summarized as "10-5-1": ten indicators that span five Areas of Influence (health, knowledge, standard of living, community, and social) that have an effect on or impact well-being. In selecting the Indicators and designing this framework, research was done to identify best practices and input was gathered from community representatives. The indicators were identified based on principles of simplicity, availability of data, and whether these Indicators can be used to capture well-being and social determinants of health across the life span of an individual-from children to adults to older adults.

The indicators consider the many different factors influencing how well a person is living in relation to the physical (built environment) and the social determinants of health. For example, where an individual lives correlates with his/her overall health and well-being (i.e., place matters). Therefore, the indicator framework consists of health outcome measures (downstream), as well as measures that address the social determinants of health (upstream). This framework enables County government to work with community partners to identify the most effective strategies to improve the health of all.

As the County of San Diego continues its journey of implementing *Live Well San Diego*, the indicators[1] will measure the improvements and successes of the initiative and its efforts to achieve health equity. In order to capture the progress, the County will identify measures, actions, and resources that contribute to improvement across the five Areas of Influence (health, knowledge, standard of living, community, and social). This includes reporting the indicators and underlying measures over time and by HHSA region and sub-regional areas, race/ethnicity, age and gender where data available to determine the health inequities between specific populations and develop strategies to achieve health equity.

Data are also documented in a report by the PHS Community Health Statistics Unit recently developed titled Identifying Health Disparities to Achieve Health Equity in San Diego County. This report describes health inequities through five lenses: age, gender, geography, race and ethnicity, and socioeconomic status.

METHODS

HEALTH EQUITY COMMITTEE FORMATION AND TEAM CHARTER

PHS established a Health Equity Committee (HEC) in August 2012 as part of the *Live Well San Diego* initiative's Building Better Health component. The HEC's initial goal was to develop a five-year Work Plan to address health inequities. The HEC meets on a monthly basis and includes representation from the PHS Branches.

Health Equity activities in PHS support HHSA's key Strategic Objective for Operational Excellence, which contributes to Healthy, Safe, and Thriving Communities. The HEC works to develop and implement the Team Charter and Health Equity Strategic Plan. The Charter is updated on an annual basis (Appendix E).

STRATEGIC PLANNING PROCESS

The County of San Diego launch of the *Live Well San Diego* initiative in 2010 opened the door to more closely explore disproportionality and health inequities among subgroups in San Diego. Using *Live Well San Diego* and the HHSA Strategic Agenda as the framework, PHS conducted a 16-month strategic planning process beginning in January 2013 to establish the Fiscal Years 2014–2019 Health Equity Strategic Plan (Volume I). The strategic planning process consisted of four phases with follow-up activities occurring between each phase: 1) Identify, Evaluate, and Summarize Trends; 2) Prioritize Issues; 3) Formulate Strategy; 4) Adopt and Implement Plan.

The HEC developed goals, strategies, and objectives that formed the Fiscal Years 2014 – 2019 PHS Health Equity Strategic Plan. Where appropriate, the Health Equity Strategic Plan was aligned with the World Health Organization recommendations, Healthy People 2020, Office of Minority Health National Stakeholder Strategy to Achieve Health Equity, the NACCHO Guidelines for Achieving Health Equity in Public Health Practice, the CCLHO Framework for Local Health Departments Introduction to Health Equity Practice, and the *Live Well San Diego* Community Health Improvement Plan. Naturally, this plan is a key component of the PHS Divisional Strategic Plan for the PHS Administrative Branch.

The process in developing Volume I was led by the PHS Administrative Office. The strategic planning team consisted of members from the PHS HEC and senior managers. The HEC included epidemiologists, health educators, public health nurses, program planners, and senior managers from each of the six Branches: Emergency Medical Services, Epidemiology and Immunization Services, HIV, STD, and Hepatitis, Maternal Child and Family Health Services, Public Health Nursing, and Tuberculosis and Refugee Health. The senior managers included executives, Branch chiefs, managers, and supervisors from the PHS Branches.

Phase I – Identify and Evaluate Trends

As part of Phase I, the HEC reviewed and discussed health equity trends and data. Beginning in January 2013, the HEC analyzed the 2012 HHSA Health Equity Assessment that was adapted from the BARHII Organizational Self-Assessment. Based on the initial analysis of the assessment results, the HEC identified that staff needed more educational opportunities regarding health equity. The HEC created a Cause and Effect Diagram to identify the causes of staff's misunderstanding of health equity (Appendix F). The root cause was: staff believes health equity is important; however, very few understand health equity or are supported in learning more about it or using it. Four major causes were identified: Knowledge, Leadership, People, and Support. Knowledge was identified as a major cause because PHS staff may need more training opportunities regarding health equity concepts, such as health disparities, health inequities, and social determinants of health. Leadership was identified as a major cause in regards to communication, culture, and management. People were identified as a major cause in terms of staff resistance to change and morale. Support was a major cause because of staff and organizational capacity.

Phase II – Organize Findings

After finalizing the Cause and Effect Diagram, Affinity Diagrams were created to identify and organize issues into groups in order to understand the challenge and develop solutions to "What gets in the way of addressing/achieving health equity?" (Appendix G). This process was conducted twice, once with the HEC and once with the Senior Managers, to gain a broader staff perspective of the challenges.

Phase III - Prioritize Issues

The HEC identified and prioritized solutions for the issues in the Affinity Diagrams. Five priority areas were adapted from the Office of Minority Health National Stakeholder Strategy to Achieve Health Equity as it related to the groups in the Affinity Diagrams: 1) Leadership; 2) Knowledge; 3) Policy Development; 4) Data, Research, and Evaluation; and 5) Community Capacity Building.

Phase IV – Formulate Strategy

Based on the Cause and Effect and Affinity Diagram exercises and review of the health equity data by age, gender, geography, race/ethnicity, and socioeconomic status in the Identifying Health Disparities to Achieve Health Equity in San Diego County reports and results from the diagrams, the HEC conducted a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis (Appendix H). The SWOT analysis identified the PHS internal strengths and weaknesses and external opportunities and threats. The HEC was able to formalize opportunities for future health equity activities and understand PHS weaknesses.

The HEC conducted planning sessions to develop and align the vision, mission, and values for the Health Equity Strategic Plan. The vision described the future state of PHS achieving health equity. While, the mission statement identified how PHS will achieve the vision statement. The value statements represented the core priorities for PHS culture. This led to the development of goals, strategies, and objectives for the five priority areas identified in Phase II.

Phase V – Adopt and Implement Plan

The Health Equity Committee submitted the Health Equity Strategic Plan to the PHS Public Health Leaders and Public Health Officer/Director for approval. Once the plan was approved, PHS Branch Chiefs encouraged their staff to review and implement the plan. The HEC oversees the implementation and revision of the plan annually.

LINKAGES WITH OTHER PLANS AND STANDARDS

The PHS Health Equity Plan is linked to other County strategies and Public Health Accreditation Board (PHAB) standards and measures (Appendix I). PHS recognizes that the health equity approach should be integrated into the County functions and nationally recognized standards. This ensures that the efforts within PHS and other County groups are collectively increasing the focus of health equity.

PUBLIC HEALTH SERVICES EQUITY STRATEGIC PLAN

VISION, MISSION, VALUES, PRIORITY AREAS, AND FRAMEWORK

Our Vision: Health equity for all San Diego County residents.

Our Mission: Public Health Services (PHS) is committed to increasing health equity in San Diego County through continual development of policies and procedures, community capacity, awareness, and operational responsiveness and support to staff.

Our Values: Diversity, Respect, and Social Justice

- **Diversity**: PHS promotes diversity throughout San Diego County and among staff.
- **Respect**: PHS respects all staff, clients, and the San Diego communities.
- **Social Justice**: PHS promotes social justice within the organization and San Diego County.

Priority Areas: Leadership, Knowledge, Policy Development, Data, Research, and Evaluation, and Community Capacity Building

Public Health Services Health Equity Framework:

1. Organization *(Internal Transformation)*	**1.1 Leadership- Changing Organizational Practices**
	1.2 Workforce - Strengthening Staff Knowledge and Skills
2. Policy Development *(Internal and External Transformation)*	**2.1 Policy Development - Reviewing and Recommending Policy and Legislation**
3. Data - Evaluation and Dissemintation *(Internal and External Transformation)*	**3.1 Data and Evaluation - Measuring Progress and Effectiveness**
	3.2 Data Dissemination - Making Report and Information Available to the Public
4. Community *(External Transformation)*	**4.1 Community Capacity Building - Promoting Community Education and Partnerships**

GOALS, STRATEGIES, AND OBJECTIVES

GOAL 1 - LEADERSHIP: INCREASE AND MAINTAIN LEADERSHIP SUPPORT ON THE HEALTH EQUITY INITIATIVE.	
Strategy 1.1: Build PHS staffing capacity to implement the PHS Health Equity initiative.	Objective 1.1.1: Fill vacant position in PHS Administration who will serve as the Divisional Health Equity Coordinator to oversee the health equity initiative for PHS.
	Objective 1.1.2: Maintain and support continuance of the PHS Health Equity Committee.
	Objective 1.1.3: Collaborate with the PHS Chronic Disease and Health Equity Unit to support efforts addressing policies, systems, and environments to prevent chronic disease by improving health equity.
	Objective 1.1.4: Seek grant funded opportunities that address the enhancement of health equity.
Strategy 1.2: Strengthen and broaden capacity for PHS Leadership to address health inequities through health equity competencies.	Objective 1.2.1: Research and identify health equity competencies that align with County of San Diego initiatives.
	Objective 1.2.2: Utilize researched and identified health equity competencies to enhance PHS Leadership knowledge.
Strategy 1.3: Support the PHS Leadership's ability to communicate the health equity initiative to their staff.	Objective 1.3.1: Designate health equity representatives for each PHS Branch.
	Objective 1.3.2: PHS Leadership will support their Branch's health equity representative in providing health equity training for their staff, as needed.
	Objective 1.3.3: Train PHS Leadership on health equity related topics, annually.
	Objective 1.3.4: The Health Equity Coordinator will provide health equity updates at the monthly PHS Leaders and Senior Managers meetings.

GOALS, STRATEGIES, AND OBJECTIVES

GOAL 2 - KNOWLEDGE: INCREASE THE ABILITY OF PHS STAFF TO TRANSLATE KNOWLEDGE INTO ACTION TO ADDRESS HEALTH EQUITY.	
Strategy 2.1: Provide ongoing educational and training opportunities for PHS staff to incorporate the health equity framework into programs and services.	Objective 2.1.1: Provide technical assistance to PHS and Health and Human Services Agency staff to train them on health equity.
	Objective 2.1.2: Promote the use of and continuously update the PHS Health Equity SharePoint site that includes definitions, PowerPoints, plans, trainings, and useful links.
	Objective 2.1.3: Utilize internal and external resources and trainings to develop the Health Equity Training to be delivered by the health equity representative for each PHS Branch.
	Objective 2.1.4: PHS health equity representatives will provide health equity training to their Branch staff.
	Objective 2.1.5: Develop health equity trainings for staff on the County's Learning Management System.
	Objective 2.1.6: Continuously explore funding for health equity training and technical assistance opportunities.
Strategy 2.2: Promote diversity and competency of PHS staff through recruitment, retention, and development of a diverse workforce reflective of the San Diego County communities served.	Objective 2.2.1: Support policies to expand diversity and cultural and linguistic competency of PHS staff.
	Objective 2.2.2: Work with schools, universities, and healthcare systems to recruit culturally competent staff.
	Objective 2.2.3: Increase awareness among diverse and underserved populations to become health professionals.
	Objective 2.2.4: Recruit a diverse workforce by using diversity advertisements for job postings.
Strategy 2.3: Promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of San Diego County's diverse communities.	Objective 2.3.1: Assess PHS staff every three to five years adapting the Bay Area Regional Health Inequities Initiative (BARHII) survey to determine staff health equity competencies.
	Objective 2.3.2: Analyze PHS Staff health equity competency survey results and provide training opportunities, as needed.
	Objective 2.3.3: Promote cultural and linguistic competency training modules and courses offered through the Learning Management System for PHS staff.

GOALS, STRATEGIES, AND OBJECTIVES

GOAL 3 - POLICY DEVELOPMENT: INCREASE HEALTH EQUITY POLICES AND LEGISLATION.	
Strategy 3.1: Utilize a health equity guideline in developing, reviewing, and updating PHS policies and procedures.	Objective 3.1.1: The Health Equity Committee will develop a guideline that ensures inclusion of health equity in PHS policies and procedures.
	Objective 3.1.2: The Health Equity Coordinator will train PHS staff on use of the health equity guideline for policies and procedures.
Strategy 3.2: Ensure concepts of health equity are incorporated into policy and legislation.	Objective 3.2.1: Develop and implement a Health Equity Policy and Procedure that ensures PHS policies, programs, services, informational materials, and processes will address social, cultural, and language differences, including specific populations at higher risk for poor health outcomes.
	Objective 3.2.2: Identify a mechanism to link with opportunities that ensure health equity is considered in legislative proposals.
	Objective 3.2.3: PHS will recommend incorporation of health equity concepts in legislation to organizations, policy makers, and elected officials, as appropriate.

GOAL 4 - DATA, RESEARCH, AND EVALUATION: ENSURE THE AVAILABILITY OF AND ACCESS TO HEALTH EQUITY DATA TO INFORM DECISION MAKING.	
Strategy 4.1: Report standardized health equity data across PHS for the community and County staff.	Objective 4.1.1: Collect and report data on age, gender, geography, race/ethnicity, socio-economic status, disability, sexual orientation, and other health disparities, as data become available.
Strategy 4.2: Collect and maintain PHS health equity program outcomes data.	Objective 4.2.1: Promote dissemination of PHS program results addressing health equity.
Strategy 4.3: Develop and implement a monitoring process to track progress on key health equity indicators.	Objective 4.3.1: PHS will identify, track, and maintain key health equity indicators.
Strategy 4.4: Publish and disseminate health data on all populations that experience health disparities, as available.	Objective 4.4.1: Publish and maintain the Identifying Health Disparities to Address Health Equity in San Diego County data report on the County of San Diego website.
Strategy 4.5: Identify and mitigate health equity data gaps.	Objective 4.5.1: Health equity data gaps will be identified and mitigated when feasible by PHS.
Strategy 4.6: Partner with community-based organizations and academic institutions on research and evaluation of community-intervention strategies to end health disparities.	Objective 4.6.1: Identify and work with community-based organizations and academic institutions to determine and disseminate replicable and evidence-based practices to end health disparities.
	Objective 4.6.2: Create and disseminate evaluations and/or reports of PHS program intervention strategies addressing health disparities.

GOALS, STRATEGIES, AND OBJECTIVES

GOAL 5 - COMMUNITY CAPACITY BUILDING: ENHANCE COMMUNITY CAPACITY TO INCREASE HEALTH EQUITY.	
Strategy 5.1: Maintain partnerships with the Regional Leadership Teams to incorporate health equity in the *Live Well San Diego* Community Health Improvement Plan.	Objective 5.1.1: Develop and maintain inclusion of activities and strategies that address health equity in the *Live Well San Diego* Community Health Improvement Plan.
	Objective 5.1.2: Identify community partners from the County of San Diego Regional Leadership Teams to serve as resources and assets to implement health equity activities as it relates to the *Live Well San Diego* Community Health Improvement Plan, annually.
Strategy 5.2: Facilitate collaborative efforts to reduce the disparate impact of the social determinants of health.	Objective 5.2.1: PHS Branches will maintain continuous partnerships with interagency departments and community stakeholders to create policies, systems, and environments to enhance health equity in San Diego County.
Strategy 5.3: Promote opportunities for community partners to learn more about health equity.	Objective 5.3.1: Provide health equity workshops to train community partners.
	Objective 5.3.2: Provide technical assistance to community partners concerning polices, systems, and environmental changes and data analysis to enhance health equity in San Diego County.

CONCLUSION

TRANSFORMING FROM HEALTH DISPARITIES TO HEALTH EQUITY

Health departments are transitioning from the concept of health disparities, a difference that is related to social or economic disadvantage, to focus on health equity. Health equity goes beyond the concept of differences among groups of people and instead concentrates on attainment of the highest quality of life for all groups in a population. Together, these concepts can advance the health of the community. Health disparities can be used to measure progress towards advancing health equity. Health equity will ensure that health will be improved for people that are at greatest risk of poor health resulting from social conditions, and not worsen the health of people that are in advantaged groups.

RECOMMENDATIONS

The County of San Diego Health and Human Services Agency Division of Public Health Services (PHS) suggests recommendations for each of the priority areas to implement the Health Equity Strategic Plan, see table below.

RECOMMENDATIONS TO ACHIEVING HEALTH EQUITY	
PRIORITY AREAS	**RECOMMENDATIONS**
LEADERSHIP	• Elevate health inequities through the *Live Well San Diego* in Action Team to work with the County's five business groups (Public Safety Group, HHSA, Land Use and Environment Group, Community Services Group, and Finance and General Government Group) • Inspire PHS Leadership and Branch Chiefs to communicate the health equity message and engage and encourage staff in the process • Create an Office of Health Equity and Climate Change within PHS to provide staff direction and support on the PHS Health Equity initiative
KNOWLEDGE	• Provide educational opportunities for internal and external stakeholders and staff • Link health equity practices and training in workforce development opportunities • Promote routine staff training on topics such as social injustice, cultural competency, and health literacy
POLICY DEVELOPMENT	• Pursue the implementation of Health in All Policies • Develop a legislative review process for health equity concepts • Create a health equity tool for PHS programs as a means to review policies, procedures, programs, and services
DATA, RESEARCH, AND EVALUATION	• Review and monitor existing baseline data for PHS client populations, specifically those that experience disproportionality, to identify the root cause(s) of health inequities • Transfer data into knowledge by creating health equity data profiles to tell the story of disproportionality • Share health equity best-practices with the community
COMMUNITY CAPACITY	• Facilitate collaborative efforts with internal and external partners to create policy, systems, and environmental changes to advance health equity • Provide technical assistance to community partners to address and increase knowledge of health equity

FINAL REMARKS

The PHS Health Equity Strategic Plan identifies strategies and recommendations to address social change, social customs, community policy, community resilience, and community/built environment to impact health inequities. PHS will develop leaders competent in health equity, increase access to culturally and linguistically appropriate healthcare services, promote a diverse healthcare workforce, and ensure all San Diegan County residents attain health equity.

PHS recognizes that partnering with key stakeholders is the most successful strategy to implement the Health Equity Strategic Plan in a sustainable manner.. The PHS Office of Health Equity and Climate Change will work with the Health Equity Committee and stakeholders to achieve the vision of *Live Well San Diego* as a healthy, safe, and thriving San Diego County.

APPENDICES

APPENDIX A
OFFICE OF MINORITY HEALTH NATIONAL STAKEHOLDER STRATEGY TO ACHIEVE HEALTH EQUITY

SUMMARY OF NPA GOALS AND STRATEGIES		
GOAL #	**GOAL DESCRIPTION**	**STRATEGIES**
1	**AWARENESS** — Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas
		2. **Partnerships** Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan
		3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience — including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals — to encourage action and accountability
		4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health
2	**LEADERSHIP** — Strengthen and broaden leadership for addressing health disparities at all levels	5. **Capacity Building** Build capacity at all levels of decision making to promote community solutions for ending health disparities
		6. **Funding Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services
		7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives
3	**HEALTH SYSTEM AND LIFE EXPERIENCE** — Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. **Access to Care** Ensure access to quality health care for all
		9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care
		10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging
		11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions
		12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits
		13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes
4	**CULTURAL AND LINGUISTIC COMPETENCY** — Improve cultural and linguistic competency and the diversity of the health-related workforce	14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities
		15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems
		16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation; encourage financing and reimbursement for health interpreting services
5	**DATA, RESEARCH, AND EVALUATION** — Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes	17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations
		18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparitie
		19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities
		20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision making about policies, programs, and grant making related to health disparities and health equity

APPENDIX B
NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS GUIDELINES FOR ACHIEVING HEALTH EQUITY IN PUBLIC HEALTH PRACTICE

1. MONITOR HEALTH STATUS AND TRACK THE CONDITIONS THAT INFLUENCE HEALTH ISSUES FACING THE COMMUNITY

- Obtain and maintain data that reveal inequities in the distribution of disease. Focus on information that characterizes the social conditions under which people live that influence health.
- Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, economic wellbeing, environmental quality) through relationships or partnerships with relevant state and local agencies.
- Identify specific population subgroups or specific geographic areas characterized by (1) either an excess burden of adverse health or socioeconomic outcomes; (2) an excess burden of environmental health threats; and (3) inadequacies in human resources that affect human health (e.g., quality parks and schools).
- Support research that explores the social processes and decisions through which inequalities of race, class, and gender generate and maintain health inequities.

2. PROTECT PEOPLE FROM HEALTH PROBLEMS AND HEALTH HAZARDS

- Prevent the further growth of environmental inequities and social conditions that lead to inequities in the distribution of disease, pre¬mature death, and illness.
- Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death, and illness.

3. GIVE PEOPLE INFORMATION THEY NEED TO ACT COLLECTIVELY IN IMPROVING THEIR HEALTH

- Lead or participate in health impact assessments of policies, programs, or plans relevant to living conditions that affect health. (Note: relevant to items 2, 4, 5, and 10).
- Make available to residents data on health status and conditions that influence health status by race, ethnicity, language, and income.
- Conduct and disseminate research that supports and legitimizes community actions to address the fundamental environmental, social, and economic causes of health inequities.
- Develop or support mass media educational efforts that uncover the fundamental social, economic, and environmental causes of health inequities.

4. ENGAGE WITH THE COMMUNITY TO IDENTIFY AND ELIMINATE HEALTH INEQUITIES

- Enhance residents' capacity to conduct their own research and share departmental information, based on the principles of Community- Based Participatory Research and the National Environmental Justice Advisory Council's community collaboration principles.
- Learn about the values, needs, major concerns, and resources of the community. Respect local, community knowledge and scrutinize and test it.
- Promote the community's analysis of and advocacy for policies and activities that will lead to the elimination of health inequities.
- Promote and support healthy communities and families through progressive practices in existing service delivery and programs based on principles of social justice.
- Support, implement, and evaluate strategies that tackle the root causes of health inequities, in strategic, lasting partnerships with pub¬lic and private organizations and social movements.
- Engage in dialogue with residents, governing bodies, and elected officials regarding governmental policies responsible for health in¬equities, improvements being made in those policies, planning initiatives, and priority health issues related to conditions not yet being adequately addressed.
- Routinely invite and involve community members and representatives from community-based organizations in strategic planning pro¬cesses and promotion of health.
- Provide clear mechanisms and invitations for community contributions to Local Health Departments (LHD) planning, procedures, and policies.

4. ENGAGE WITH THE COMMUNITY TO IDENTIFY AND ELIMINATE HEALTH INEQUITIES

- Assist in building leadership among affected residents and respect their existing leadership, thereby honoring their capacity.
- Provide technical assistance to communities with respect to analyzing data, setting priorities, identifying levers of power, and developing strategies.
- Engage with the public health system and related institutions in comprehensive planning.
- Use grant funding to support community-based programs and policies.
- Connect with relevant social movement organizations.

5. DEVELOP PUBLIC HEALTH POLICIES AND PLANS

- Advocate for comprehensive policies that improve physical, environmental, social, and economic conditions in the community that af¬fect the public's health while recognizing that health policy is social policy.
- Enable residents to sustain their advocacy activity and support their capacity to become involved in regulatory activity.
- Support revisions of statutes that govern LHDs and other regulations and codes to ensure non-discrimination in the distribution of pub¬lic health benefits and interventions.
- Promote public investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment, and neighborhood grocery stores.
- Focus on policies related to primary prevention and the improvement of social and economic conditions and not just remediation of conditions.
- Monitor relevant issues under discussion by governing and legislative bodies.

6. MAINTAIN A COMPETENT PUBLIC HEALTH WORKFORCE

- Develop an ongoing process of education and structured dialogue for all staff across departments and divisions that (a) explores the evidence of health inequity and its sources; (b) explains the nature of the root causes of health inequities and the ways in which prac-tice may be changed to address those root causes; (c) examines the values and needs of the community; and (d) assists in providing core competencies and skills that build the ability to do what is necessary to achieve health equity.
- Make sensitivities to and understanding of root causes of health inequities part of hiring, including willingness to learn, cultural humil¬ity, creativity, and listening skills.
- Develop an assessment of and training to improve staff knowledge and capabilities about health inequity.
- Conduct an internal assessment more generally of a LHD's overall capacity to act on the root causes of health inequities, including its organizational structure and culture.
- Recruit the public health workforce from those who have been disproportionately affected and also those with the education, training, and experience to address inequitable social and environmental conditions.
- Hire staff with the skills, knowledge, and abilities to take part in community organizing, negotiation, and power dynamics and the abil¬ity to mobilize people, particularly those from communities served.
- Recruit staff with culturally and academically diverse backgrounds, with knowledge of the population they serve in relation to racial, ethnic, class, and gender characteristics as well as social and economic conditions in the jurisdiction.
- Mentor and inspire staff to address health inequities in their local jurisdiction.
- Establish greater flexibility in job classifications to tackle the root causes of health inequity.
- Develop relations with high schools and colleges to ensure that diverse groups of youth will strive towards joining the public health workforce.
- Develop anti-racism training as part of building a competent workforce.

7. CONTRIBUTE TO AND APPLY THE EVIDENCE BASE OF PUBLIC HEALTH AND RELEVANT FIELDS

- Develop public health measures of neighborhood conditions, institutional power, and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.
- Include knowledge based on social and economic context, subjective understandings, history, and social experience that goes beyond quantifiable data from epidemiological investigation when informing decision making and action.
- Stay current with the literature on health equity, synthesize research, and disseminate findings as they are applicable to staff and community.
- Evaluate and disseminate knowledge of findings and efforts related to health equity.

APPENDIX C
TABLE 2
CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICIALS (CCLHO) FRAMEWORK FOR LOCAL PUBLIC HEALTH DEPARTMENTS (LHDS) INTRODUCTION OF HEALTH EQUITY (HE) IN PUBLIC HEALTH PRACTICE DEVELOPED IN 2010 BY WILMA J. WOOTEN, M.D., M.P.H.

DOMAIN AREA	GOAL	STRATEGIES	TACTICS/ ACTIONS	RESULTS	NACCHO GUIDELINES*	OMH	WHO
STEP 1: ORGANIZATION (Internal Transformation)	Transform organizational culture to make health equity a priority.	1. Institutionalize the health equity culture in all facets of the organizational structure 2. Engage interagency and interagency departments and groups	Incorporate HE into core values, mission, or principles of organization. Achieve programmatic competency in health equity	Include HE as Agency/Dept priority Include HE in: -Mission Statement -Strategic Plan -Policy (e.g., contract, HR, planning documents) Programmatic strategic alignment	#4 #5	Awareness Leadership Health & health systems experience Coordination of research/ evaluation	#1 #2 #3

DOMAIN AREA	GOAL	STRATEGIES	TACTICS/ ACTIONS	RESULTS	NACCHO GUIDELINES*	OMH	WHO
STEP 2: WORKFORCE (Internal Transformation)	Transform workforce	Create a competent workforce regarding HE and related topic areas (i.e., social injustice, cultural competency, health literacy)	Assess and train workforce in concepts of HE & social injustice (SJ) Recruit a diverse, culturally competent workforce Incorporate HE/SJ in hiring and interview process Link work plans to strategic direction	Conduct employee training Provide leadership development Include HE/SJ sensitive questions in interview process Provide health communication (e.g., health literacy, cultural competency and LEP) training Develop policies that support unified health communication and other concepts of health equity Link to personnel performance and incentives	#2 #8 #10	Awareness Leadership Health & health systems experience Cultural & linguistics competency Coordination of research/ evaluation	#2

DOMAIN AREA	GOAL	STRATEGIES	TACTICS/ ACTIONS	RESULTS	NACCHO GUIDELINES*	OMH	WHO
Step 3 COMMUNITY (External Transformation)	Transform the broad definition of community	Engage all levels of the community including private sector organizations, schools, businesses, other governmental entities, and health systems.	Educate all sectors Engage in committee planning efforts Engage c ommunity in assessment and implementation plans Explore areas for strategic partnerships	Community Profiles Health Assessments Plans Health Improvement Plan Apply for joint funding opportunities	#2 #4 #5 #10	Awareness Leadership Health & health systems experiences Cultural & linguistics competency Coordination of research/ evaluation	#2

DOMAIN AREA	GOAL	STRATEGIES	TACTICS/ ACTIONS	RESULTS	NACCHO GUIDELINES*	OMH	WHO
Step 4 DATA (EVALUATION & DISSEMINATION) (Internal and External Transformation)	Transform information	Generate data to assess & evaluate accountability	ID measurable outcomes Develop monitoring process Engage committee in planning & evaluation process Disseminate findings Transparent communication (e.g., website, publications)	Disparity report Committee profiles Convene community forum Ancillary support materials (e.g., fact sheets, reference documents, PowerPoint presentations)	#1, #2 #3 #10	Leadership Cultural & linguistics competence Coordination of research/ evaluation	#3

APPENDIX D: *LIVE WELL SAN DIEGO* INITIATIVE

APPENDIX E
HEALTH EQUITY COMMITTEE (HEC) CHARTER

Health Equity activities in PHS support HHSA's key Strategic Objective for Operational Excellence, which contributes to Healthy, Safe, and Thriving Communities. The HEC works to develop and implement the Team Charter and Health Equity Strategic Plan. The Charter is updated on an annual basis.

MEMBERSHIP

HEC members are from the various Branches of PHS: Emergency Medical Services, Epidemiology and Immunization Services, HIV, STD, and Hepatitis, Maternal Child and Family Health Services, Public Health Nursing Administration, Public Health Services Administration, and Tuberculosis and Refugee Health.

- **Attendance at monthly meetings is voluntary by representative or alternate**
- **Minutes to reflect attendance**
- **Quorum is established at meeting for action items by members**

TO WHOM ARE WE ACCOUNTABLE?

As an organizational structure, the HEC is accountable to PHS Branches to support the efforts in achieving health equity. The committee's function is to implement the Work Plan and Strategic Plan that guides health equity activities in PHS.

SCOPE (BOUNDARIES)

PHS staff, specific concepts of health equity, and contracted services.

STRATEGIC PLAN

Vision

Health equity for all San Diego County residents.

Mission

The committee will develop and implement a plan to support the incorporation of health equity in all PHS programs and services.

Values

- **Diversity**
- **Respect**
- **Social Justice**

PRIORITY AREAS

Five priority areas have been developed and are as follows:

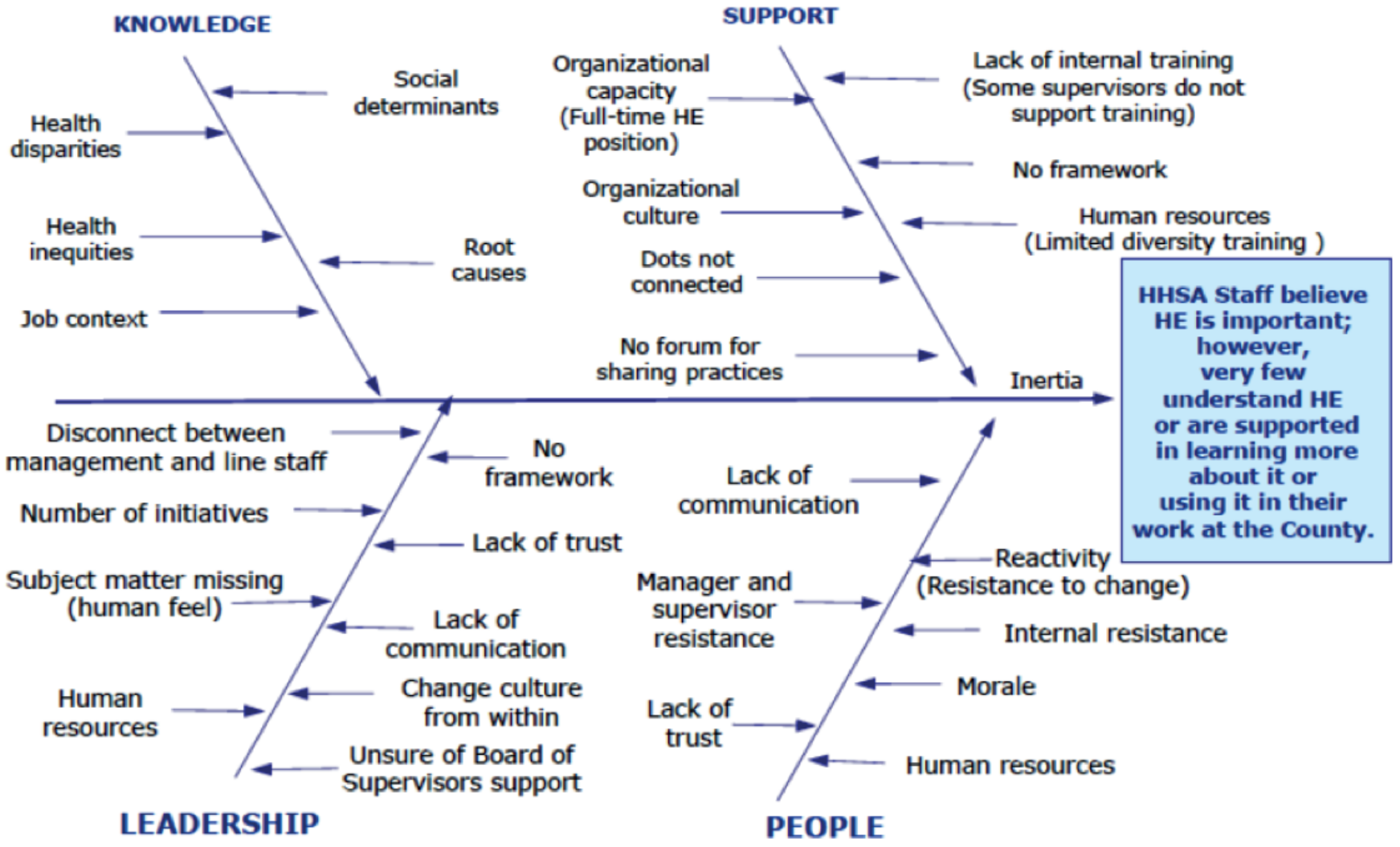
1. Leadership;
2. Knowledge;
3. Policy Development;
4. Data, Research, and Evaluation; and
5. Community Capacity Building.

The priority areas and corresponding goals, operational objectives, performance measures, supporting activities, and timelines are detailed in the Work Plan. The priority areas have been adapted from the Office of Minority Health National Stakeholder Strategy to Achieve Health Equity. The HEC also created Cause and Effect and Affinity diagrams to identify which priority areas had the highest significance to PHS.

APPENDIX F

CAUSE AND EFFECT DIAGRAM WITH HEALTH EQUITY COMMITTEE

CAUSES OF STAFF'S MISUNDERSTANDING OF HEALTH EQUITY (HE)



APPENDIX G
AFFINITY DIAGRAMS
AFFINITY DIAGRAM WITH HEALTH EQUITY COMMITTEE - SEPTEMBER 2013

WHAT GETS IN THE WAY OF ADDRESSING HEALTH EQUITY (HE)?

LEADERSHIP

- Not all management enforce addressing HE
- Lack of or mixed messages of where we are headed, expectations, outcomes, goals, and vision (2)
- Lack of support from leadership (3)
- HE is not a priority for "my" program (1)
- Lack of ability or authority to do anything about it (1)
- Lack of trust among staff, co-workers, management, and administration (to be honest and truthful) (1)

POLITICS

- Human Resources (HR) does not always all the Health and Human Services Agency (HHSA) to address HE (1)
- Avoiding issues that might lend to aid current HR problems (1)
- Fear: Not wanting to rock the political boat (1)

INITIATIVE FATIGUE AND WORKLOAD

- Burnout over too many initiatives (1)
- Lack of staff/resources to address HE adequately (1)
- Other projects get higher priority than HE (2)
- Staff do not have time for new projects (1)
- Time: Not enough time to add another component to "My" job (1)

RESISTANCE TO CHANGE

- Staff resistance to new concepts (2)
- There is so much unmet need already and this will not help immediately (1)
- Change is always hard (1)
- The subject of HE probes resistance (it makes proper uncomfortable) (1)
- Truly embracing HE will require us to change the way we do things and that can be threatening (1)
- Not all staff buy into change (1)
- HE runs counter to the dominant "personal responsibility" framework (1)
- People not wanting to do "personal" level work in the work place (1)

CONNECTION TO JOB/ROLE

- Not connecting HE to staff work/roles (1)
- No buy-in from employees (1)
- It really doesn't fit my role (2)
- Understanding how it can be applied to our work (1)

KNOWLEDGE/EDUCATION

- More education on how to address HE (1)
- Lack of understanding about how social determinants affects health (1)
- Not all staff understand what HE is (6)
- It's not immediately apparent what the benefits are (1)
- The concept is new/alien to many staff, so they don't value it (1)
- Disbelief that some issues exist (1)
- We already address HE, so what more do "you" want from "us"? (1)

ENORMOUSNESS

- The problem appears to be very huge, thus not knowing where to start (1)
- Cannot really be achieved (1)
- Knowing that you can really make a difference (1)
- Feeling like nothing can/will be done (1)

AFFINITY DIAGRAM WITH SENIOR MANAGERS - MARCH 2015

WHAT GETS IN THE WAY OF ACHIEVING HEALTH EQUITY? (INTERNAL PHS CAPACITY)

ACCESS TO CARE AND COORDINATION

- ACCESS TO SERVICES
- FUNDING
- HEALTH SYSTEM
- INSURANCE

BEHAVIOR

- ATTITUDE
- BEHAVIORAL HEALTH
- DENIAL
- LIFESTYLE CHOICES
- SUBSTANCE ABUSE
- TRAUMA

CULTURAL NORMS

- CONTROVERSIAL
- CULTURAL BELIEFS
- DISCRIMINATION
- FEAR
- STIGMA

COMMUNICATION

- COMMUNICATION
- LANGUAGE
- MEDICAL TERMINOLOGY
- NON-ENGLISH POPULATION
- TRANSLATION

KNOWLEDGE AND AWARENESS

- STAFF BARRIERS
  - Training
  - Understanding needs
  - Connection
- CLIENT BARRIERS
  - Education

SOCIOECONOMIC DETERMINANTS

- BUILT ENVIRONMENT
  - Neighborhood, access to healthy food, etc.
- FINANCES OF COMMUNITY
  - Income, economic status, affordability (i.e., housing)
  - Unequal distribution of wealth

SYSTEMS/RESOURCE ISSUES

- DATA FOR SPECIFIC POPULATIONS
- GRANTS/FUNDING
- ORGANIZATIONAL CAPACITY
- POLITICAL SYSTEM

APPENDIX H
STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS (SWOT) ANALYSIS

	STRENGTHS	WEAKNESSES
INTERNAL	• Health in All Policies • Public Health Services (PHS) Chronic Disease and Health Equity Unit • Place matters • Majority of PHS programs and services address health equity and health inequities to improve access to care for vulnerable populations • Community Health Statistics Unit provides data analysis • Developed a health equity data report that will be published continuously • PHS Data Threading Committee • Established a Health Equity Committee • *Live Well San Diego* • PHS audacious goal of developing a Binational Border Health Strategic Plan • Refugee efforts • Black Infant Health contract with the state • SNAP-Ed grant that provides funding for low-income population • State and Local Public Health Action to Prevent Stroke, Diabetes, and Heart Prevention Initiative grant (Healthy Works Prevention Initiative)	• Limited staff knowledge of health equity • Initiative fatigue that limits staff focus and engagement • Resistance to change • Staff faces multiple competing priorities • Limited focus on upstream cause of health inequities • No formal Health Equity Coordinator • Lack of staff time to address health equity • Primary data collection gaps • Not using existing data to its full potential • Limited funding to address health equity
	OPPORTUNITIES	**THREATS**
EXTERNAL	• Support and funding opportunities from California Endowment • Public Health Accreditation Board • California Department of Public Health Office of Health Equity (developing a Health Equity Strategic Plan) • San Diego County community colleges addressing health equity • Potential technical assistance from contractors • CPHEN • Opportunity to work with HHSA Regions and Leadership Teams • *Live Well San Diego* • Patient Protection and Affordable Care Act • Renewed interest in developing Employee Resource Groups • Changing demographics • KIP (Knowledge Integration Project) • San Diego Health Connect • Partnership with SANDAG • Childhood Obesity Initiative • Border Health Collaborative • CTS contract for language line	• Lack of funding from external sources (i.e., state, federal, etc.) • Political climate • Changing demographics • Leadership changes • Secondary data gaps collection • Lack of public knowledge regarding public health, specifically health equity • Unstable economy

APPENDIX I
LINKAGES WITH OTHER PLANS AND STANDARDS

Linkage to Public Health Accreditation

Measures 3.1.3 and 11.1.4 are important aspects of the Public Health Accreditation Board (PHAB) Version 1.5 Standards and Measures that address health equity. The Public Health Services Health Equity Strategic Plan is in alignment with the PHAB Version 1.5 Standards and Measures.

PHAB REQUIREMENT	SECTION/PAGE IN HEALTH EQUITY PLAN	
3.1.3 A: Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes		
3.1.3 A. RD 1. b: Public Health efforts to address identified community factors that contribute to specific populations' higher health risks and poorer health outcomes and to impact health equity indicators	Social change	Goal 3, Objective 3.2.1
	Social customs	Goal 3, Objectives 3.2.1, 3.2.2, and 3.2.3
	Community policy	Goal 3, Objective 3.2.1 Goal 5,Objectives 5.2.1 and 5.3.2
	Level of community resilience or community environment	Goal 1, Objective 1.1.3 Goal 5, Strategies 5.1, 5.2, and 5.3
11.1.4 A: Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes		
11.1.4 A. RD 1: Policy or procedure for development of interventions and material addressing health inequity and are culturally and linguistically appropriate	Policy or procedure incorporating health equity as a goal in development of policies, processes, and programs	Goal 2, Strategy 2.2, Objectives 2.2.1 and 2.2.2 Goal 2 Strategy 2.3, Objective 2.3.3 Goal 3 (All Strategies and Objectives)

Linkage to the *Live Well San Diego* Community Health Improvement Plan

The County of San Diego Health and Human Services Agency (HHSA) has utilized a collective impact approach to achieve equitable communities for 3.2 million San Diego County residents while implementing *Live Well San Diego*. The County's collective impact approach calls for bringing appropriate stakeholders together to determine strategies for social change in each region. *Live Well San Diego* can only succeed if the needs of the San Diego County's diverse population are addressed and the voice of the community is heard. This is due to the fact that the county is demographically and geographically diverse, as it is a refugee resettlement location, entails a high number of non-English speaking populations, and is near the busiest land-border crossing in the world. HHSA implemented the Mobilizing for Action through Planning and Partnerships (MAPP) to conduct a strategic planning process with the community to address their specific needs and health inequities. Five *Live Well San Diego* Leadership Teams for the six County of San Diego Regions were formed to assess the community's health needs (*Live Well San Diego* Community Health Assessment). The Leadership Teams developed a *Live Well San Diego* Community Health Improvement Plan to address the health needs and social inequities of its diverse communities. The regional approach ensured that health needs were addressed equitably across San Diego County. The *Live Well San Diego* Community Health Improvement Plan addresses health equity in the following areas: active living; behavioral health and substance abuse; healthy eating; health care access; safety and violence; and worksite wellness.

Region	*Live Well San Diego* Strategy Area			
	Building a Better Service Delivery System	Supporting Positive Choices	Pursuing Policy Change	Changing the Culture Within
Central	Access to Health Care	Food Equity/ Access to Healthy Food Tobacco Worksite Wellness	Safety and Built Environment	Agency-wide implementation internal to county government employees
East		Active Living Healthy Eating	Substance Abuse Prevention	
North Central	Preventive Health Care	Physical Activity	Behavioral Health Physical Activity	
North County	Behavioral Health	Physical Activity Nutrition	Physical Activity	
South	Health Care Access	Physical Activity and Healthy Eating	Improve Security and Decrease Violence	

Linkage to Public Health Services Strategic Plan

The Public Health Services Health Equity Strategic Plan fiscal years 2014-2019 is aligned with the overall five-year organizational Public Health Strategic Plan fiscal years 2013-2018.

PUBLIC HEALTH SERVICES STRATEGIC PLAN FISCAL YEARS 2013-2018
Public Health Services Administration (PHSA) **Goal 4: Assure organizational accountability, transparency, and effectiveness.**
PHSA Strategy 4.4: Institute a PHS Health Equity Committee to develop and implement a plan that will increase PHS capacity to address Health Equity.
Maternal Child and Family Health Services (MCFHS) **MCFHS Goal 1: Improve health equity for clients served by Maternal, Child, and Family Health Services programs.**
MCFHS Strategy 1.1: Implement programs that decrease health disparities in clients served by MCFHS programs. **MCFHS Strategy 9.1: Chronic Disease Prevention to Improve Health Equity: Create policies, systems, and environments to prevent chronic disease by improving health equity.** **MCFHS Strategy 9.3: Community Transformation Grant: Improve population health, reduce health disparities, and lower health care costs through the following strategic directions: tobacco-free living, active living, and health eating; increase use of clinical and community preventive services, social and emotional wellness, and healthy and safe physical environments.**

Linkage to Public Health Services Communication Plan

The Public Health Services Communication Plan incorporates cultural and linguistic concepts related to health equity for specific populations that are accessing vital public health information. The plan ensures that Public Health Services staff use effective approaches when communication with diverse populations to enhance outreach and impact of public health prevention. For example, communicating with populations that experience different cultural and social norms or speak a different language other than English.

Linkage to Public Health Services Performance and Quality Improvement Plan

The Public Health Services Performance and Quality Improvement Plan links to health equity as various Branches within the division monitor and assess services for diverse communities. As addressed in the Performance and Quality Improvement Plan, annual quality improvement projects and performance measures are evaluated to ensure continuous quality improvement and operational excellence of services provided to the diverse communities in San Diego County.

Linkage to Public Health Services Workforce Development Plan

The Public Health Services Workforce Development Plan incorporates aspects related to health equity, including cultural, linguistic, and health equity competencies, health equity and trauma informed care training, recruitment of a diverse workforce, and integrating health equity in every day practice, programs, services, policies, and plans.

PUBLIC HEALTH SERVICES WORKFORCE DEVELOPMENT PLAN	SECTION/PAGE IN HEALTH EQUITY STRATEGIC PLAN
Goal 4: Increase awareness and training regarding health equity, including cultural competency.	Goal 1, Strategies 1.2 and 1.3
Objective 4.1: Provide staff training regarding health equity, cultural competency, and trauma informed care.	Goal 2, Strategies 2.1, 2.2, and 2.3
Objective 4.2: Develop tools to integrate health equity in every day practice, programs, services, policies, and plans.	Goal 3, Strategies 3.1 and 3.2

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