1-1-2019

Addressing Racial Health Inequities In San Francisco: A Qualitative Research Project With The Maternal Child And Adolescent Health (mcah) Section Of The San Francisco Department Of Public Health (sfdph)

Lydia Kwarteng
lydia.kwarteng@yale.edu

Addressing Racial Health Inequities in San Francisco

A qualitative research project with the Maternal Child and Adolescent Health (MCAH) section of the San Francisco Department of Public Health (SFDPH)

02.14.2019
Yale School of Public Health, 2019

—

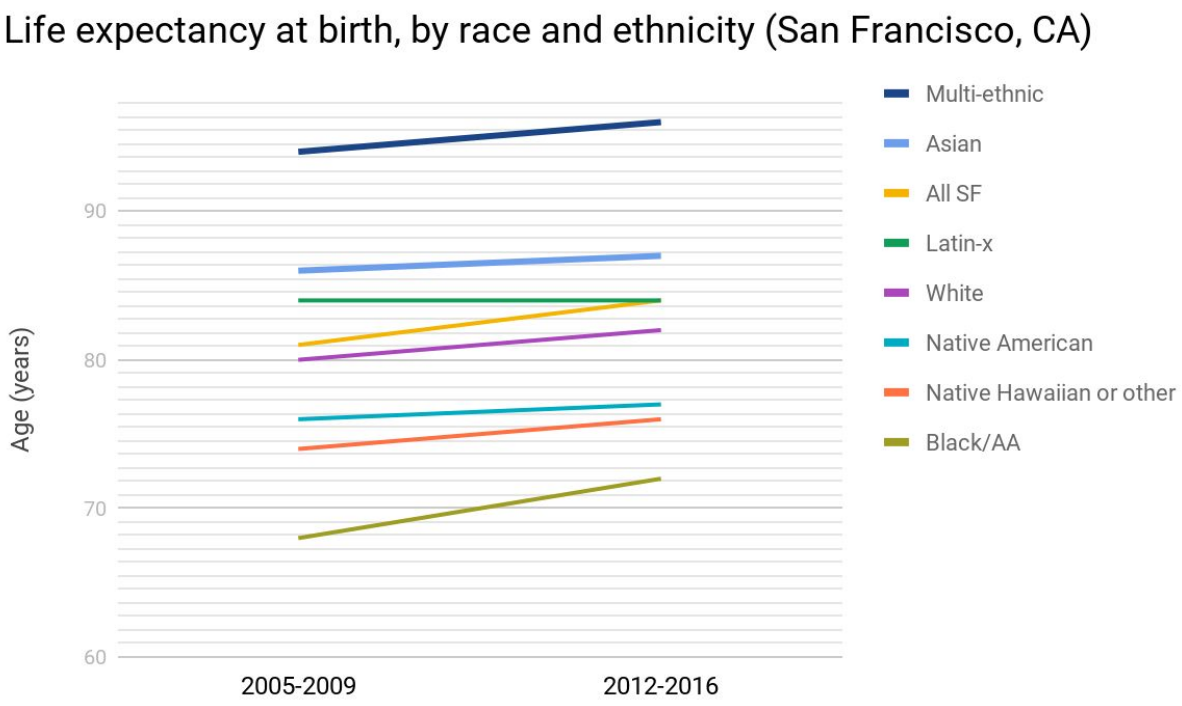
Lydia Kwarteng
Master of Public Health
Advisor Chair: Trace Kershaw, PhD
Committee Members: Christin Fort, PhD

Background and problem

The Centers for Disease Control and Prevention (CDC) define health equity as the opportunity for all people to attain their full health potential[1]. In the United States, however, the impact of barriers to health equity are readily seen in the significant health disparities that exist between racial groups[1]. In the U.S., black/African American individuals have the lowest life expectancy (75.3 years), and are more likely to die at early ages from all causes[2]. 42.25% of Black/African American individuals over 20 have hypertension, 44.8% are obese, and are twice as likely to have diabetes compared to their white counterparts[3] . The World Health Organization characterizes these inequities as avoidable and arising from various social and economic conditions[4].

Despite its progressive history, San Francisco is no stranger to these racial health disparities. According to the 2018 Black/African American Health Initiative (BAAHI) Report, Black/African Americans have the highest mortality rate for nine of the top ten causes of death in San Francisco[5]. Figure 1 below shows the life expectancy at birth in San Francisco by race/ethnicity.

[1] Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf
[2] National Vital Statistics System, https://www.cdc.gov/nchs/nvss/index.htm
[3] CDC National Center for Health Statistics, 2014. https://www.cdc.gov/nchs/index.htm
[4] World Health Organization: Social Determinants of Health, https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/
[5] Black/African-American Health Report 2018. San Francisco, CA. https://www.sfdph.org/dph/files/reports/StudiesData/BAAHI-2018-Black-Health-Report.pdf



Data source: Life Expectancy at Birth: State of California, California Department of Public Health, VRBIS Death Statistical Master File Plus 2005-2017 in Black/African-American Health Report 2018, pg 4

These disparities have persisted for decades, as reported in the annual CDC Health Disparities and Inequalities Report--an assessment that shows the disparities in health outcomes, behavioral risk factors, environmental exposures, social determinants, and health-care access by sex, race and ethnicity, income, education, disability status and other social characteristics[6]. Worth noting is the fact that these disparities are the worst among black people in the U.S.[2]. Current efforts around reducing health disparities have been on individual-level determinants[7]. However, these inequities persist even after programs to improve individual-level determinants were implemented[4]. Health is a complex function of lifestyles that are intricately linked to living and working conditions; therefore, effective efforts to reduce these racial

[6] CDC Health Disparities and Inequalities Report, https://www.cdc.gov/minorityhealth/CHDIReport.html
[7] The Social Determinants of Health: Coming of Age, https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031210-101218

disparities in health need to focus more on addressing the social determinants of health such as such as institutional practices, policies, and environment within and outside of the healthcare system[8].

Racism--which acts on both interpersonal and structural levels within institutions and policies--has been identified as a deeply-entrenched perpetuator of these disparities[9]. Institutional racism refers to the "...differential access to goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator"[9]. As this research disseminates, departments of public health are beginning to study where racism colors their internal structures and how to undo this but to date, there are less than 5 publicly available reports of departments of public health that have done this work. It is important for more departments of public health to do this in order to provide policy makers and leadership with concrete actions for moving forward.

San Francisco Department of Public Health (SFDPH) upholds equity as a True North Principle, meaning that it embraces equity as an objective, external, and timeless value that describes the ideal state that the organization should continually be striving towards[10]. Given the context outlined above, a team at SFDPH designed and began a qualitative project to better understand the status of addressing racial health inequities within the Maternal Child and Adolescent (MCAH) division. The project spanned from February till August of 2018, during which thirty-four interviews among staff and leadership of programs in MCAH were conducted (see interview questions here). Interviews were coded and analyzed for themes that came up, and the process is outlined on the following page.

---

[8] Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. Journal of public health management and practice: JPHMP, 14(Suppl), S8.

[9] Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. American journal of public health, 90(8), 1212.

[10] True North Metrics. https://www.sfdph.org/dph/hc/HCAgen/HCAgen2016/Feb%2016/TN-MetricsUpdate-HC-21616.pdf Accessed February 25, 2019.

Team:

Jenna Gaarde MPH -- Senior Health Program Planner

Alecia Martin -- Quality Improvement and Integration Manager

Ameerah Thomas -- Quality Improvement Program Manager

Zea Malawa M.D., MPH -- Director of *Expecting Justice*

Solaire Spellen, MPH -- Program Associate, *Expecting Justice*

Stephanie Arteaga -- Program Associate, *Expecting Justice*

Christine Smith (Team lead)

Lydia Kwarteng (Team lead)

Methodology

Jenna Gaarde, Dr. Zea Malawa, and the Quality Improvement (QI) team collaborated to develop this project. The goal of the undertaking was to identify strengths and gaps in what MCAH is doing to address racial health inequity, and to use this information to propose a racial equity plan and potential activities that MCAH could pursue. The Quality Improvement (QI) team participated in the project because they are heavily invested in racial equity and have strong relationships with all the programs in MCAH. The QI team typically provides technical assistance to all the programs in MCAH in understanding their program data (i.e. the story behind the data) and uses various tools to help them improve their programs and services.

The section was first broken down by program:

Program	Mission/Goal
Black Infant Health (BIH)	To improve African-American infant and maternal health, as well as decrease Black-White health inequities and social inequities for women and infants.
CalWORKS	A public assistance program that provides cash aid and services to eligible families that have a child(ren) in the home.
Cavity-Free SF	To eradicate health disparities in childhood oral health and making San Francisco cavity-free.
Child Care Health Program (CCHP)	To improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.
Child Health & Disability Prevention (CHDP)	To provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care.
CA Children's Services (CCS)/Medical Therapy Unit (MTU)	To provide specialized medical care and rehabilitation for children whose families cannot provide all or part of the care
Expecting Justice (formerly Collective Impact to Prevent Preterm Birth)	Aims to improve maternal and infant health among Black and Pacific Islander people, and reduce preterm births in those communities.
Family & Children's Services (FCS)	Responsible for responding to reports of child abuse and neglect in

	San Francisco County.
Family Planning	To help reproductive aged women get the best care for their reproductive health and overall health as well.
Field Public Health Nursing (FPHN)	To provide pregnant and postpartum women with support, information and necessary resources.
Nutrition Services (WIC, FGP)	Supplemental Nutrition Program that provides supplemental foods, nutrition education, breastfeeding education and support, and referral to health care and community services.
Nurse Family Partnership (NFP)	Nurse-Family Partnership empowers first-time moms by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, and continuing through the child's second birthday.
Planning Epi Admin QI (PEAQ)	To provide operational, quality improvement planning, epidemiology and fiscal support to MCAH.
Perinatal Services	To provide a wide range of culturally competent services (standard obstetric, nutrition, psychosocial and health education services) to Medi-Cal pregnant women, from conception through 60 days postpartum.
MCAH Leadership Epidemiology	To regularly monitor health-related data to identify and investigate health problems affecting mothers, children, and adolescents in San Francisco.
Teenage Pregnancy and Parenting Program (TAPP)	To provide comprehensive case management to help ensure that expectant and parenting families up to age 19 have access to all available health, education, and social services for which they are eligible.
Project 500	Project 500 (P500) helps San Francisco's most at-risk families find meaningful pathways up and out of poverty that allow them and their future generations to reach their full potential.

During the first month, planning meetings were held to develop the interview guide and identify participants. The team identified one participant per program using index sampling and as the project progressed, word of mouth and referral were used to identify one to two other individuals from each

program to yield a total of 2-3 participants per program. In the course of participant recruitment, care was taken to ensure representation from both front-line staff and leadership.

The interview guide was informed by interview resources from the Bay Area Regional Health Inequities Initiative (BARHII). BARHII is a coalition of the 11 public health departments in the bay area that aims to eliminate health disparities and create healthy communities[11]. Towards this end, BARHII has free online resources for assessing what racial equity currently looks like and how to incorporate advancing racial equity as a goal into program agendas. Questions were curated from BARHII to create one interview guide that could be used for both front-line staff and leadership. (See final interview guide here)

After creating the interview document, it was piloted with a few participants. Each member of the project team conducted interviews, and care was taken in assigning interviewer to interviewee to maximize participant engagement and transparency. Participants were contacted via email and interviews were conducted at their preferred place of meeting. There were a total of 5 people interviewing at the beginning of the project (February 2018), and each interview was 45 minutes on average. For the sake of reducing social desirability bias and keeping interviews short, the interviews were one-sided i.e. the interviewer did not provide their own views/responses to the interview questions when prompted to do so by participants. Thirty-four interviews were conducted from February through July, and bi-weekly meetings were held during this time to develop codes, troubleshoot, and assess any needs for adaptation.

Each interview was transcribed and subsequently coded in Microsoft Excel. The codes were developed and discussed during bi-weekly meetings over the course of the interview process. A set of codes was derived from the interview questions, and additional codes were added as needed over the course of the project. Emerging themes were distilled from the codes based on frequency of mention. Preliminary findings were presented to MCAH at the end-of-summer Intern Presentation.

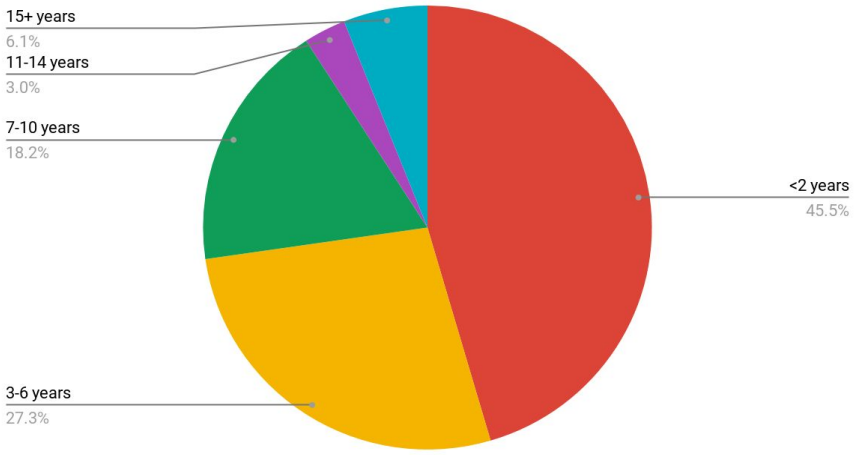
[11] Bay Area Regional Health Inequities Initiative. From http://barhii.org/

Example of codes

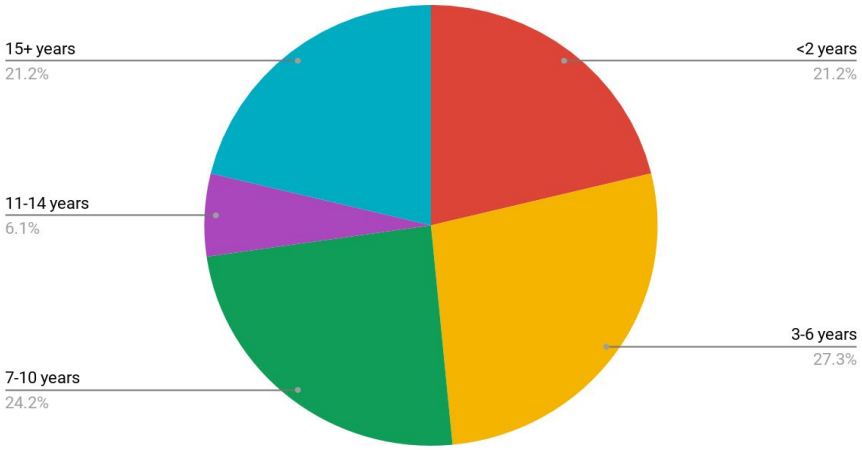
Illustrative Quotation	Code Assigned	Number of Mentions
"Sometimes clients will just talk/ask for what they need. We try to accommodate them as best they can – but there is no developed avenue for feedback."	Client perspectives	30
"We are not really addressing workforce at this point. We don't have that as part of our strategy."	Cultivating workforce (to address racial health equity)	41
"To enhance the care of children birth to five in SF childcare settings. {We} Focus on the health aspect of early child care in SF, closing the gaps in achievement."	Mission	34

Demographics

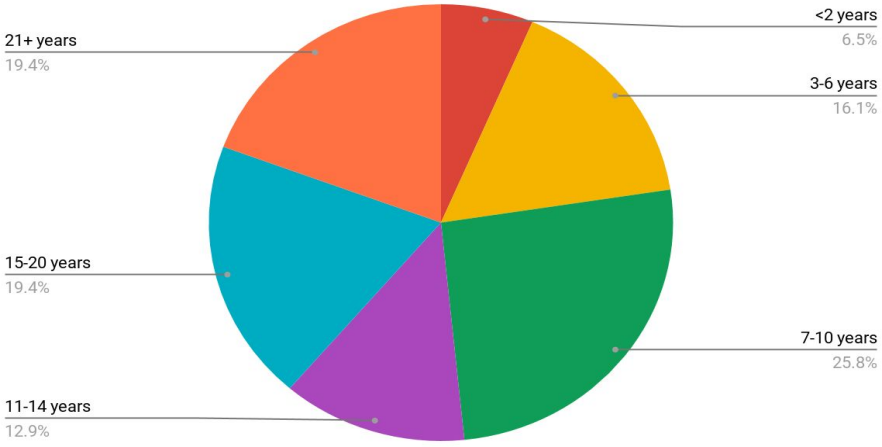
Time in current position (range: 0.5 - 18 years; mean: 4.4 years)



Time at SFDPH (range: 0.6 - 30 years; mean: 8.1 years)

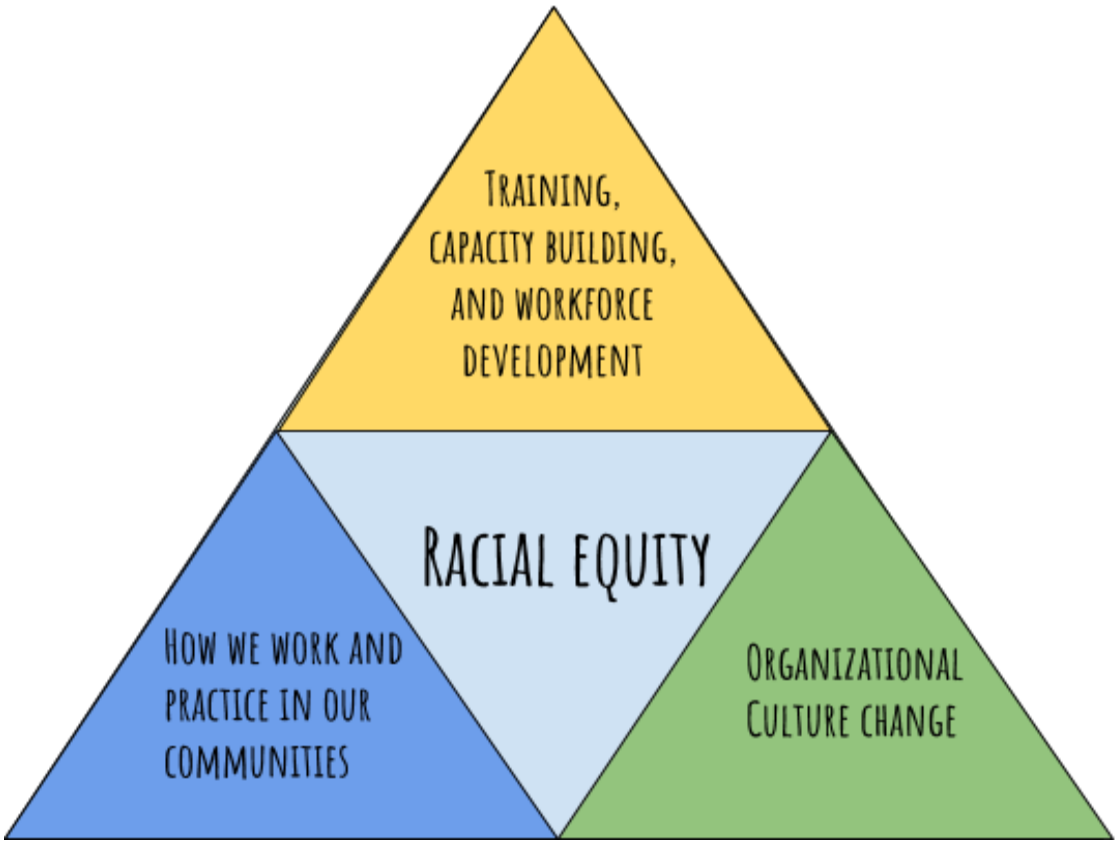


Time in Public Health (range: 0.6 - 36 years; mean: 13.8 years)



Findings

The interviews suggested that the three main areas to focus on in order to build a workforce that is prepared to address racial health inequities are: a) training, capacity building, and workforce development, b) community engagement and client-centeredness and c) organizational culture change. These three themes are explained in detail below.



I. Training, capacity building, and workforce development

Of all individuals interviewed, 80% brought up the issue of training as something they felt they needed for addressing racial health inequities. Notably, 53% of interviewees expressed that addressing racial health inequities felt out of their scope--a sentiment that was expressed with equal frequency among both leadership and staff and points to the need for training. When asked about what steps their program was taking, or had taken, to cultivate a public health workforce that is prepared to address racial health inequities 72% responded saying none.

Some previous and ongoing training resources that were highlighted as having been especially useful for imparting knowledge and ideas for praxis with respect to anti-racism and racial health inequity include:

- Centers for Disease Control and Prevention (CDC)'s documentary series, *Unnatural Cause*s, that explores the systemic sources of racial disparities in health in the US;
- Dr. Zea Malawa's talk, *The Origins of Black Poverty*, to debunk the racist myth that black poverty is due to something inherent in black people
- Healing Organization Workgroup (HOW)'s work around trauma informed care and services within MCAH
- Brown Bag series run by MCAH's equity committee once a month during lunch to provide an informal setting to learn about anti-racism and race equity.
- Ken Hardy's training on implicit bias and racial humility
- QI Academy, for providing quality improvement training for the different programs in MCAH

The following were cited as ways that these trainings could be built upon:

What future trainings should contain

- Content to develop a common language around racism and health inequities

> *"There is no shared language. I always assumed that people knew that disparities were rooted in racism, but I have learned that they do not. " --Staff*

> *"In SF we feel we are so progressive, you hear this all the time...there is a tremendous amount of racism in the department but it goes unacknowledged. Racism is often disregarded as unconscious bias, but they are not the same thing."--Leadership*
>
> *"There are a lot of people who have a basic idea of equality versus equity. Try to shine a light on where equality is problematic: in order for all ships to rise, some ships need more buoyancy than others. Some people don't understand equity in a way that isn't offensive to them. That's the battle that needs to be waged at a leadership level." --Leadership*
>
> *"[A barrier to this work is] staff's understanding and knowledge about and around racism—knowing that it's really there rather than thinking that people are pulling the race card. Some are woke, but not everyone sees it or sees it as something the program should work on." --Leadership*

Scholars in the field have noted that it is only in *naming* racism that we are able to mobilize with others towards confrontation in order to make any progress in reducing racial health disparities[12]. It is essential, then, that staff and leadership are on the same page about what racism is and how historical and present racism results in health disparities among program clients. The conflation of equity and equality illustrated in the last quote also signals the need for additional clarity on what distinguishes the two. Some words that will be essential in understanding racial equity and that should be built into future training to ensure a common language include: racism (institutional, structural, interpersonal, and internalized), equity, equality, power, privilege, implicit bias, prejudice, discrimination, and microaggressions.

- Training geared towards unlearning personal racism

> *"[There is a need] For people to really deal with their own racism! You can come together with other races later to try and work on this but first you have to deal with your own racism. The problem is the privilege of being born white and the entitlement that comes along with that."--Staff*
>
> *"People also just don't know what to do. Those who need to be engaged are afraid, and many of us as a workforce are not in tune enough with ourselves to check ourselves."--Staff*

It is important that as people build a common vocabulary, they similarly orient themselves to look inward and identify things such as racism, power, prejudice and implicit bias in themselves. Anti-racism trainers have reported being met with resistance and defensiveness from members of more privileged groups

[12] Jones, C. P. (2002). Confronting institutionalized racism. Phylon (1960-), 7-22.

when they facilitate conversations around confronting racism and personal implicit bias[13]. it is important to confront privilege and the ways that we have been complicit in racism before there can be any true progress in dismantling racism.

- Training on how to advocate for policy change around issues related to racial health inequities

> *" I do not feel like I have the tools to make an impact in a meaningful way, because what I do will be on my own and not to scale. We need legislative work, or training on how to be a part of legislative work".--Staff*
>
> *"Something we could improve on is better understanding our role as Health department employees around policy shift—what power do we have to shift institution culture? Zea and Jenna bring a lot of knowledge about that. Those are tools we don't have or that have not yet spread across MCAH. We don't have a process for analyzing policies or even the groundswell to develop the policies".--Leadership*
>
> *"We as MCAH need to advocate for housing prioritization of pregnant women, families, and children; we really need to fight for it because we're not fighting for it enough."--Staff*

Housing and employment were the determinants that were mentioned as examples of issues that employees would like to engage in advocacy around.

- Training that will equip employees to operationalize racial equity and address the sense of helplessness

> *"But we have virtually no control over the gigantic issues that are a huge contributor to health inequities; like the housing crisis and institutional racism in our medical institutions (I wish we had more to do—we do the best we can but we are faced with huge barriers)".--Leadership*
>
> *" I appreciate that MCAH has uncomfortable conversations but sometimes it gets tiring to just have these conversations. We need concrete tools moving forward from these conversations—the Nurse Leadership Conference was a great source of some tools, but that was for leadership. Leadership could most certainly use more tools, but overall we are exposed to more tools than the people on the frontline".--Leadership*

While it is important to have conversations around understanding race equity, work cannot stop there--it is essential to move beyond conversations and self-reflection to action. Staff and leadership can hold planning sessions to identify concrete ways through which they can apply the knowledge into their various roles in order to advance racial equity.

[13] DiAngelo, R. (2011). White fragility. The International Journal of Critical Pedagogy, 3(3).

How trainings should be structured/carried out

- Training that is ongoing, on all levels, and mandated.

> *"Yes. I know people complain about having to do yearlong trainings, but because we had to do QI, we learned. Having constant discussion about it. We all had to do trauma-informed training. If we had to have racial equity discussions, we're more likely to feel confident in addressing it. It's in our social environment to talk about racism because of the climate. Is this the next "hot" thing, like TIS, will it end in 3 years? We need to embed it in our policies in a way that staff understand it and why and how to incorporate it into the work. It's currently not explicit, like how to not tokenize. It's really important to engage all levels of collaborative. It would be great if it's required for all collective impacts to get training to take this to the next level. This needs to be mandated from leadership. Messaging needs to be processed through the whole city (not just specific point people)."--Staff*

The above quote exemplifies the sentiment expressed by other participants as well--a desire for racial equity training and work to be a consistent part of all work at MCAH and DPH. This will help in the normalization of conversations around race and also establish accountability. Other interviewees suggested that the section should work on making access to these trainings equitable in order to ensure that everyone has easy access. Barriers to equitable access that were mentioned included the time of the training, whether the location of training was central and easily accessible, and how expensive the training was.

- Employees who lead and are responsible for racial health equity work

> *"I would like a trainee position that is focused on health equity. We should set aside funding to support good-paying internships for underrepresented communities. This is not yet embedded in our infrastructure."--Leadership*

All of the people currently performing racial equity training and capacity-building at DPH do so in addition to their full-time positions. Along with vocalizing a strong desire for consistent training around operationalizing racial health equity in the different programs, interviewers also acknowledged the need for an office that drives this work. This would ensure sustainability and prevent burnout among those currently involved in this work.

II. Community engagement and client-centeredness

Community engagement and client-centeredness was the second most recurring code from the interviews (N=94). 23% reported that they had systematic ways of collecting client feedback:

> *"We have worked with programs that are geared towards recruiting minorities into STEM, as well as other organizations to provide experiences related to health services/sciences for young women, one-on-one counseling for career and working with individual health services plans."--Leadership*

> *"We are working on reassessing how/who gets services. Right now we are at times serving schools that are more resourced, so we are trying to make a shift – this has led us to take on more family child care sites. These sites often have more need but are serving fewer children, so we are trying to figure out that balance."--Staff*

67% reported that they did this informally:

> *"Sometimes clients will just talk/ask for what they need. We try to accommodate them as best we can – but there is no developed avenue for feedback."--Staff*

13.3% were not sure of how client perspectives were obtained:

> *"There's been very little interest in partnering with communities. It's been disturbing."--Staff*

Interviewees suggested the following as avenues through which MCAH can engage the community better:

- Collecting client feedback in a way that is more systematic

> *"We need a more intentional process [for client feedback] and accountability for our direct service programs."--Leadership*

> *"The way this happens is nurse-specific and more from direct interactions with clients. It would be good to consider a uniform way of doing this, so that everyone does it the same way across the board."--Staff*

Interviewees suggested that while the informal way of collecting feedback from clients (i.e. asking clients for feedback during interactions) was convenient and quick, it did not allow for accountability. They also expressed that informal collection of feedback meant that this was done without uniformity across the board, and that when done in person, collecting feedback informally could be skewed and unreliable due to power dynamic between staff and client.

- Getting members of the community employed at DPH and increasing representation among leadership

> *"But folks at the table making the decisions aren't representative of the community. Some communities are represented, but not all. We have high representation from the Chinese community, and moving into high representation from the Latino population, but not African American. There aren't many providers that are African American – pediatricians, dentists, dental hygienists."--Staff*
>
> *"Continue to promote change in leadership racial composition. That will speak volumes. That will trickle down out into the community and clients. They'll feel like they have a voice when someone who looks like them at table. Also, including client voice at CAB meetings is very important. If we are doing program evaluation, we need to hear from clients – we need to hear from clients."--Leadership*
>
> *"We want clients to see that they are represented and look at jobs here and feel like they belong here and in those positions. It will not be a space conducive to career growth if you look at the leadership and don't see yourself in them."--Leadership*

In general, it was reported that frontline staff was mostly diverse and reflective of the client population. However off the 17 programs interviewed, 5 reported having diverse leadership, one did not provide leadership breakdown, and the 11 remaining programs reported having leadership that was almost exclusively white. The hiring process (the exam in particular) was suggested as a barrier: "*Testing systems are not a good way to test someone's ability – the one taken to get this position felt like it was meant to trick people. It was poorly worded and not intuitive. It's a barrier to getting good people to work at the DPH.*"--Staff

- Strengthening existing partnerships with Community Based Organizations (CBOs) and building new ones

> *"I think as a public health organization, listening to the public is essential to who we are and how we function. The ties with community organizations need to be tight and tighter."--Staff*
>
> *"Being collaborative with those community orgs is crucial in this job because one needs to know what's available for all populations."--Staff*

Participants expressed that their programs should listen to their clients more, scope out what local organizations are doing and what resources are available to community members. Alameda County Public Health Department (ACPHD), a public health department in the Bay Area that has also began to explore operationalizing racial health equity, created a model that suggests that MCAH could also provide

assistance for community-led initiatives, teach residents how to lobby, and foster neighborhood self-sufficiency.

III. Building an organizational culture around race equity

This theme was the third most recurring with N= 85 references. As succinctly and eloquently put by the Government Alliance on Racial Equity (GARE), "*Racial inequities are not random; they have been created and sustained over time. Inequities will not disappear on their own*". This study suggests that work to undo deeply entrenched racist structures cannot be passive; it should be active and accountability can be ensured through explicitly integrating this work into current work descriptions and employee expectations.

- Dispelling the idea that racial equity work is separate from other DPH work

> *"...We cover areas that we see as part of our role, but don't yet see racial equity as part of our role. We should. But we don't. Housing is coming in and racial equity could come in too. We've been in racial crisis since Columbus landed here. But something has changed significantly for housing, and racism has always been there."--Staff*
>
> *"Right now we're just overwhelmed with the work we're short on and are trying to catch up."--Staff*
>
> *"We are too busy doing the work for them that we don't deal with the race. This is our way of making things right for people. Race becomes secondary, because you're so busy getting things done for the client."--Staff*

Responses from participants suggested that they did not currently see racial equity work integrated into their roles. It is important to create a culture of discussing this within programs regardless of position or role so that employees think racial equity is their responsibility and the responsibility of the organization. As it stands, 44% of interviewers responded saying that they had conversations about racism (both in formal settings such as meetings and informal settings such as during lunch). This indicates an openness to have these conversations and room for expanding this across the section.

- Explicit commitment to this work

> *"We need to make it more explicit that we are talking about racism in our mission statements. We should make it real and operationalize it."--Leadership*

"Department-wide: between setting true north metrics, participating in RBA metrics, and making presentation to the health commission in addition to having conversations internally, our leadership is respected and has the opportunity to elevate this issue in ways that have not seen from our department yet. While a lot of this work is coming from grassroots level, it also needs to come from leadership in order to be successful."--Staff

"Since I have been here, the program leadership has increased support but we still have a long way to go. It is one thing to be supportive and another thing to say that it's a priority."--Staff

"I don't think racial equity work is institutionalized and it is not a culture. It is ingrained in our system to think and talk about income and wealth but not race. We need to get more comfortable with it. There are some models, but it has not been done here so it's hard to do that. I don't think that staff readiness is an issue, or that time is an issue but there needs to be time given to planning."--Leadership

The commitment to addressing racial health inequities should be clear in mission statements, employee evaluations, and support from leadership. Rigid role descriptions that serve as barriers to racial health equity work should be adjusted and re-developed from a racial equity perspective.

- More collaboration across sections and programs

"We should also collaborate across sections more, like what we are doing with chronic disease— we have a collective voice, and so we should consider what can we say together to make impact in the communities we serve."--Staff

Initiatives to understand what different programs and sections in DPH do and collaborating on projects should be encouraged to discourage siloed functioning. Pooling together resources--be it skills, expertise, or financial--programs will be able to learn from and challenge each other while maximizing their impact on racial health inequities.

- Data collection on racial health inequities, stratification by race, and data sharing across DPH

[on collecting and sharing data] "Nope, not that I know of. And if they do, then it hasn't been made known to us. We need to hear it. It would help us be even better advocates for our clients. It is not shared with community."--Staff

"We are down from 2500 to 1600 clients compared to 20 years ago. And we don't know how many of those are Black. Undocumented and Latino population has likely gone down too. We aren't capturing race – so how do you know? I have a hunch, but I don't know."--Staff

65% of respondents reported that they collected some kind of data, but only 20% of these could confirm that the data could be disaggregated by race. Data is a necessary part of operationalizing racial equity; the Government Alliance for Racial Equity (GARE) highlights being data-driven as one of the action points for the successful operationalization of racial equity[14]. Data collection ensures accountability in terms of setting goals and measuring progress towards achieving those goals, helps to unearth hidden inequities and helps to define details of specific problems. Some questions compiled by GARE[8] to help with data-driven anti-racism work within program are as follows:

- What are the desired results? What are the clear race equity results you want to see in your community?
- What would the result look like in this community/neighborhood?
- What are the community indicators that would measure the desired result?
- What does the current data trend tell us?
- Who are your partners?
- What works to change the data trend towards racial equity?
- What actions should you start with?
    - Values: Is it strengths-based, people-centered, and culturally relevant/anti-racist? Does it advance a racial equity agenda?
    - Leverage: How likely is it to change the trendline? What additional resources for change does it activate?
    - Reach: Is it feasible? Will it actually benefit communities of color experiencing racial inequities?

[14] Racial Equity: Getting to Results. https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf

- Specificity: Does it have a timeline with deliverables that answer the questions who, what, when, where, and how?

The creation of tools to collect data should be done with the community and clients, however, in order to empower them and reduce the likelihood of data being biased due to biased collection tools. This is something MCAH could improve on, as 78% of interviewees that data was not shared with clients or the community.

Implications

The goal of this project was to better understand what MCAH programs are doing to advance racial health equity, and what gaps need to be filled. The themes that emerged in this project were similar to those uncovered by the Alameda County Public Health Department (ACPHD) in an evaluation of their employees; the strategies that were underscored by both projects as important steps for moving forward are as follows:

- transforming internal functioning of our organization through training and institutional change;
- collaborating with residents on neighborhood initiatives and building partnerships to address the root causes of health inequities;
- addressing local, state, and federal policies that impact social and health inequities;
- supporting this innovative work with data and research; and
- connecting our programs and services to all of these areas.[15]

These strategies fit into the framework presented by the Government Alliance on Racial Equity (GARE) for achieving racial equity: normalize conversations about race and racism, operationalize anti-racist behaviors and policies, and embed these in institutional culture[16]. Below are some SFDPH-specific recommendations from the qualitative research project.

Core competencies

I worked with the project team to analyze the responses to identify some skills and knowledge that would be useful for cultivating a public health workforce that is equipped to address racial health inequities. These were consolidated into a list of core competencies--weblink: Core work competencies (or see

[15] Alameda County Health Department. What is health equity and why is it important? http://www.acphd.org/social-and-health-equity.aspx

[16] Government Alliance on Race Equity. *Racial Equity Toolkit: An Opportunity to Operationalize Equity* https://www.racialequityalliance.org/2015/10/30/racial-equity-toolkit/

Appendix A); the competencies were modeled after the Center for the Study of Social Policy (CSSP)'s core competencies for their staff. This list could be used in employee evaluations to develop a workforce that is skilled in operationalizing racial equity as well as embedding it in organizational culture.

Racial Equity 101 Training Package

From the needs voiced in the interviews, a training package could be created to ensure that all new (and current) staff understand racial equity and are equipped with skills to address it. Building off ACPHD's Public Health 101 curriculum, I curated a framework for a Racial Equity 101 training package that can be further built upon and adjusted to the needs of MCAH and SFDPH. Links are attached to these modules below (in blue) to provide additional information as well as ideas for adapting the module to different contexts:

Module I : Public Health History, Public Health System, Core Functions and 10 Essential Services

Module II: Racial Equity and Undoing Racism

Module III: Community Capacity Building

Strategic Plan

Lastly, inspired by ACPHD's strategic plan, I broke down the main themes from this project's findings into action areas, arranged around five themes in the table below. The actions listed can be built upon by brainstorming with staff, leadership, and community members on how to break them down further within specific contexts into SMART (Specific, Measurable, Achievable, Relevant and Time-bound)[17], and in particular, how to make these time-bound. The actions are arranged thematically in the table below:

[17] Guide to Goal setting, Harvard 2013. https://hr.fas.harvard.edu/files/fas-hr/files/fy14_fas_guide_to_goal_setting_9.23.13_v2.pdf

Potential Strategic Plan

Transform our organizational culture and align our daily work to achieve health equity	**Ensure organizational accountability through measurable outcomes and community involvement**	**Support the development of a productive, creative and accountable workforce**	**Advocate for policies that address social conditions impacting health**	**Cultivate and expand partnerships that are community-driven**
1. Expand staff understanding of racism, public health, and health equity.	1. Collect program and services data and stratify by race and use results for decision making.	1. Ensure that employees are equipped to operationalize racial equity in their various roles.	1. Advocate for flexible funding to address social determinants of health.	1. Ensure staff capacity to forge and maintain community-driven partnerships.
2. Incorporate addressing racial health inequities into job descriptions and PH activities.	2. Engage community by obtaining feedback through more systematic avenues.	2. Provide equitable access to training and professional development opportunities.	2. Ensure that staff is supported to engage in policy creation and change.	2. Mobilize communities to build their capacity to improve their own health.
3. Align HR goals as well as hiring and promotion processes with anti-racism and health equity.	3. Share data with clients and communities.	3. Diversifying program, sectional, and organizational leadership and having representation from communities.	3. Build alliances and partnerships with CBOs and other organizations that are seeking to effect policy change.	3. Involve community members in planning and decision-making.
4. Facilitate cross-sectional collaboration to produce innovative ways of addressing racial health inequities.	4. Establishing a pipeline for getting members of the community hired, professionally developed, and retained at DPH.			

Appendix A

Racial Equity Core Competencies

Overarching Competencies:

1. **Foundational Knowledge:** You have foundational knowledge in the history and context of racism, shared language, and an understanding of your own institutional processes & systems to address racism.
2. **Emotional Resourcing & Communication:** You have the skills to emotionally handle racial stress that arises in conversations about race, and actively communicate about racism.
3. **Race Consciousness**: You actively integrate self-reflection and self-awareness throughout your interactions, and have political & structural competence when viewing the systems that our clients engage in.
4. **Translating Knowledge into Action:** You are able to apply what you know and understand into concrete actions to advance racial equity.
5. **Motivation & Prioritization**: You have personal motivation to advance racial equity, and prioritize this within your work.

Knowledge:

- Staff will understand (or, be able to define and identify) racism (internalized, interpersonal, institutional, structural), equity, equality, power, privilege, implicit bias, prejudice, discrimination, microaggressions. Specific emphasis on:
    - Establishing a common language
    - Clarifying the race-poverty and equality-equity conflation
- Staff will understand how historical and present racism result in health disparities in SF/among our clients.
    - Debunking the myth of "progressive San Francisco"
    - How everyday white supremacy shows up
- Staff will be able to understand the difference between individual-level interventions and environmental/structural-level interventions and their respective impacts (or lack thereof) on the various levels of racism.
- Staff will know basic data and metrics about the scope, extent of, and the economic and human costs of racial inequities, with particular attention to their clients/community they serve.
- Staff will know what to do when something racist happens in front of them.
- Staff understand why it's everybody's responsibility in their institution to address racism.
- Staff will understand how white supremacy divides marginalized or oppressed groups, and how solidarity is necessary for addressing racism.

Skills:

- Staff will be able to use a critical race lens to examine racism's impact on themselves, others, and the institution.
- Staff will be able to take action and create an action plan/next steps to advance racial equity in their work.
- Staff will be able to communicate and converse effectively about racism and issues related to racial equity.

- Staff can internally resource themselves to tolerate racial stress.
- Staff will have the skills to name racism, even if afraid or uncomfortable
- Staff will be able to productively engage in conversations about race and receive feedback
- Staff will be able to name and own their own privilege

Appendix B

Compiled Citations and Further Resources

Statistics for health disparities in the US broadly, and SF more specifically:

1. National Vital Statistics System, https://www.cdc.gov/nchs/nvss/index.htm
2. CDC National Center for Health Statistics, 2014. https://www.cdc.gov/nchs/index.htm
3. Black/African-American Health Report 2018. San Francisco, CA. https://www.sfdph.org/dph/files/reports/StudiesData/BAAHI-2018-Black-Health-Report.pdf

Structural racism and healthcare

1. Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. *Journal of public health management and practice:* JPHMP, 14(Suppl), S8.
2. Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American journal of public health*, 90(8), 1212.
3. Racial Equity Core Teams: The Engines of Institutional Change https://www.racialequityalliance.org/resources/racial-equity-core-teams-the-engines-of-institutional-change/
4. Racial Equity: Getting to Results https://www.racialequityalliance.org/resources/racial-equity-getting-results/
5. Racial Equity Action Plans: A How-to Manual https://www.racialequityalliance.org/resources/racial-equity-action-plans-manual/
6. Racial Equity Toolkit: An Opportunity to Operationalize Equity https://www.racialequityalliance.org/resources/racial-equity-toolkit-opportunity-operationalize-equity/
7. Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas Into Action https://www.racialequityalliance.org/resources/advancing-racial-equity-and-transforming-government-a-resource-guide-to-put-ideas-into-action/
8. Jones, C. P. (2002). Confronting institutionalized racism. Phylon (1960-), 7-22.
9. Alameda County Health Department. What is health equity and why is it important? http://www.acphd.org/social-and-health-equity.aspx
10. Bay Area Regional Health Inequities Initiative. From http://barhii.org/
11. DiAngelo, R. (2011). White fragility. The International Journal of Critical Pedagogy, 3(3).
12. Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: coming of age. Annual review of public health, 32, 381-398.
13. CDC Health Disparities and Inequalities Report https://www.cdc.gov/minorityhealth/CHDIReport.html
14. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf
15. World Health Organization: Social Determinants of Health, https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

Goal setting

1. Guide to Goal setting, Harvard 2013. https://hr.fas.harvard.edu/files/fas-hr/files/fy14_fas_guide_to_goal_setting_9.23.13_v2.pdf