Trust for America's Health
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Advancing Health Equity: What We Have Learned from Community-based Health Equity Initiatives

March 1, 2018

Convening Summary

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EXECUTIVE SUMMARY

There is overwhelming evidence that inequitable social, economic and environmental factors—such as racism, discrimination, poverty, and poor-quality education—contribute to disparities in health outcomes. Researchers and communities have proven and acknowledged the impact of such factors, gained a greater understanding of their root causes, and provided viable action steps to address these root causes. While many efforts are underway to address these disparities and promote health equity around the country, identifying the key lessons learned from these initiatives, and importantly, translating the most promising efforts into federal, state and local policies, remain a challenge.

On March 1, 2018, Trust for America's Health (TFAH), with support from The California Endowment, held a convening *Advancing Health Equity: What We Have Learned from Community-based Health Equity Initiatives* in Oakland, CA. The convening brought together 30 cross-sector leaders to identify and examine promising practices from existing community-based health equity initiatives. Special attention was paid to understanding the lessons learned from these practices to craft policy recommendations to promote the spread and scale of similar initiatives. Participants included federal, state and local public health officials; community organizers; business leaders; philanthropic organizations; researchers; tribal public health organizations; and advocates working within the health equity arena. Participants discussed the feasibility of—and necessary conditions for—building, replicating and sustaining health equity initiatives in different community settings, as a means to develop action steps to move a policy agenda forward.

There was acknowledgement that the specific implementation of each initiative must and should be adapted to and differ based on the community setting, target population, available resources and specific needs. Nonetheless, the convening participants identified core strategies of successful community-based health equity initiatives that would likely apply to any situation. The community-based health equity initiatives discussed at the convening:

1. **Build community voice and leadership capacity in order to build power.**
2. **Explicitly analyze and address various forms of structural oppression (racism, classism, sexism, xenophobia, etc.).**
3. **Shift the cultural narrative from one of exclusion to one of inclusion.**
4. **Build relationships, leadership structures, and trust to advance their goals and prepare for the opportune moment to shift policy and systems in support of equity.**
5. **Align community systems, assets, and skills into a new, coherent force for change.**
6. **Leverage policy and system changes to realign funding and resources to support community-driven equity goals.**
7. **Lead with humility and acknowledge that everyone has contributions.**

The following is a synthesis of the presentations and discussions of the March 2018 convening and recommendations for next steps in creating and advancing a policy agenda to promote community-based health equity initiatives.

KEY DEFINITIONS

Health Equity
Definitions of health equity vary across sectors and within organizations—and terms like "disparities," "inequities" and "inequalities" have important nuanced meanings. For the purposes of this convening, health equity was defined by the National Academies' 2017 *Communities in Action: Pathways to Health Equity* report as: "the state in which everyone has the chance to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or any other defined circumstance."[1] This framing recognizes the root causes of health inequities as "unequal allocation of power and resources" and "intrapersonal, interpersonal, institutional, and systemic mechanisms."

Structural or Institutional Oppression
Structural or institutional oppression refers to forms of oppression—such as racism, classism, sexism, xenophobia, and other forms of discrimination—that are built into the policies, laws, institutions, customs, or other social, economic or political power structures. Structural oppressions can exist regardless of whether an individual within an institution personally practices discrimination, and require larger policy, system or environmental change to correct.

Power
Power refers to the ability of an individual or community to meaningfully, and fully, participate in political, social, economic or other decision-making processes that impact them. This includes having equal opportunity to have their voices heard and reflected in the collective agenda, the identification of issues and the implementation of solutions. Empowered communities are equipped with the awareness, knowledge, and capacities to affect change at the policy, system and environmental levels—and possess the capacity to identify and navigate institutional or structural barriers.

THE CASE FOR ACTION

Over the last few decades, the concept of health has undergone a major shift in both the healthcare and public health sectors. Fueled in part by changing incentives for both sectors under the Affordable Care Act (ACA), the concept has expanded beyond the traditional medical model to one that recognizes the impact of the social determinants of health—and in turn from individual- to community-level interventions that span sectors–from health to healthcare to social services.

This change of scope and incentives has, in many cases, catalyzed collaboration and partnerships between healthcare, public health and traditionally "non-health" sectors (social services, in particular). For non-profit hospitals, the ACA's Community Health Needs Assessments requirements have put in place new mechanisms to encourage cross-sector collaboration in identification of community health needs. In some instances, this has led to better identification of issues and targeting of interventions within communities. Increasingly insurers and healthcare providers are recognizing the importance of screening patients for their social and economic needs and linking them to community agencies that can address their needs.

The concept of a future-oriented Public Health 3.0—a model for public health that focuses on cross-sector community collaboration to address the social determinants of health and promote equity—has likewise established new, similar responsibilities for local public health departments.[2] With an enhanced focus on policy and systems change, public health agencies and their leaders are increasingly cast as the Chief Health Strategist, a prominent convener of cross-sector stakeholders in their community.

These new partnerships, incentives and roles for the public health and healthcare sectors have in part been a result of, and have contributed to, similar shifts in health interventions and initiatives. The move "beyond the clinical walls" has led to greater investment in community-based initiatives to improve non-clinical, yet health-related factors—such as transportation or neighborhood safety—and the cross-sector partnerships needed to support these non-traditional health interventions. These incentives for cross-sector partnerships have, in some cases, encouraged the transfer of evidence and best practices between sectors. As noted by participants, the adoption of community-based participatory research (CBPR) methods, and asset- rather than needs-based assessments, have also contributed to a growing recognition within the public health sector of the need to do *with*, rather than do *to* communities—and within this, the notion of rebalancing power.

Nevertheless, to date relatively few resources have been dedicated to building the leadership capacity of communities. Federal funding for community-led initiatives, which was never plentiful, has decreased over the last several years. Where governmental funding allowed, certain local and state agencies have prioritized such initiatives in settings such as Los Angeles, Vermont, Rhode Island and Minnesota. The philanthropic sector, led by such national exemplars as The California Endowment, Robert Wood Johnson Foundation, W.K. Kellogg Foundation and Kresge Foundation, have increasingly invested in community-led and oriented health efforts. But, participants noted, there have simply been insufficient dollars to achieve the goal of equity, change the norms, and, in particular, to adequately invest in communities with the fewest resources and the greatest inequities.

A FRAMEWORK FOR ADDRESSING HEALTH EQUITY

In adopting an upstream model of health (addressing the socio-ecological conditions contributing to health consequences), some community-based *health* initiatives have changed their focus to be community-based *health equity* initiatives. Both types of initiatives may:

- Target specific health outcomes at the community level (e.g. obesity, heart disease or substance misuse);
- Engage community stakeholders;
- Implement evidence-based and promising practices or policies at the individual and community levels; and/or
- Engage residents with lived experience.

However, more traditional community-based initiatives often focus on a changing a specific health behavior, health issue or employ approaches pre-identified by a public or private funder.

Community-based health equity initiatives specifically acknowledge and address the underlying unfairness in policies, systems, and environments contributing to poor health outcomes. This may mean an initiative focuses on an issue that initially might not appear to be connected to health,

such as a school discipline or a transportation policy. They authentically engage the community (along with others) in identifying the priority issues and the approaches to address them. A community-based health equity approach also invests in building the strength, influence and activism of community members. A central goal is to ensure a sustainable and powerful "voice" of the community in identifying and changing the conditions that affect their health and well-being writ large.

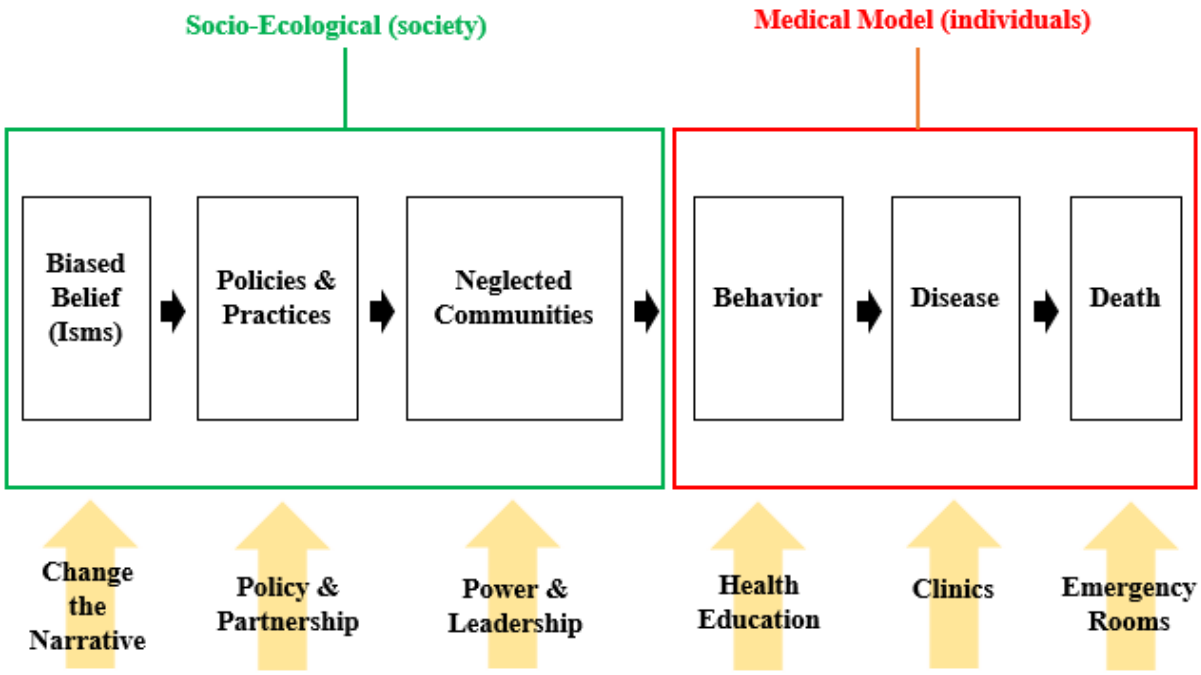


Figure 1*: A Framework for Health Equity. Source: The California Endowment (Adapted from the Bay Area Regional Health Inequities Initiative, Summer 2008)*[3]

As depicted in the *Framework for Health Equity* above (Figure 1), the consequences of socio-ecological inequities manifest in disparities in health behaviors, disease prevalence and mortality. Addressing these upstream conditions are critical for addressing downstream health disparities. Based on The California Endowment's Building Healthy Communities (BHC) *Framework for Health Equity*, community-based health equity initiatives employ three distinct strategies to target inequities: [4]

1. Changing the narrative or the beliefs about the reasons for inequities by discussing the ways that racism, poverty and other factors create conditions that lead to poor health;
2. Leveraging partnerships beyond the traditional allies, enhancing collaboration and spurring policy innovation to address institutional drivers of inequities; and
3. Fostering people power within communities, including investing in youth development and leadership to organize communities to address social inequities.

Attendees at the convening agreed that to have impact and create sustainable change, initiatives must intervene on each of these three levels.

LEARNINGS FROM CURRENT COMMUNITY-BASED HEALTH EQUITY INITIATIVES

There is no one-size-fits-all approach to community-based health equity initiatives, which can complicate attempts to spread and scale them. However, despite the differences between community contexts and approaches, there are common elements of successful initiatives that are applicable to questions of scale and replication.

At the convening, case studies of three community-based health equity initiatives were presented to identify commonalities, promising practices, as well as important differences to consider when replicating, adapting, or scaling health equity initiatives. Each initiative utilized a distinct set of strategies for advancing health equity—including a focus on different populations or settings, engagement of diverse partners, tapping different funding streams, and addressing distinct goals. Yet, from convening discussions, common themes emerged around several shared elements or strategies utilized by community-based health equity initiatives, including those represented in the case studies and other initiatives shared by convening participants.

The case studies presented below are summaries from the larger case studies provided at the convening, and are intended to briefly illuminate some of the themes from the March 2018 convening. Full, unabridged versions of the case studies are provided in Appendix 2.

Healthy Heartlands – WISDOM, WI

"People needed examples of things that are succeeding, not a blueprint to replicate, but ideas for how they could operate—inspiration."

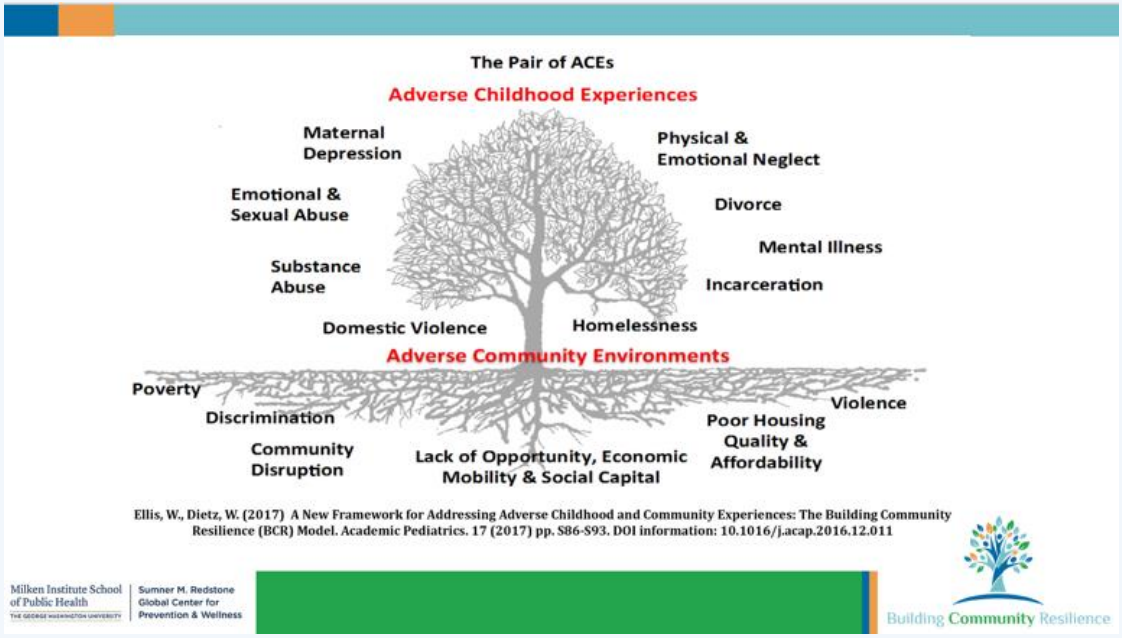
Launched in 2009 by Minnesota-based community advocacy group ISAIAH, Healthy Heartlands is a multi-state health equity initiative that fosters cross-state learning and partners with participating states on cross-sector coordination and investments to drive health equity action. Healthy Heartlands invests in partnerships between public health and community organizers, leveraging the research assets and credibility of the public health sector together with neighborhood engagement expertise and advocacy power from community organizers in a coordinated network approach. Each participating state in the initiative is led by a central state-based "hub" that acts as a connector between the local grassroots leaders in their state and the other states participating in the Healthy Heartlands initiative.

In Wisconsin, the Healthy Heartlands hub is Thrive WI. Thrive WI is a statewide health equity alliance that brings together community organizers and public health researchers to address equity. Thrive is led by WISDOM, a statewide network of faith communities, and the UW Madison Population Health Institute. Thrive WI focuses its health and social equity efforts on several issues, including reforming the state's criminal justice system. Wisconsin's incarceration rate for African-Americans is among the highest in the nation, and impacts the health outcomes of those incarcerated and their families. Communicating the connection between poor health outcomes and incarceration is challenging, so WISDOM enlisted Human Impact Partners to quantify the health and economic impacts of such investments through a health impact assessment. This year-long assessment revealed that implementing treatment alternatives (as opposed to incarceration) could reduce crime, increase chances of recovery, create stronger families and better economic opportunities for the newly released, and ultimately reduce costs since alternative treatments can be up to four times less expensive than incarceration. WISDOM

partners with organizations representing those most impacted by incarceration, like Ex-Prisoners Organizing (EXPO), which works to end mass incarceration, eliminate all forms of structural discrimination against formerly incarcerated people, and restore formerly incarcerated people to full participation in the life of their communities. Healthy Heartlands hubs like Thrive WI leverage these community partnerships to build alliances of diverse stakeholders that learn together, share best practices, and engage in collective action to affect the root causes and social, economic, and environmental determinants of health.

Building Community Resilience – Portland, OR

"Authenticity is key. Humility is essential. And an awareness that oppression equals trauma, thus the response to this work—even to those who are dedicated to undoing it—must be a trauma response."



Building Community Resilience (BCR) is a George Washington University (GWU) led national collaborative that seeks to improve the health of children, families, and communities by fostering engagement between grassroots community service organizations and public and private systems. BCR focuses on developing a protective buffer against adverse childhood experiences (ACEs) (e.g. exposure to physical, sexual and emotional abuse, poverty, neglect, etc.) occurring in adverse community environments (ACEs) (e.g. those with poor housing, low economic mobility, or community violence)—what BCR collectively refers to as the "Pair of ACEs."

BCR's success stems not from implementing a step-by-step program in the communities it serves, but rather, working with communities and organizations to craft a path toward wellness and resilience. In Portland, Oregon, BCR is working to foster a community-wide effort to improve child health and wellness outcomes by creating channels of communication, connections and authentic partnerships between community members and larger institutions working within the child health arena.

BCR Portland utilizes a trusted backbone organization to connect state and local health and education agencies, healthcare systems and higher education institutions with community advocacy groups to

create a sustainable partnership to implement trauma-informed care within one Portland community. To overcome the lack of coordination and collaboration in addressing the needs of traumatized youth in the community, BCR engaged Trillium Family Services, an organization specializing in the behavioral health of children and families. Trillium's strong community connections and awareness of the importance of health equity positioned it well to be the anchor in the effort to coordinate and improve wellness services. Working with BCR, Trillium engaged with Concordia University to open a "3 to PhD" school that focuses on the health and well-being of its K-5 students, resulting in reduced student suspensions, increased student attendance rates and higher reading achievement. They engaged with the Oregon Health Authority, which oversees the Oregon Health Plan (the state Medicaid provider) and instituted a statewide trauma-informed care collaborative, thus creating favorable Medicaid policies for supporting the establishment of the BCR initiative. Trillium enlisted the Oregon Public Health Institute to improve community outreach with a specific focus on increasing health equity and works with a variety of media-focused entities to amplify messaging around wellness and resilience.

Building Healthy Communities – East Salinas, CA

"Cultivating racially equitable governments requires real community partnership, where residents can guide policy goals, share decision-making power and create measures for accountability. Only a mature infrastructure of community-based organizations can provide the leadership and social network necessary for residents to partner in institutional transformation."[1]

Building Healthy Communities (BHC) is a 10-year, $1 billion place-based initiative of The California Endowment working in 14 California communities to promote prevention policy, system and environmental changes through cross-sector collaborations and community engagement. Launched in 2010, BHC aims to reduce health inequities through improvements in neighborhood safety, unhealthy environmental conditions, access to healthy foods, education, housing, and employment opportunities. Each BHC hub appoints a BHC Hub Host organization to act as the central coordinator for implementation of health improvement initiatives.

In 2011, BHC selected East Salinas, California as a hub. East Salinas suffered historically from significant racial tension and recent race-based violence. The BHC East Salinas hub aims to address racial injustice by healing the relationship between the City of Salinas and the community residents. By promoting spaces for racial healing, the initiative is working to reduce the stress and trauma in the lives of the city's residents, particularly its youth, whose response to trauma can be manifested in defiant behavior, disengagement, and ultimately, a decline in their physical health. BHC East Salinas implemented a Healing-Informed Governing for Racial Equity (GRE) model to unify community members and local government around how their city should operate to create the best possible conditions for its people. A three-day training was conducted to increase emotional capacity for racial healing and equip teams to pursue equity-focused solutions to racial issues.

To promote sustainable change, BHC East Salinas also leads a nine-month leadership academy with community members—and importantly includes youth leaders—to develop and build residents' awareness and capacities to actively engage in civic participation.

The following emerging practices that surfaced from the convening are not intended to be a definition of community-based health equity initiatives, but rather a list of common elements, practices or lessons which could be adapted to specific community settings or contexts.

Community-based health equity initiatives:

1. **Build community voice and leadership capacity in order to build power.**

   Participants identified community power—or the collective ability to affect change and have equal participation in political, social or economic systems—as a crucial component for achieving health equity. It was noted that creating equity requires a *rebalancing* of power and relationships in communities—including social, political and economic power. Participants recognized that changing power structures necessitates ceding power. Ultimately, building power is a means for achieving policy and institutional change and an end goal of equity initiatives.

   Building sustainable leadership capacity in the community rose to the top in terms of strategies to foster community power— including by engaging and nurturing the leadership capacity of community youth. BHC East Salinas, for example, is forming a network of future community leaders, including youth, by training residents in leaderships skills and capacities through their nine-month leadership academy. The academy aims to build civic engagement among community residents by building skills, creating more informed citizens, increasing awareness of various commissions or boards residents can participate on, and helping residents harness the power of storytelling.

   As demonstrated by the case studies, capacity building can be both bottom-up and top-down. With Healthy Heartlands, the larger national initiative hosts cross-state leadership trainings for their community hub leaders which feed into community hubs', like Thrive WI and WISDOM's, leadership trainings and capacity building initiatives for local leaders. As a learning network, leadership approaches, resources and best practices from local organizations are likewise passed in reverse through state hubs and across states through meetings of the national network.

   To create changes in system-level leadership capacities, participants recognized that all community stakeholders should be considered—including those living in, working in, or funding communities. BHC East Salinas intentionally included residents, community organizations, local officials, and philanthropic organizations in its racial healing trainings—enhancing leadership capacity across sectors and systems. The BCR Portland initiative includes an explicit goal to address the capacity constraints in grassroots and community-based organizations to form a coherent organizing strategy or voice. The backbone organization, Trillium Family Service, identifies and connects the various assets and strengths of each community entity to form a collective network of organizations addressing health equity. Building experiences of agency and leadership for people of color is the basis of the Healthy Heartlands strategy. The Healthy Heartlands initiative builds individual- and community-level leadership through its formal learning network of state-level hub organizations. The multi-state network provides leadership trainings, organizes conferences and calls, and disseminates

resources to develop the skills and capacities of organizations and leaders to catalyze action in their communities.

Convening participants noted the critical role that community organizers and activist networks play in building power by uplifting the assets, narratives and capacities that already exists in communities. As noted by one participant, social movement theory is old science, and widely taught and implemented within the community organizing field; however, the public health and healthcare sectors have not historically been taught these practices, attesting to the different assets and knowledge bases contributed by different sectors. In supporting and connecting leaders from public health and community organizing, Thrive WI is amplifying their impact by building cross-sector leadership capacity. Thrive WI provides technical assistance and trainings to local leaders on the benefits of initiatives that use authentic and mutually beneficial partnership between community organizers and public health.

2. Explicitly analyze and address various forms of structural oppression (racism, classism, sexism, xenophobia, etc.).

Participants drew upon the evidence that disparities are in part the result of inequities in the social determinants of health. These inequities are not random; they have been created and sustained over time.[7] Simply put, not everyone has the same opportunity to be healthy in America.[8] Some participants felt strongly that health equity initiatives must recognize and acknowledge the historical institutions and forms of structural oppression that have led to the current levels of health disparities in the United States.[9]

Community-based health equity initiatives examine policies, programs and practices that perpetuate inequities to ensure that they do not perpetuate or create a less fair system, as depicted in the case studies and reiterated through the input of convening participants. BHC East Salinas implemented a Healing-Informed Governing for Racial Equity (GRE) model to unify community members and local government around how their city should operate to create the best possible conditions for its people. This approach combined racial healing with an examination of systemic equity and included building a joint process led by the city government and community advocates. Each decision is analyzed based on its impact on

Government Alliance on Race and Equity[5] & Governing for Racial Equity

Government Alliance on Race and Equity (GARE) has issued a series of guides and tools to help local governments and communities examine their actions using an equity lens, to ensure that they do not perpetuate structural forms of oppression. Local, state and federal government agencies can employ GARE's Governing for Racial Equity (GRE) approach to change how resources and funding are allocated, and ensure a racial equity lens is applied to all decision-making and institutional practices by:[6]

1. Using a racial equity framework;
2. Building organization capacity;
3. Implementing racial equity tools;
4. Being data-driven;
5. Partnering with other institutions and communities; and
6. Operating with urgency and accountability.

equity. Positive outcomes of this endeavor include policy and program improvements in the Salinas Police, Public Works and Community and Economic Development departments.[10]

The BCR Portland site was selected as one of the five BCR sites in part due to Oregon's history as a free White state and its deep-seated interpersonal and systemic racism. The initiative recognizes the historical impacts of racism and exclusion in shaping the lived experiences of the communities it works in. Their focus on trauma-informed care and practices are rooted in addressing the influences of these forms of structural oppression on children and families. The BHC East Salinas initiative addresses health equity through a shared acknowledgement of the mutual humanity and experiences of the communities it works with, including historical trauma and an emphasis on racial healing. These practices aim to change community institutions (schools, justice system, local government, philanthropy, etc.) and create an ecosystem for a racial justice shift in their community.

3. Shift the cultural narrative from one of exclusion to one of inclusion.

To change the downstream effects of inequities, initiatives often tackle the biased beliefs and cultural narrative perpetuating these inequities. This includes changing ideas about who matters and belongs, what creates health, and the role of government and other stakeholders. As part of presentations and discussion, the convening participants noted that acknowledging structural oppression helps to reframe the dominant cultural narrative to ensure that everyone is included, since the narrative of exclusion is fundamentally about "isms"—sexism, racism, classism, etc. Participants noted that the dominant cultural narrative views the past through rose-colored glasses, looks towards the future with fear, and dehumanizes people.[11] Drawing on the case studies and additional experiences of participants, participants noted that shifting the narrative to one of inclusion begins with individual reflection and learning about racial and other forms of justice and continues with community-level training and creating spaces for healing. The experience of hearing stories of similarly situated people helps foster a sense of belonging and inclusion which helps counter the erosive sense of "otherness", invisibility, and marginalization that those that have been excluded report. Participants emphasized that, for sustainable change, narratives told by opportunity structures—such as schools or the criminal justice system—must shift towards inclusion.

Capturing and presenting authentic narratives is another important, yet challenging, strategy to shift the cultural narratives, as identified in the case studies. Lifting up people's stories and experiences which have not historically been acknowledged was identified as critical to changing biased beliefs and is a common strategy of many health equity initiatives. Participants noted a need to deconstruct the stories and determine when people's experiences have not just gone unacknowledged, but have been destroyed. Storytelling also holds immense power as a means to humanize data and statistics on health disparities and drive policy change.

4. Build relationships, leadership structures and trust to advance their goals and prepare for the opportune moment to shift policy and systems in support of equity.

Participants recognized that the local, state and federal political environment or political will of leadership is not always supportive or conducive to advancing equity initiatives—or may

not be in the future. However, participants agreed this does not mean that communities cannot take steps to build relationships, partnerships, or other capacities to advance their work and to prepare for when the political momentum is ripe, or other events catalyze action.

Building the leadership capacities of young people, establishing patterns of strong civic engagement, and forging relationships between unlikely partners (such as in the case of law enforcement and community residents in East Salinas) can be done in the absence of a supportive political environment. This conscious effort to act now creates an ecosystem for racial justice shifts and the infrastructure for change, allowing for action when the moment arises.

Improvements in health equity take multiple years of effort. Short-term changes and gains can be made toward the ultimate goal of improving health equity, as demonstrated by the case studies and the experiences of convening participants. Local initiatives need time to build trust, develop relationships and increase leadership capacity. The process of identifying and agreeing upon priority issues and plans to address them can be lengthy. The California Endowment made a 10-year commitment to its funded communities and is considering extending its commitment beyond the initial 10 years.

BCR Portland attributes part of its success to the support of its funders for long-term, sustained and authentic trust-building with community members and organizations. The initiative intentionally built this phase into their funding request. While these initial efforts may not result in traditional, quantitatively measurable health outcomes, these critical intermediary, process outcomes create the foundation for sustainable system, policy, and narrative changes. The BCR Portland backbone organization leverages the trust it has developed with community members and institutions to gain commitment and buy-in from government and other organizations, such as hospitals, health plans, and school systems, to implement trauma-informed practices and policies.

5. Align community interests, assets, and skills into a new, coherent force for change.

The case studies demonstrate how community-based health equity initiatives align interests across groups to build power and momentum for policy and systems change. Every sector has something to gain from a more equitable community—and there is a business case to be made to drive change. All of the case studies employ methods to help partners see their role in and the potential benefits of improving health equity and work to engage these partners to create a multi-sectorial community-wide effort. This includes helping stakeholders commit to mutual goals and align assets to accomplish these goals.

Rather than working on one policy change at a time, the case studies emphasize the need to nurture power in the community, allowing communities to self-identify and self-mobilize to work on multiple policy changes simultaneously. The case studies and similar initiatives helped residents embrace their identity and mobilize for change, recognizing that identity is intersectional and individually defined, and that action at times requires multiple communities banding together.

Prior to the implementation of BCR, Portland's activist community was disconnected, lacking the capacity to coordinate between grassroots entities and issues. BCR Portland leverages its backbone organization, Trillium, to identify commonalities between disparate grassroots efforts and align the interests, capacities and resources between these community-led campaigns and anchor institutions to enact change. This endeavor to align efforts and forge authentic partnerships is now a central goal, alongside the implementation of a trauma-informed system, to improve health equity in a Portland community.

Participants also identified a need to create a common language between stakeholders to help align priorities, goals, and outcomes across sectors. Participants recognized the many different viewpoints, as expressed by different language and meaning for terms such as inequity, inequality, disparity, social determinants, power and even the word community.

6. **Leverage policy and system changes in institutions to realign funding and resources to support community-driven equity goals.**

The case studies and experiences of participants strongly emphasized the importance of driving change not just through provision of services, training or other supports, but also by working at the systems level to enact policy changes. As with the rebalance of power cited above, community-based health equity initiatives typically work to create policy, systems and environmental changes to address the health equity issues they prioritize and create sustainable change.

BCR Portland's 3 to PhD Consortium helps create safer and healthier schools, and implements the Chrysalis program, a school-based prevention program to support teenage, female-identifying trauma survivors. The Consortium leverages partnerships with established institutions and systems to redirect existing funding, resources and capacities toward community-identified needs that drive equity. For example, 3 to PhD used resources from Portland Public Schools (a capital bond), Concordia University, and Kaiser Permanente to partially fund the rebuilding of the Faubion School (the campus of 3 to PhD), co-locate the Concordia University's School of Education within this elementary school (redirecting teaching capacities into the school), and establish a wellness center staffed by Kaiser Permanente. Similarly, they teamed with the Oregon Public Health Institute—an established institution with strong partnerships with public health stakeholders and marketing capacities—to ensure a focus on health equity and community outreach and to amplify their statewide wellness and resilience communications campaign.

7. **Lead with humility and acknowledge that everyone has contributions.**

As noted previously, participants acknowledged that health equity work must start with an internal understanding and humility at both the individual and organizational level. Organizations participating in health equity initiatives—including public health organizations, government offices, and philanthropic organizations—should examine how their own internal actions and institutional policies may perpetuate structural oppression. This includes government institutions and philanthropy, which should be a driving force in identifying and remedying their own institutional practices creating, contributing to or perpetuating inequities.

The convening participants emphasized that no one person has all of the answers for addressing health equity. The case studies emphasized the importance of valuing community experience and expertise side-by-side with traditional experts (like researchers and professionals from various disciplines). Communities have knowledge, expertise, and experiences that can add to traditional research when identifying assets and needs within a community, and importantly, for selecting solutions. The case studies take the approach of listening to and learning from communities, rather than telling communities what to prioritize and what to do about it.

Jemez Principles for Democratic Organizing [12]

- Be Inclusive
- Emphasis on Bottom-Up Organizing
- Let People Speak for Themselves
- Work Together in Solidarity and Mutuality
- Build Just Relationships Among Ourselves
- Commitment to Self-Transformation

Speaking from their own experiences, several participants noted that when creating a community-based health equity initiative—or even engaging in specific activities within a health equity initiative—it is critical to reflect and consider if you or your organization are the right people to be doing that work. This requires recognizing perceived power dynamics that may exist; assessing the strength and validity of relationships with individuals, organizations, or institutions; considering various forms of evidence; and analyzing collective assets and gaps among partners.

In their work on mass incarceration, WISDOM strengthens communication with smaller community justice groups to increase the diversity of voices involved. One partner, ExPO, which was started and is led by formerly incarcerated people who organized to support each other and change Wisconsin's penal system, provides critical leadership in ensuring that those most impacted by mass incarceration are leading the solutions, see themselves as full participants in the initiative, and are connected with the other WISDOM partners.

In East Salinas, residents organized themselves and partnered with the City of Salinas to develop the Alisal Vibrancy Plan, a two-year $750,000 planning process to create a community-driven plan for East Salinas. The plan was built on a process that considered community expertise and sought to build community voice, by fostering leadership capacity among residents and authentic civic engagement. The Alisal Vibrancy Plan was designed *with* the community, versus *for* the community, and represents the first time the City of Salinas has developed a bilingual plan specific to East Salinas.

AREAS FOR FURTHER EXPLORATION

Community-based health equity initiatives are a work in progress. Their missteps and challenges reveal potential policy and programmatic barriers that new and existing initiatives can benefit from learning. Lessons on what does not work in health equity initiatives are as important to catalog as lessons on what does work. It is critical for these initiatives to fail fast and move on to avoid perpetuating or unintentionally widening inequities.

Input from the convening participants contributed to the development of the following areas needing further exploration to develop and advance a policy agenda for health equity.

Spreading and Scaling

Convening participants cautioned against applying a traditional model of spread and scale to health equity initiatives. While many lessons can be gleaned, and some can be transferred, generalization has been a major factor in perpetuating or exacerbating inequities. Replication to scale must be balanced with adaptability to local communities and populations. Because they are designed to be conscious of an individual community's assets, challenges and contexts, community-based initiatives cannot necessarily be directly replicated in other settings. Different communities face different multifaceted barriers to achieving health equity that are often rooted in a community's ever-changing historical context and driven by current leadership. Communities may be at various levels of readiness for implementing health equity initiatives—from communities with a strong history of community organizing and action around identified issues to those just beginning to build their collective voice.

Defining Success

There is no current definition of success, or any standard set of either process or outcome measures, for community-based health equity initiatives. Outcomes cannot always be predicted (or prescribed by funders) in advance if the community is truly engaged in identifying the needs and priorities. The goals of community-based health equity initiatives may not be easily measured and may fall outside of existing indicators of success held by philanthropic or government organizations. This requires public and private funders to consider proxy and/or interim measures for health equity initiatives, such as the establishment of community trust and relationships, collective impact, emotional intelligence and social responsibility. Additional research is needed to link intermediary outcomes to long-term outcomes. Participants noted that leveraging both practice-based evidence and evidence-based practice is important—i.e. considering how to balance evidence generated by the traditional research approach with community wisdom.

Technical Assistance and Support

The case studies presented at the convening are each part of an organized network that provides them with assistance and support (from The California Endowment, George Washington University and Healthy Heartlands). Further exploration is needed to understand what type and level of support is necessary for success and/or spread, and what level of resources this support will require. For example, one component of this assistance is translation of the evidence-base into practice; further exploration is needed to identify the best methods for this translation. Another example is the methodology for assessing disparities. Some initiatives have employed a health impact assessments (HIAs) to identify the impacts of inequities. This methodology can be helpful for bridging understanding across sectors. Community initiatives need help identifying, gathering and analyzing data. BCR intentionally uses both community data and systems data (such as HIA, community health needs assessments, etc.) to ensure a full picture of needs that reflects both the desires of the systems and anchors (such as hospitals) as well as those of the community.

Building Community Capacity and Leadership

As demonstrated in the case studies, existing initiatives are implementing a variety of capacity and leadership building activities. To date, these practices have not been fully researched, yet the effects on community power and civic participation—and the resulting health outcomes—are widely recognized in practice and in other sectors beyond public health (e.g. community organizing). Lessons and experience from the business sector can be leveraged to better understand how to build leadership capacity.

Defining Community

Convening participants acknowledged the different meanings attributed to the term "community". They noted that the term does not capture the intersectionality of individuals, neighborhoods or localities—and is often used by different people to mean different things. Those on the outside of community may define the setting and population for an initiative differently than the residents themselves.

Rather than defining a community solely by one demographic, one participant asserted that initiatives should instead define an issue around which to organize people. However, simply organizing the community writ large around a topic can exclude or diminish the participation of marginalized populations. For example, WISDOM organized the community around parole violations and thus organized individuals who are formerly incarcerated, noting that this group of people otherwise would not have convened naturally.

The Role of Philanthropy

Philanthropy has played an instrumental role in investing in health equity initiatives—and represents a key force to advance health equity initiatives, particularly in light of scant government support. As noted above, philanthropic institutions have their journey, much like communities, governments and other anchor institutions. The power inherent to philanthropic organizations should be better balanced with the goals, assets, and power in communities.

As an example, the outcomes and indicators of success historically set by the philanthropic sector (and public sector) can contribute to this notion of a need to reframe a given issue, population, or setting to meet the constraints of a funder—rather than funding being shaped to meet the identified priorities of the target population. Philanthropic organizations should consider exploring approaches that more fully engage community members and/or organizations in priority setting and decision-making. This might include increasing investment in grassroots organizations, particularly those led by people of color.

Foundations are making this shift—including many of those funding at the local-level. As a result of the efforts of the BHC East Salinas coalition, the Monterey County Funders group—a group of eight local foundations—is developing a racial justice framework for grantmaking. The group is undertaking a critical analysis of how their expected grant outcomes may or may not be driving progress towards the roots of racial inequities in their community.

Level of Investment

A key question for further exploration is the level of investment needed for impact at the targeted community level and for the networks that provide support to the community initiatives.

Participants noted that the goal of health equity initiatives should not be to buy one's way to equity, but rather to leverage one's way through existing resources and assets in the community, government and private sectors. That said, the question remains as to what level of initial and ongoing investment is needed to seed and sustain these types of initiatives that take years (or even decades) to get results. The convening case studies varied drastically in their funding mechanisms, sources, amounts and duration.

Of note, just as not all programmatic elements of health equity initiatives are transferable, not all funding mechanisms may work or be available in each community setting. Communities may not have, or even want, the same level or types of investment to advance their health equity initiatives. Government funding may not, for example, be accepted by every health equity initiative due to sometimes restrictive requirements and limited timeframes.

Federal Policy Opportunities

Participants in the convening identified several opportunities to advance federal policies to promote health equity. Participants recognized the importance of defending and expanding public health and social support programs that build individual and community resilience, recovery, self-sufficiency and civic engagement. A compelling case was made for greater investment in long-term population-level research and demonstration projects to evaluate the structure/design process and effectiveness. Participants noted numerous challenges to advancing federal health equity policies. Nonetheless they also felt strongly that action can and should be taken to identify the short, medium, and longer-term cost- and life-saving transformational changes that can be achieved in communities where equity is promoted and where community members are actively engaged. Forward progress can be accelerated by continuing to make the case that health equity is part of a broader agenda of advancing health for all.

NEXT STEPS

The lessons from this convening are a contribution to the growing momentum for a national agenda to improve health equity that is centered on building community power and addressing the systems, policies, and institutional practices that perpetuate inequities. Experiences and perspectives vary across settings and disciplines, and are influenced by the political, social and economic context. This convening was the first in a series of regional convenings designed to gather additional promising practices and lessons learned from community-based health equity initiatives. Through each subsequent convening, TFAH will refine the lessons and policy considerations articulated above to further the national policy dialogue and action on health equity.

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APPENDIX 2: FULL CASE STUDIES

Healthy Heartlands – WISDOM

"People needed examples of things that are succeeding,
not a blueprint to replicate but ideas for how they could operate—inspiration."

Background on Healthy Heartlands: A Network Approach to Advancing Health Equity

Launched in 2009 by Minnesota-based community advocacy group ISAIAH, Healthy Heartlands is a multi-state health equity initiative that fosters cross-state learning and supports participating states through coordination and some financial contributions to drive health equity action. Healthy Heartlands' aim is to create a systemic and collaborative approach to drive positive policy change in society, starting with the spread of a broad vision that promotes health equity outcomes. Through its approach, Healthy Heartlands aims to tackle a perpetual challenge in the public health sector: how to translate knowledge and research around health equity and social determinants into action and policy.

To do so, Healthy Heartlands utilizes a network approach. Each participating state in the initiative is led by a central state-based "hub", often a community organizing group. This group serves on the Healthy Heartlands leadership team and acts as a connector between the local grassroots leaders in their state and the other states participating in the Healthy Heartlands initiative. Organizations and individuals participating in this collaborative communicate through their state's hub organization, creating a web of relationships for dissemination of information and best practices. These hubs leverage the research assets and credibility of the public health sector and neighborhood engagement expertise and convening power from the community organizers to drive impactful action.

As a community organizer, the hub is able to utilize its strong community relationships and organizing power to build an on-the-ground "network" of constituents in their state, including individual residents, academic researchers and their institutions, and public health workers. These allies can be trained using the collaborative's webinars, case studies and other resources and then mobilized to address needs specific to their locales. Their involvement allows the Healthy Heartlands initiative to catalyze action with stakeholders at all levels: from state-agencies to targeted neighborhoods, as trust and understanding already exist.

Building experiences of agency and leadership for people of color and engaging organizations in a process of racial healing are not only goals but the basis of their entire strategic approach. Intermediate goals include activating a grassroots base through leadership training and breakthrough issue campaigns, facilitating a formal learning network of organizers and health leaders. They also aim to provide effective technical assistance and national support through the state hubs and to carry out Health Impact Assessments to publicize issues from a quantitative perspective. The Healthy Heartlands Collaborative measures success differently than many other health equity initiatives. Because they do not seek to do specific work themselves, necessarily, much of what defines progress is highly qualitative. For example, goals include the formalization of their learnings, expansion of the initiative, supporting and building power for community affiliates, and disseminating knowledge both informally and through a formal learning network of organizers and health leaders.

Lessons from Healthy Heartlands' WISDOM Hub

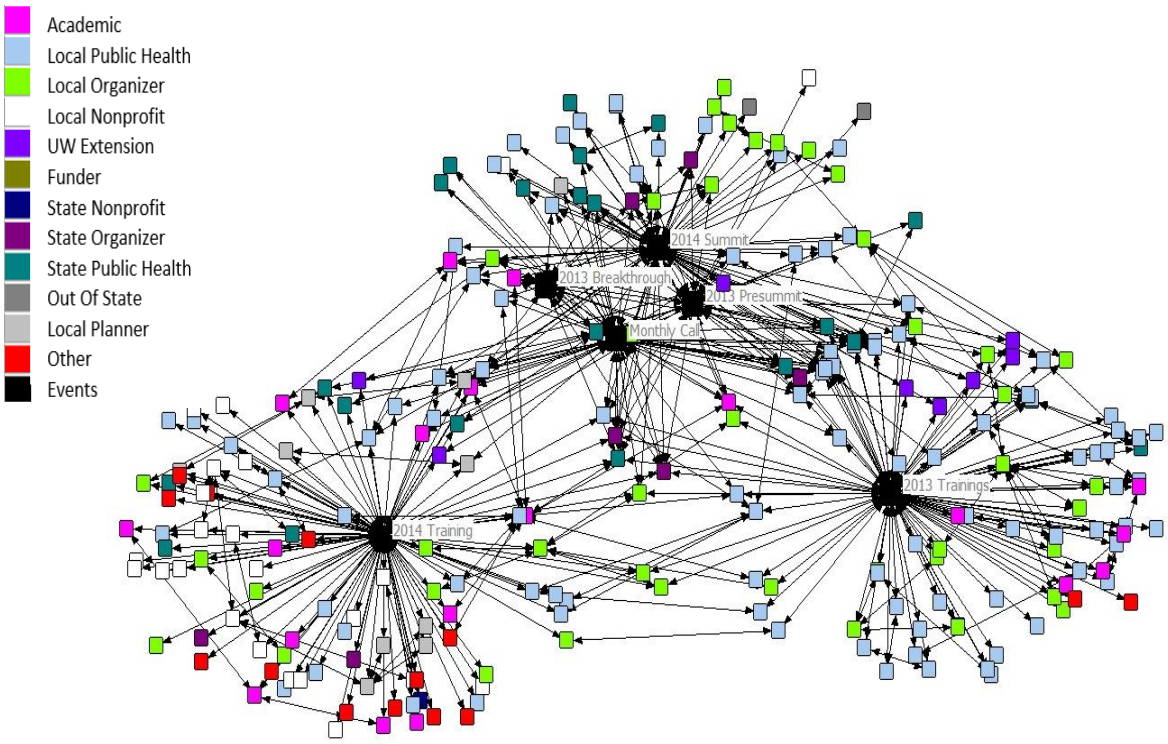
No two communities are the same. The priorities in one Healthy Heartlands hub may be wildly different than the priorities in another Healthy Heartlands hub due to differences in demographics, historical context, or respective political climates. As such, the approach for addressing health inequities varies across each of the eight Healthy Heartland hubs—and is rooted in their community-specific contexts.

In Wisconsin, the work is multi-pronged. There is a community organizing partner, engaged constituent leaders and public health partners. WISDOM works on several social issues and in recent years has focused on addressing mass incarceration as a means to reduce health inequities in their state—an issue with clear racial divisions. In 2010, the state was ranked as having the highest African-American and Native American incarceration rates in the country. Mass incarceration has strong linkages to poor health outcomes not only for the incarcerated individual, but their family. Children who have at least one incarcerated parent are more likely to have poor mental and physical health in adulthood.[13]

The Milwaukee-based grassroots organization has long been a champion of social justice and equity within Wisconsin. WISDOM brings an established network of 160 congregations and other community organizers from across Wisconsin who are collectively working to promote social justice in their communities. In its role as a hub, WISDOM connects communities to resources, re-grants money, and provides leadership education resources, and importantly, drive collective action for community-lead efforts to address mass incarceration. In 2014, WISDOM, who had been engaging deeply with those most impacted by incarceration, partnered with these constituents to support the development of Ex-Prisoners Organizing (ExPO). ExPO works to end mass incarceration, eliminate all forms of structural discrimination against formerly incarcerated people, and restore formerly incarcerated people to full participation in the life of their communities.

EXPO emerged when formerly incarcerated people from around Wisconsin began to gather to discuss what it would look like to have their own statewide organization. Previously imprisoned women and men lead EXPO. The members provide support to each other and organize to change Wisconsin's unjust penal system. They receive support from family members of currently and formerly incarcerated people and allies who have not experienced incarceration. EXPO has active chapters in Milwaukee, Madison, and Eau Claire and are developing chapters in Racine, Kenosha, Beloit, Green Bay, the Fox Cities, and Wausau.

Thrive WI is a statewide health equity alliance that was inspired by Healthy Heartlands. Thrive aims to advance health equity by building a statewide relational alliance of diverse stakeholders to co-learn, share best practices, and engage in collective action to affect the root causes and social, economic, and environmental determinants of health. Thrive does this by building relationships and coalitions between public health and community organizing efforts, building capacity of partners through training and technical assistance to local leaders and efforts, and partnering to increase statewide alignment, connectivity and infrastructure to advance health equity. Thrive WI has trained hundreds of stakeholders on the potential for initiatives when authentic and mutually beneficial partnerships are established between community organizing and public health and has supported shared action on several WISDOM and ExPO initiatives, including on a one-million-dollar grant to reimagine incarceration in Wisconsin through using a health equity lens. The following image provides a network-based snapshot of Thrive WI partners.



Goals and Outcomes

Aware of its connection to health outcomes, in 2012, WISDOM set out to spur greater state-level investments in evidence-based treatment alternatives and diversion (TAD) initiatives as means to reduce inequities in mass incarceration in their state. As a means to gain credibility with policymakers, WISDOM partnered with Human Impact Partners to quantify the health and economic impacts of increasing funding for TAD initiatives through a formal health impact assessment (HIA). The year-long HIA revealed TADs would reduce crime, increase recovery, strengthen families, improve economic opportunities, and importantly reduce costs (with TAD being four times less expensive than the average prison stay).[14] Through this work, WISDOM spurred the addition of $7 million for treatment deferral in the state's budget.

Through their work on mass incarceration, they have also strengthened communication with smaller community justice groups to increase diversity of community voices involved in the projects. ExPO provides critical leadership towards assuring those most impacted by mass incarceration are leading solutions. ExPO and WISDOM has contributed to noticeable improvements in community power and agency; people see themselves as full participants in society and reach out to engage new partners. Long term impacts will be measured through changes in incarceration rates and improved access to necessities like transportation. Thrive WI provides important connectivity to public health leaders and coalitions.

Challenges and Barriers

The drive to state-level change is not easy, and challenges persist as WISDOM moves forward in the fight against racial inequality and mass incarceration. Building the connection between community health outcomes and incarceration rates is difficult; it is not always clear to those outside of the group that incarceration of people affects communities directly due to fear and stress, among other problems. WISDOM's goals are largely long-term, and there are challenges making the case for equity initiatives based on future return on investment, rather than concrete, short-term measures, leading to slow progress

and the necessity to reframe goals. Additionally, there are limited options for local partners, as many justice groups are constrained by unions and public health officials by the sensitive nature of the field. When these cross-sector partnerships are formed, there are still difficulties with establishing effective communication methods, shared missions and common vocabulary.

Key Learnings

WISDOM's campaigns for equity have taught about the importance of community organizers as drivers of community partnerships with public health workers. Despite this partnership bringing legitimacy and passion to each side, it is important to note that the distinction between public health professionals and organizers is necessary and natural. These differences can be leveraged by helping people to apply their skills and teaching them how to make use of the skills of others to generate outcomes. One of the benefits of a network approach like the one displayed here is the constant flow of information. The Healthy Heartlands administrative faculty host calls and leadership convenings with each of the state hub organizations to determine strategic plans. The states that participate diffuse ideas and best practices through the hubs and then through the main Healthy Heartlands administration, allowing for responsive and flexible units. This in and of itself can be considered progress; success is bringing new people to the table than were there when you started.

Building Community Resilience – Portland, OR

"Authenticity is key. Humility is essential. And an awareness that oppression equals trauma, thus the response to this work—even to those who are dedicated to undoing it—must be a trauma response."

Background on Building Community Resilience

Building Community Resilience (BCR) is a George Washington University (GWU) led national collaborative seeking to improve the health of children, families, and communities by fostering engagement between grassroots community services and public and private systems to develop a protective buffer against adverse **c**hildhood **e**xperiences (ACEs) occurring in adverse **c**ommunity **e**nvironments (ACEs) – the "Pair of ACEs." Connecting community organizations (through a trusted food pantry or parenting group, for example) with larger systems (including those in health care, education, juvenile justice, law enforcement), while working toward policy change at the institutional, local, county and state levels, can begin to build a durable network to improve community wellbeing.

BCR staff at GWU lead site teams in gaining sustainable processes and partnerships, creating a framework to work *with* the community to align large systems with one another and with community advocacy groups. GWU provides technical assistance, strategic planning, facilitation of information sharing, support for data measurement, development of policy strategies, convening, and communications support.

Portland, Oregon: Fostering a Trauma-Informed Community

The BCR site in Portland, Oregon was selected as a BCR site for a multitude of reasons. It provides geographical and political variation; Oregon's history as a free White state and deep seated interpersonal and systemic racism were influential in the choice. Despite these movements, Portland has a strong network of human rights activists. Additionally, Oregon Health Authority, the entity who oversees Oregon Health Plan (the state Medicaid provider), instituted a state-wide trauma-informed care collaborative, thus creating favorable Medicaid policies for supporting the establishment of a BCR initiative. Portland also plays host to Trillium Family Services, a community-facing and Medicaid-eligible service provider that has embraced the Sanctuary Model and began training others in trauma-informed care. This organization, which became the backbone of the BCR project, specializes in the behavioral health of children and families. Their explicit desire, commitment to, and organizational buy-in for providing trauma-informed care – from the C-Suite level all the way down – is influential in the community, instructional in systems-change to address the Pair of ACEs, and inspiring to other BCR sites.

To round out the Portland team, Trillium partners with Concordia University, Faubion School (a public school), Pacific Foods and Kaiser Permanente, to facilitate 3 to PhD, a consortium focusing on creating safer and healthier schools, and the Chrysalis program, a school-based prevention program to support teenage, female-identifying trauma survivors. They also team with the Oregon Public Health Institute to ensure the focus on health equity and community outreach to amplify their equity efforts across the state. Communication is fronted by a multi-media team, which has included Alpha Media, iHeartMedia, Learfield Sports, Tegna/NBC, IMG and a network of celebrity spokespeople and supporters to circulate updates about Trillium's Keep Oregon Well anti-stigma initiatives and opportunities, as well as public service announcements and advertisements centered around equity and inclusion, psychoeducation and general wellness narratives. Media partner Skype Live Studio also livestream the BCR Town Halls, a two-way conversation between agency-level and community stakeholders. The meetings begin by ensuring a shared understanding between all parties and moves to address resiliency in the community and work to find more areas for collaboration and synthesis of processes. Additionally, the "Wellness Zone" in that space has hosted countless conversations with bands and artists related to mental health and wellness, helping to mobilize the state of Oregon around health equity.

Goals and Outcomes

Before the implementation of BCR, Portland's activism community largely worked in piecemeal. Trillium understood that there were inequities to be addressed but lacked the organization or capacity to coordinate between grassroots entities. This became part of the central goal of the project, alongside the implementation of a trauma-informed system and the overall aim of health equity. Through the implementation of the 3 to PhD program at Faubion School, the team saw a 7 percent reduction in suspensions and a 7 percent improvement in school attendance, as well as improvements in third grade reading levels. The secure residential facility administered by Trillium provides even more quantifiable outcomes. In the program's 2016 to 2017 run, they found:

- 75 percent reduction in restraint & seclusion practices;
- 75 percent reduction in peer-to-peer aggression;
- 73 percent reduction in staff assaults;
- 81 percent decrease in suicidal behaviors; and
- 53 percent decrease in self-harm.

Challenges and Barriers

The largest barriers impeding the work of the Portland team were clinical and systemic in nature. Hospitals trapped in fee-for-service environments are limited in programming for community outreach, as there is no way to recoup money from their efforts. There is a striking lack of training in the clinician population for social needs screening and many have difficulties or are inexperienced in connecting patients to community-based resources and agencies to address those needs. Additionally, as with any large system, the inability to consistently and safely share information remains a barrier. On the community organizing front, the fractured nature of Portland's activist entities lent itself to discord. For example, after the fatal spring 2017 hate-crime stabbing in Portland, a large march was planned. The intention was to invite everyone to discuss equity writ large, but when some voices were perceived as louder than others, the intersectional goal was lost.

Key Learnings

In facing these challenges, the BCR Portland team advises, "Say yes to the mess." Culture change takes time, attention, and effort for which there should be a dedicated full-time manager. Successful implementation comes with flexibility and adaptability - a notion easier to take on when the framework is a process rather than a prescriptive model, which is one of BCR's strengths.

Trillium Family Services' positive relationships with the surrounding community, and recognition of community inequities, were key to driving the BCR Portland initiative through a healthcare backbone organization. In the absence of a supportive and trusted healthcare backbone organization, another community partner or backbone organization is critical to work as liaison between healthcare and the community.

Building Healthy Communities - East Salinas

"Cultivating racially equitable governments requires real community partnership, where residents can guide policy goals, share decision-making power and create measures for accountability. Only a mature infrastructure of community-based organizations can provide the leadership and social network necessary for residents to partner in institutional transformation." [15]

Building Healthy Communities (BHC)[16] is a 10-year, $1 billion place-based initiative of The California Endowment working in 14 California communities to promote prevention policy, system and environmental changes through cross-sector collaborations and community engagement. Launched in 2010, BHC aims to reduce health inequities through improvements in neighborhood safety, unhealthy environmental conditions, access to healthy foods, education, housing, and employment opportunities. Each BHC appoints a BHC Hub Host organization to act as the central coordinator for implementation of health improvement initiatives.

East Salinas was selected as one of the hub communities for BHC investment and has a focus on building a healthier community by addressing inequities using a racial justice framework. Through their community-driven actions, the BHC East Salinas coalition is working to foster greater community power, build leadership capacity, increase civil engagement, and bolster political participation among East Salinas residents as a pathway to promote greater health equity.

East Salinas: "Building the We"

Throughout the 20th Century, the agriculturally-based Salinas Valley was a magnet for immigrants, drawn to the area's need for farm laborers. Workers came, settled their families, and a community and culture grew around the farming environment. As the agriculture industry in Salinas grew, so did the conflicts between White growers and minority laborers, sometimes erupting into violence. Further exacerbating the racial divide was the adoption of a city ordinance in the 1930's that created a legal, physical division of the Latino (East Salinas) and White (West Salinas) populations that persisted into the 21st Century. Through the years, while West Salinas enjoyed the benefit of municipal resources, East Salinas suffered from overcrowding, as well as a lack of basic needs such as street lights, schools, health care facilities, and city maintenance. Today, East Salinas is 75 percent Latino, and a large percentage of this population speaks only Spanish.

Racial tension has existed for many years in Salinas, but a series of racially inflaming events in 2014, notably the shooting of four Latino men in a span of four months, catapulted the issue of racial equity to the forefront of the community, highlighting the need and desire for community advocates and city officials to work together to address racial tensions and create the best possible living conditions for all of Salinas' residents. Addressing racial injustice with the goal of healing the relationship between the City of Salinas and the community residents would help to reduce the stress and trauma in the lives of the city's residents, particularly its youth, whose response to trauma can be manifested in defiant behavior, disengagement, and ultimately, a decline in their physical health.

The BHC East Salinas Hub convenes local organizations and supports their efforts to develop the leadership capacity of community residents and institutional leaders to improve overall health in the city. Thus, in November of 2014 then BHC Hub Manager Carmen Gil and TCE East Salinas Program Manager Lauren Padilla-Valverde determined to bring city and community leaders together to address racial injustice through a Healing-Informed Governing for Racial Equity process.

Healing-Informed Governing for Racial Equity

Healing-Informed Governing for Racial Equity (GRE) is a model designed to unify community members and local government around how their city should operate to create the best possible conditions for its people. TCE Program Manager Padilla-Valverde reached out to the Salinas police chief, city manager, and director of public works to forge a citywide agenda toward racial healing. Ensuing conversations between city staff and community advocates resulted in the creation of a three-day BHC-City of Salinas Racial Healing and Racial Equity training to enable residents and government representatives to come together with a common purpose, build relationships, and learn racially conscious decision-making and follow-through. The training was designed and led by the National Compadres Network (NCN) and Race Forward, combining NCN's expertise in addressing trauma across systems with Race Forward's systemic equity framework.

Prior to the convening, invitees confessed their reluctance to attend the training based on the tense history of the relationships between city and community leaders and perceived conflicts of interest. Both city and community representatives acknowledged the risks involved in such a convening (e.g., making themselves vulnerable and overcoming the persistent "us versus them" mentality) but were encouraged by NCN and Race Forward that transformational change would require commitment from all participants and willingness to move beyond past grievances to embrace the opportunity for systemic change.

Objectives of the training included: 1) increased emotional capacity for healing around race and racism; 2) an expanded definition of racism and racial justice; 3) shifting the focus from individual intentions to systemic impacts; and 4) equipping teams to pursue solutions with equity at the center. The three-day training was intended as a launching point for deeper citywide efforts toward the GRE model. Participants were encouraged to shed blame and guilt, engage with one another on a personal level, and develop shared goals for their city. Post-training participant reflections indicate a positive, forward-thinking outlook and hope for continued relationship-building based on common purpose and a newly developed trust. After the training, a steering committee comprising five city staff and five community advocates was created to develop a long-term work plan and implement the Racial Equity Impact Assessment toolkit to ensure future city decisions would be based on an analysis of potential impact on racial and ethnic groups.

Forging Ahead

Healing-Informed GRE requires stakeholders to view their city with different lenses, to align goals, and share in the accountability for meeting those goals. City staff in Salinas learned how to view community members not as critics of their role, but as partners in the effort to serve their city and its residents. In turn, Salinas community members began to undo the historic "us versus them" mentality and work to forge new relationships with those who were previously viewed as adversaries. Racial healing requires building new relationships based on honesty and requires all parties to be courageous and truthful.

To be truly successful, GRE requires a commitment from those with power and resources at every level of the governing entity to demonstrate the importance of the effort, as well as influence additional key players and staff. It requires creating a joint, positive experience based on aligned goals, with common language, and ongoing, structured opportunities to continue to build relationships and act together.

Since the meeting, the collective efforts of the BHC East Salinas coalition has resulted in city and county officials, as well as local philanthropic organizations, taking concrete steps to institutionalize GRE in their respective organizations, including:

- The City of Salinas and encompassing County of Monterey have joined the Government Alliance on Race and Equity cohort to create a tool to institutionalize racial healing practices in their respective government agencies.

- In September 2017, the County of Monterey passed a resolution to commit to incorporate GRE practices into their institutional practices—including increased departmental accountability towards authentic community engagement, and critical analyses of how county systems may be failing to engage and address the needs of every Monterey County resident.
- The City of Salinas in partnership with residents of East Salinas, is developing an Alisal Vibrancy Plan. This two-year, $750,000 planning process represents the first time that the City of Salinas has developed a plan specific to the efforts in East Salinas—as well as the first time the city has implemented a planning process in Spanish. The community-driven Alisal Vibrancy Plan aims to build the leadership capacity among residents in East Salinas to foster authentic civic engagement and participation.
- The Salinas City Manager hired three directors that embody the city's vision of moving towards a more healing and racially equitable city.
- The Monterey County Funders groups—a group of eight local foundations—is developing a racial justice framework for grantmaking. The group is undergoing a critical analysis of how their expected grant outcomes may or may not be driving progress towards the roots of racial inequities in their community.

Measuring Progress

Promoting racial healing through systemic change takes time; it is a process. Sharing a single positive experience around race encourages parties to continue to work together to find new solutions to existing problems. The GRE model enables both community members and city decision-makers to focus on real people and their real experiences and continue to seek opportunities to achieve an inclusive democracy where residents have a sense of belonging and are active decision makers in their quality of life/health outcomes.

Endnotes:

[1]National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in action: Pathways to health equity*. Washington, DC: The National Academies Press. doi: 10.17226/24624.
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