Supporting Communities and Local Public Health Departments During COVID-19 and Beyond

A ROADMAP FOR EQUITABLE AND TRANSFORMATIVE CHANGE

Public Health Alliance™
OF SOUTHERN CALIFORNIA

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» Our sister regional public health coalitions, the Bay Area Regional Health Inequities Initiative and San Joaquin Valley Public Health Consortium, who assisted with conducting interviews of their member local public health departments and community stakeholders.

» Local health departments across the State who took the time to fill out surveys and participate in one-on-one interviews, including:

Alameda County Public Health Department
City of Berkeley Department of Health Services
Butte County Public Health Department*
Calaveras County Public Health Department
Colusa County Public Health Division*
Contra Costa Health Services
Del Norte County Public Health Department*
El Dorado County Public Health Division*
Fresno County Department of Public Health
Glenn County Health and Human Services Agency*
Humboldt County Department of Health and Human Services
Imperial County Health Department
Kern County Health Department
Lake County Health Department*
Lassen County Public Health*
City of Long Beach Department of Health & Human Services
Los Angeles County Department of Public Health
Madera County Public Health
Marin Health and Human Services
Mariposa County Health Department
Merced County Department of Public Health
Modoc County Health Services*
Monterey County Health Department
County of Napa Health and Human Services
Nevada County Public Health Department*
Orange County Health Care Agency
City of Pasadena Public Health Department
County of Placer Health and Human Services*
Plumas County Public Health Agency*
Riverside University Health System-Public Health
Sacramento County Department of Health Services
San Benito Public Health Services Department*
County of San Bernardino Department of Public Health
County of San Diego Health and Human Services Agency
San Francisco Department of Public Health
San Luis Obispo County Public Health Department
County of San Mateo Public Health Department
Santa Barbara County Public Health Department
Santa Clara County Public Health
Santa Cruz County Health Services Agency
Shasta County Public Health
Sierra County Public Health Department*
Siskiyou County Public Health Department*
Solano County Public Health
Sonoma County Public Health Division
Stanislaus County Public Health Department
Tulare County Health & Human Services
Tuolumne County Public Health*
Ventura County Public Health
Yolo County Health and Human Services Agency*
Yuba County Health and Human Services Department*

LHDs marked by an asterisk (*) only participated in the survey. All others completed both a survey and a key informant interview.

» Other key partners representing philanthropy, healthcare, community-based organizations and other sectors who were interviewed and/or surveyed (in alphabetical order):

Adelanta Youth Alliance

Altura Centers for Health

ArtCenter College of Design's ArtCenter Extension

Blue Shield of California

Blue Shield of California Foundation

California Accountable Communities for Health Initiative (CACHI)

California Community Foundation

The California Endowment

California Consortium for Urban Indian Health

California Pan-Ethnic Health Network

California Primary Care Association

California Wellness Foundation

Camarena Health

Canal Alliance

Center for Race, Poverty and the Environment

Central Coast Alliance United for a Sustainable Economy

Central Valley Opportunity Center

Centro Legal de la Raza

ChangeLab Solutions

ClimatePlan

Collaborate PASadena

College Access Plan

Community Action Partnership of Madera County, Inc.

Community Clinic Association of Los Angeles County

Community Vital Signs

Conrad N. Hilton Foundation

Day One

East Bay Community Law Center

Environmental Health Coalition

Flintridge Center

Fresno Community Health Improvement Partnership

Governor's Office of Innovation

Greenlining Institute

Human Impact Partners

Inland Empire Health Plan

Kaiser Permanente

L.A. Care Health Plan

Leadership Counsel for Justice & Accountability

Lideres Campesinas

The Los Angeles Trust for Children's Health

Mixteco Indigena Community Organizing Project

Northern California Grantmakers

People for Mobility Justice

Planned Parenthood Pasadena & San Gabriel Valley

PolicyLink

Prevention Institute

Public Health Advocates

Regional Pacific Islander Task Force

Richmond Neighborhood Housing Services

Roberts Enterprise Development Fund (REDF)

Roots Community Health Center

The San Francisco Foundation

Service Employees International Union (SEIU) California

St. Johns Well Child & Family Center

Street Level Health Project

Urban Habitat

Executive Summary

INTRODUCTION

The COVID-19 pandemic has caused immeasurable devastation and loss for individuals, families, communities, the State of California, and the nation. As of July 2022, COVID-19 has claimed over 6.3 million lives globally, over 1 million in the United States, and over 91,000 in California. These grave statistics do not begin to capture the emotional, social, and economic impacts that have unfolded since the pandemic began in March 2020, especially among communities of color, low-income communities, and those working on the frontlines in essential services. Furthermore, the chronic disinvestment in communities and systems designed to serve communities, such as public health, undermined the collective capacity for an efficient, effective, and equitable response. In the wake of this crisis, California and the nation are poised to transform their systems in a way that was not possible before, to advance an equitable and just future. Transitioning from short-term crisis response to longer-term recovery, provides a unique moment to catalyze transformative action to reimagine and rebuild systems, strengthen communities, and redefine social contracts with community resilience and equity at the core. The transformation will require co-visioning, and co-creating with community leaders and members to ensure that as California rebuilds its systems, the needs and priorities of communities most disproportionately impacted by inequities are the driving force and pillars of our reimagined systems.

The California Department of Public Health's Office of Health Equity contracted with the Public Health Alliance of Southern California (Public Health Alliance) to produce this report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments (LHDs) are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19 as well as future public health emergencies. This report elevates best practices, including local public health department, community-based, healthcare, and philanthropic efforts, to support communities most vulnerable to the impacts of COVID-19 throughout the response and recovery process. Research for this report took place from October 2020 thru January 2021 and represents the context of that time period. Certain statistics have been updated to reflect the most recent data as of July 2022, however the majority of the content of this report is reflective of the time period outlined above.

METHODOLOGY

To inform the content of this report, the Public Health Alliance collected information and insight from the following sources: 68 key informant interviews across sectors, including public health, community, healthcare, philanthropy and others; 110 survey responses; local, regional, and state level public health professional meetings; and a scan and review of policy and best practices.

This report is broken down into seven key content areas that emerged through in-depth interviews, surveys, and practice and policy scans over the past year with diverse stakeholders, including: public health professionals and data experts, community-based organizations and advocates, healthcare systems and health plans, philanthropic groups, and labor organizations.

1. **Bolster Investments in Public Health Departments and Communities to Advance Health Equity**
2. **Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century**
3. **Embed Equity throughout Local Public Health Department Emergency Planning, Response and Recovery**
4. **Catalyze Transformative Shifts in Utilizing Data**
5. **Advance Health Equity and Strengthen Resilience through Ongoing Community-Informed Policy and Practice Changes**
6. **Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts when Issuing Health Orders and Guidance**
7. **Build Effective, Actionable Partnerships between Local Public Health and Healthcare Systems**

Each section includes high level framing, challenges that influenced the COVID-19 emergency response and recovery, best practices, and a mixture of practical, short-term recommendations, and long-term guidance to address structural issues. The major challenges and associated best practices explored in the report include:

CHALLENGES & BEST PRACTICES

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Bolster Investments in Public Health Departments and Communities to Advance Health Equity	Public health departments have been chronically underfunded for decades, and the shift to pandemic response had major impacts on local public health department capacity and funding to protect the health of communities most impacted by inequities	• Federal funding and equity-based targeted investment plans • Pooled funding to enhance local public health department capacity
	Lack of resources and investments for community-based organizations to address the response and recovery	• Local health departments used fiscal intermediaries to allocate funds more quickly to community-based partners • Philanthropy made quick shifts in grantmaking to support rapid COVID-19 response activities, including support for community-based organizations
	Pandemic funding has focused on addressing short-term immediate needs, not long-term needs to build a more sustainable infrastructure, and to address root causes and the social determinants of health	• Emergency pandemic funding stabilized public health funding in many states
	Pandemic funding has had challenging requirements that have hindered an equitable response	
	Multi-sector partnerships between LHDs, CBOs and other sectors were stalled or slowed by the pandemic due to a lack of capacity	• Robust, established partnerships between public health, healthcare and the community enabled quick pivots to adapt to COVID-19 needs

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century	The COVID-19 emergency exacerbated existing chronic staffing shortages	• Local health departments worked quickly to rapidly hire and on-board staff, including case investigators, contact tracers, nurses, and others • Expansion of networks of Community Health Workers and Promotores increased outreach to and support for impacted communities
	Staff often do not reflect communities most burdened by inequities and disproportionate health impacts	• Funded programs within local public health departments designed to build trust, connect residents to resources, and navigate health and economic issues for disproportionately impacted communities • Inclusion of Community Organizer positions within local public health department staffing structure
	Lack of specialized staff, including epidemiologists, public health nurses, communicable disease specialists, and health equity experts	
	Diversion of staff from other critical public health programs that provide support to vulnerable populations	
	Local health departments are frequently in crisis response mode, therefore many departments are unable to prioritize health equity and the social determinants of health	• Local governments, in partnership with local public health departments and other sectors, passed critically important policies and programs to help protect and support communities disproportionately impacted by COVID-19

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Embed Equity throughout Local Public Health Department Emergency Planning, Response and Recovery Processes	Many jurisdictions did not have structurally funded or sufficient equity staff in place to help lead efforts throughout response	• Local health departments utilized COVID-19 resources to advance health equity • Leveraging regional local public health department coalitions to provide critical equity support
	A model/uniform approach for embedding equity into emergency response did not previously exist; this has led to inconsistent processes for addressing disproportionate impact	• Counties and cities with Equity Officers or dedicated equity staff teams who were actively deployed through the Incident Command Structure (ICS) and Emergency Operations Center (EOC) were best positioned to respond to the disproportionate impacts of the pandemic • Embedding an Equity Officer in the ICS Structure
	Community-based partnership were critical in reaching those most impacted throughout the crisis; jurisdictions without strong partnerships in place were less able to respond equitably to the crisis	• Authentic collaborative partnerships between local public health departments and community-based organizations
	There have been inconsistent opportunities to fund community-based partners throughout the crisis; when funding has been available, internal governmental contracting/procurement processes have created barriers to funding for some community-based organizations	• Ensuring funds quickly and efficiently reach community partners • Leveraging trusted community partners to streamline critical funding needs

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Embed Equity throughout Local Health Department Emergency Planning, Response and Recovery Processes *(continued)*	There have been ongoing challenges in creating culturally relevant and effective public health messaging for communities most impacted by the COVID-19 crisis	• Partnering with trusted community partners and messengers for culturally relevant, in-language outreach and communications support
	It has been difficult to find effective ways of reaching disproportionately impacted community members throughout the crisis	• Leveraged county's "Reverse 911" systems to send urgent communications related to the pandemic to their community members most vulnerable to the crisis • Deployed Promotores or Community Health Worker models to reach members of their communities most vulnerable to the health and economic impacts of the crisis • Local, community-based radio stations have been vital resources for many Latinx and Indigenous community members in those communities
Catalyze Transformative Shifts in Utilizing Data	Missing, incomplete, or inaccurate demographic data – particularly by race/ethnicity, alone or as a stratification variable for other outcomes – impede monitoring and addressing equity impacts	• State mandated the collection of race/ethnicity and sexual orientation and gender identity data
	Outdated and inflexible data systems paired with a lack of data standards failed to meet demands of COVID-19 response	• Enhancements of existing systems to reduce burden of reporting and increase uniformity and transparency
	Missing or incomplete methodology provided for State-required COVID-19 surveillance and reopening metrics	• State shared statistical code used by the California Department of Public Health to generate Blueprint metrics with local public health departments
	Communicating data to communities	• Local health departments released data disaggregated by gender and race/ethnicity • Local health departments analyzed their data to better understand the COVID-19 among their vulnerable populations, and identify local strategies and resources to address disparities in COVID-19 outcomes

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Advance Health Equity and Strengthen Resilience through Ongoing Community-Informed Policy and Practice Changes	The impact of structural racism and systemic disinvestment on health outcomes has been amplified throughout the pandemic; jurisdictions were not well equipped to communicate and address the role of structural racism on health inequities throughout the pandemic	• Declaring racism a public health crisis and developing strategies for addressing and dismantling the impact of racism on health outcomes
	Prior to COVID-19, there was not a consistent statewide mechanism in place for prioritizing disproportionately impacted communities in public health emergencies, resource allocation and policy decisions	• Established mechanisms to prioritize communities most impacted by Inequities, like the Health Equity Metric
	Policies in place at the federal, state and local levels prior to the crisis proved insufficient for addressing the needs of disproportionately impacted community members during the crisis; policy changes that occurred to address those needs during the pandemic, must be institutionalized long-term in order to better support individuals and families most impacted by inequities	• Established public health councils • Implemented "hero pay" for frontline workers • Strengthened eviction protections and rental assistance support • Increased and expanded food assistance
	Social service supports available to disproportionately impacted individuals and families before the crisis, proved insufficient during the crisis; eligibility restrictions and access challenges have created additional barriers for those most in need of assistance	• Expanded housing for those who needed it the most • Connected residents to basic resources • Provided vital financial support for undocumented residents
	The compounding impact of climate change further exacerbates inequitable outcomes during public health and climate emergencies	• Local health departments issued guidance for responding to climate events during the COVID-19 emergency

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts when Issuing Health Orders and Guidance	Coordination issues between different levels of government led to conflicting communications and messaging	• Regional public health coalitions provided valuable space for open dialogue, constructive brain-storming, and coordinated decision making • Regional public health coalitions provided technical assistance and acted as a staff extender for overstretched local public health departments • Statewide public health associations provided resources and a clearinghouse of COVID-19 information and updates through regular meetings, daily email updates, listservs, and other critical information sharing
	Resistance from jurisdictional leadership, elected officials, other sectors and the general public to ensure compliance with local public health officer orders undermined ability to protect impacted communities	• Advocacy partners provided guidance on the legal authority of local public health officials to issue health orders and guidance in the face of threats
	Almost all health directors/officers received harassment and even death threats	• Many public health, philanthropic, and advocacy partners issued supportive statements • Philanthropy also provided rapid response communications for several local public health departments who were dealing with these threats
	Health orders and guidance were difficult to communicate and disseminate to the most impacted communities	• Local public health departments conducted regular telebriefings with specific sectors throughout the response • Philanthropy created an ethnic media guide, funded ethnic media outlets to provide information to the most impacted and hardest to reach communities • Community partners created culturally & linguistically appropriate, consumer-friendly materials for COVID-19

	CHALLENGES	BEST PRACTICES HIGHLIGHTED
Build Effective, Actionable Partnerships Between Local Public Health and Healthcare Systems	Overall lack of coordination and communication between the public health and healthcare systems	• Established communication and coordination between healthcare and public health systems • Cross-jurisdiction coordination between healthcare systems and health plans
	Difficulties making organizational and operational changes to reflect different local public health orders	• Regional trade organizations and professional associations facilitated coordinated response activities
	Challenges collecting, sharing, and using data between healthcare systems and public health	• Communication between healthcare systems and regional public health coalitions
	Inability to capture inequities using global, aggregated data analysis	
	Dramatic increase in social needs rapidly followed "stay at home" orders and business closures	• Healthcare systems and health plans pivoted resources to meet social needs of patients
	Limited ability to address root causes of COVID-19 disproportionate impacts	• Healthcare systems investing in place-based, upstream initiatives
	COVID-19 revealed the serious vulnerability of long-term care facilities	• Deployment of skilled-nursing facility strike teams to mitigate outbreaks • Organized local resources to meet staffing and supply needs
	Healthcare system is more prepared for short-term than long-term emergencies	• Rapid acquisition and distribution of PPE • Implementation of strategies to reduce exposure risk and burden on healthcare systems
	Negative financial impact on the healthcare system	• Rapid advocacy for telehealth to support patient access and healthcare system resilience • Maintain and support clinic and provider financial health

RECOMMENDATIONS

Each section also includes a robust set of recommendations for diverse actors and stakeholders, including local, state, and federal agencies, private sector partners in healthcare and philanthropy, and community-based organization and advocates. The recommendations were crafted to advance equity in ongoing COVID-19 emergency response, longer-term recovery efforts, and innovative strategies to further transformational change in essential systems. The sections include the following recommendations:

	RECOMMENDATIONS
Bolster Investments in Public Health Departments and Communities to Advance Health Equity	• Significantly increase funding for local public health departments • Invest in communities in ways that support public health and addresses health inequities • Infuse a health and equity in all policies approach with investments from other sectors • Promote innovative community investment strategies to address community health and equity • Ensure healthcare funding streams include investments in public health and community needs • Develop a statewide equitable public health resilience plan
Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century	• Establish programs and funding to advance a community-centered public health workforce • Adopt and implement structural changes to internal policies to retain, support, and promote staff, with a specific focus on communities most impacted by inequities • Establish standing, funded community-based partnership programs to strengthen the public health system • Increase cross-training for public health staff to strengthen and support a more nimble workforce • Coordinate with State and Federal public health agencies and leaders to establish incentives to draw and retain a robust public health workforce • Establish a national public health reserve program to rapidly expand the public health workforce during emergencies • Develop a statewide public health workforce resilience plan

	RECOMMENDATIONS
Embed Equity throughout Local Public Health Department Emergency Planning, Response and Recovery Processes	• Support the creation of a robust, structurally funded equity team within each local public health department • Build and activate community partnerships for transformative equity solutions • Embed equity into emergency response structures and processes • Incorporate an equity metric into all emergency response and recovery processes • Fund community-based partners to conduct culturally informed and relevant outreach and engagement • Prioritize hiring community members from disproportionately impacted communities • Integrate equity into all recovery planning and implementation processes
Catalyze Transformative Shifts in Utilizing Data	• Support development of a modern public health data infrastructure • Integrate local public health department stakeholders in state governance of data for policies, practices, and metrics • Institute "Health Equity Metrics" across State and local government operations and investments • Expand and improve collection of demographic data • Standardize data practices statewide, in collaboration with local public health departments, to more effectively track disparities • Support comprehensive and transparent public reporting of impact data • Develop a unified, bidirectional statewide health information exchange with interoperability between State and local public health departments, and healthcare and hospital systems

Advance Health Equity and Strengthen Resilience through Ongoing Community-Informed Policy and Practice Changes

- Address racism as a public health crisis
- Support community-informed policy priorities both locally and in State and Federal policy priorities
- Institutionalize the use of a health equity framework, including the development of health equity metrics, in ongoing investment and resource allocation decisions
- Center communities most impacted by inequities in policy, program and resource allocation decisions
- Conduct a comprehensive review of emergency assistance funding sources at the Federal level and work to remove eligibility restrictions when said restrictions prohibit individuals from obtaining resources needed during an emergency
- Expand access to resources and protections needed to meet immediate social needs and protect health and safety during COVID-19 and beyond
- Identify and fund comprehensive strategies to strengthen community resilience during COVID-19 and in preparation for future public health and climate emergencies

Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts when Issuing Health Orders and Guidance

- Ensure that State of Emergency declarations at all levels are broadly framed and communicated
- Develop community-informed mitigation plans that analyze equity impacts and incorporate equity metrics into health orders and guidance
- Foster greater public courage in support of Local Public Health Officials
- Implement basic preventative measures at the State or Federal level
- Provide local public health departments with more advanced notice and a greater opportunity for meaningful feedback before enacting or changing state orders and guidance
- Fund regional public health department coalitions to facilitate collaboration and provide technical assistance
- Ensure culturally competent communications and messaging about orders/ guidance
- Engage public relations for public health messaging

Build Effective, Actionable Partnerships between Local Public Health and Healthcare Systems	• Build and support stronger partnerships between healthcare, public health and community • Develop a unified, bidirectional statewide health information exchange • Establish effective, efficient, ethical and equitable data sharing agreements • Embed equity into healthcare system emergency response structures • Assess and address healthcare system vulnerabilities for future emergencies • Improve oversight and resilience of long-term care facilities • Support and expand opportunities for telehealth and telemedicine • Incentivize pay for value-based care versus volume • Leverage resources made available through Medicaid demonstration waivers to advance health equity • Establish collaboratively funded investment mechanisms to advance equity and prevention • Ensure existing healthcare funding streams include investments in prevention and local public health departments

CONCLUSION

This report provides a roadmap forward. It is informed by many firsthand accounts from community-based organizations, local public health departments, health systems, philanthropy and other sectors who were on the frontlines or served as intermediaries for groups experiencing the most inequitable impacts of this pandemic. Each of the seven content areas outline ways that the nation's systems both supported, and failed, the communities most impacted by COVID-19 and other longstanding health inequities and racial injustices. The report also provides concrete recommendations and emergent best practices for moving forward. Out of necessity, the pandemic provided the nation's systems with opportunities to rethink traditional approaches and test new models. There were many best practices of rapid adaptation to protect and support the most impacted communities, as well as sweeping and novel equity-driven approaches implemented across the State. Some of these approaches should be continued and expanded, while others that were not implemented can be advanced and explored. Promoting greater innovation in the approaches to addressing health inequities and racial injustices will catalyze the actions needed to reimagine and rebuild public health systems, strengthen communities, and redefine social contracts with community resilience and equity at the core.

Introduction

The COVID-19 pandemic has caused immeasurable devastation and loss for individuals, families, communities, the State of California, and nation. As of July 2022, COVID-19 has claimed over 6.3 million lives globally, over 1 million in the United States, and over 91,000 in California. These grave statistics do not begin to capture the emotional, social, and economic impacts that have unfolded since the pandemic began in March 2020, especially for communities of color, low-income communities, and those working on the frontlines in essential services. The world has witnessed the exacerbation and elevation of stark inequities across all of these impacts, rooted in structural racism and systemic inequities. The killing of unarmed black men and women in 2020 and the sweeping calls for racial justice against the backdrop of the COVID-19 emergency, have made it undeniably clear that the nation's most fundamental systems, such as justice, health, and housing, were designed to benefit some and exclude and harm others. Furthermore, the chronic disinvestment in communities and systems designed to serve communities, such as public health, undermined the collective capacity for an efficient, effective, and equitable response. In the wake of this crisis the nation is poised to transform its systems, in a way that was not possible before, to advance an equitable and just future.

Transitioning from short-term crisis response to longer-term recovery, provides a unique moment to catalyze transformative action to reimagine and rebuild systems, strengthen communities, and redefine social contracts with community resilience and equity at the core. The transformation will require co-visioning, and co-creating with community leaders and members to ensure that as the nation rebuilds its systems, the needs and priorities of communities most disproportionately impacted by inequities, are the driving force and pillars of our reimagined systems. Now is the time for innovative thinking and bold action to shape the long-term recovery, building upon some of the novel equity-driven approaches implemented over the past year. There were many best practices of rapid adaptation to protect and support communities, for example:

- Community organizations and advocates rapidly coordinated task forces in partnership with local public health departments (LHDs) and multi-sector partners to address the immediate needs of farmworkers, while engaging in ongoing advocacy to enhance worker protections and access to government support.
- Local public health departments worked to embed Equity Officers into the Incident Command Structures and leveraged new funding to hire dedicated equity staff in their departments, many for the first time.
- Healthcare systems rapidly advocated for the expansion and reimbursement of telehealth options to meet the ongoing healthcare needs of their patients, reducing exposure risk and increasing access for rural communities and those with limited transportation options.

- Philanthropy nimbly pooled funds to support community-based organizations who were leading community-driven COVID-19 response activities and contact tracing efforts.

Few systems were tasked with doing more with less resources than local public health departments. They have experienced chronic disinvestment for decades, leaving them understaffed and under resourced before the COVID-19 emergency, and utterly unprepared to meet the needs of the crisis. Despite this reality, local public health leaders, staff, and temporary employees are the unsung heroes of this emergency. Now is the time to pivot from the unseen and under-resourced, to a public health system prepared to meet the challenges of the 21st century. Our public health system is poised to shift to an equity-centered, community-based system that enables transformational change to support healthy, powerful communities. The world cannot return to the status quo; now is the time for courage and bold action to reimagine and rebuild an inclusive, equitable, and just future for all.

This report, contracted by the California Department of Public Health's Office of Health Equity, addresses the challenges faced by LHDs and the communities they serve throughout the COVID-19 emergency. The report shares emergent best practices and recommendations to reimagine and rebuild the public health system in partnership with community, healthcare, and other key sectors. At the time of receiving the contract, all parties assumed this report would be an after the fact analysis, but it is now clear that COVID-19 has been an ongoing and ever-evolving crisis. In the development of this report, the Public Health Alliance has come to understand and present the challenges, best practices, and recommendations in alignment with the short-term crisis response phase, mid-term adaptation phase, and long-term innovation phases, respectively. This report will highlight the challenges that arose during the crisis response phase, and the immediate actions implemented to limit spread, reduce disease burden, and meet the short-term social needs of communities. Best practices that emerged during the mid-term adaptation phase of the crisis provide a glimmer of the potential for transformational change in public health, healthcare, and related systems. As of July 2022, California, and the United States more widely, are transitioning from the mid-term adaptation phase into what can be the long-term innovation phase, in which the nation has the opportunity to lay the foundation for lasting community resilience and equity. In alignment with the innovation phase, this report provides practical short-term and longer-term recommendations to guide a just and equitable recovery and transformation.

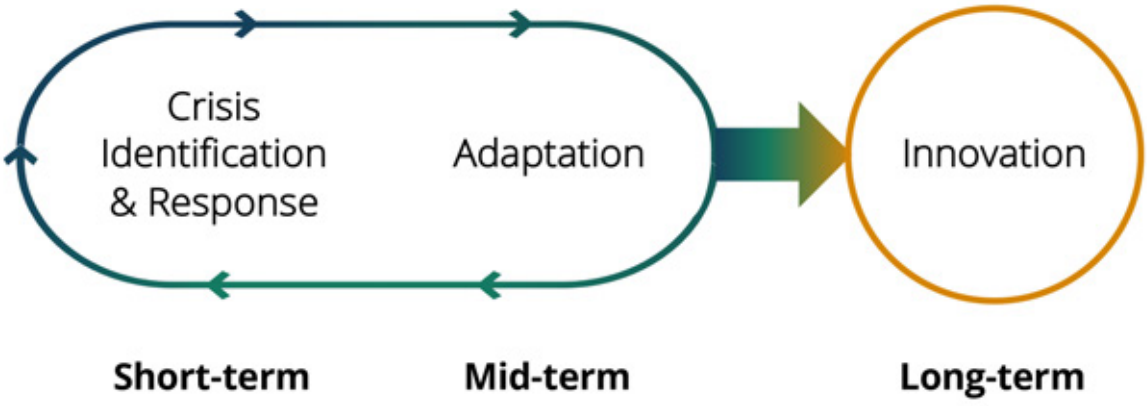


Figure adapted from Vision Foresight Strategy LLC

METHODS

To inform the content of this report, the Public Health Alliance collected information and insight from the following sources:

- **68** Key Informant Interviews with Local Public Health Departments, Community-Based Organizations, Healthcare Systems and Health Plans, Funders, and Equity and Public Health Advocacy Groups
- **110** Survey Responses, including:
  - » 58 Local Public Health Departments Leaders
  - » 22 Local Public Health Department Data Experts
  - » 30 Community-Based Organizations

See Appendix A: Methodology for more information.

STRUCTURE OF REPORT

This report is organized around seven content areas. Each contains an overview, challenges, best practices and recommendations, with supporting evidence from surveys, interviews and a research and policy scan conducted by the Alliance:

1. Bolster Investments in Public Health Departments and Communities to Advance Health Equity
2. Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century
3. Embed Equity throughout Local Public Health Department Emergency Planning, Response and Recovery Processes
4. Catalyze Transformative Shifts in Utilizing Data
5. Advance Health Equity and Strengthen Resilience through Ongoing Community-Informed Policy and Practice Changes
6. Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts when Issuing Health Orders and Guidanc
7. Build Effective, Actionable Partnerships between Local Public Health and Healthcare Systems

The Public Health Alliance would like to thank all of those that participated in informing and shaping this report (see Acknowledgements). We would also like to thank all of those in public health, healthcare, essential workers, and the community who rallied together to respond to the most devastating crisis in recent memory. We thank the teachers who rapidly adapted to virtual instruction to support and protect their students. We thank the people who picked up and delivered groceries and prescriptions to their neighbors. We thank the advocates and communities who have marched in the streets to demand accountability and justice. We thank the visionaries and movement builders for sharing ideas and opportunities to reimagine, transform, and rebuild systems to shape a truly resilient and equitable future.

1

Bolster Investments in Public Health Departments and Communities to Advance Health Equity

RECOMMENDATIONS

- Significantly Increase Funding for Local Public Health Departments
- Invest in Communities in Ways That Support Public Health and Addresses Health Inequities
- Infuse a Health and Equity In All Policies Approach with Investments from Other Sectors
- Promote Innovative Community Investment Strategies to Address Community Health and Equity
- Ensure Healthcare Funding Streams Include Investments in Public Health and Community Needs
- Develop a Statewide Equitable Public Health Resilience Plan

"The health emergencies of the past year—from flooding to wildfires, vaping-associated lung injuries to the novel coronavirus (COVID-19)—are a stark reminder of the critical importance of a standing-ready public health infrastructure and workforce. Such a public health system requires adequate and sustained funding"
Trust for America's Health

OVERVIEW

Low-income and communities of color have endured centuries of historic disinvestment, a lack of resources, and structural racism. These factors led to the disproportionate impacts of these communities by COVID-19 as well as other public health and climate change-related emergencies. COVID-19 was the third leading cause of death in 2020, with deaths among people of color being double those of the White population. At the time of this writing in 2020-2021, state data showed that Census tracts with the least opportunities for health as identified by the Public Health Alliance's Healthy Places Index ((HPI) are home to 24% of Californians, but they have accounted for 40% of COVID-19 cases. Black, Latinx and Native Hawaiian and Pacific Islander Californians have disproportionately shouldered the burden of this pandemic. Black residents represent approximately 6% of California's total population, but close to 8% of all COVID-19 related deaths. While Latinx people represent approximately 39% of all Californians, they represent 61% of the cases and over 48% of all the deaths. This is nearly half of all COVID-19 related deaths in California. Data also reveal inequitable health outcomes that are especially stark for younger (ages 18-34) Black, Latinx, and Native Hawaiian and other Pacific Islander (NHPI) Californians.

These disparate COVID-19 outcomes are rooted in and exacerbated by structural inequities that have long existed in communities. In California, like the rest of the country, centuries of policies and practices have created barriers to stability and health. From Jim Crow, to redlining and predatory lending, Black, Latinx, Indigenous, and other communities of color were pushed into under-resourced, highly segregated neighborhoods, and locked out of wealth-building opportunities that were afforded to many White Americans. The effects of these policies are still felt today, as many of the same communities still disproportionately face worse economic, environmental, and health outcomes and injustices, including those associated with COVID-19 and climate change. Moreover, the community-based organizations that serve as trusted messengers within these communities are often small and resource-limited in normal times, let alone a pandemic where they are going above and beyond to get accurate information, services and resources to the hardest hit and hardest to reach communities in California.

The institutions meant to provide critical services to these communities, including local public health departments (LHDs), have also been decimated by budget cuts. Local public health departments provide critical services to their communities, especially those most impacted by inequities. When LHDs do not have adequate resources, the community is adversely impacted. California's LHDs have been leaders in advancing health equity, but because of budget decisions by political leadership at all levels, this work has become

Public Health Infrastructure is defined in this report as the policies, systems and, resources that protect the health and safety of the entire population, especially those groups impacted by inequities. It encompasses resources and investments in communities, as well as the government (e.g. local public health departments) and private sector systems (e.g. healthcare providers) that ensure community health and well-being.

increasingly hard to do with diminishing resources and increasing public health and climate threats. Almost all funding sources for LHDs have been declining at the same time that public health threats are growing. LHDs are consistently underfunded and, even during the worst pandemic in most people's lifetimes, are facing further funding cuts. Under-resourced, dedicated public health workers have put in long hours to address the COVID-19 response, while departments are understaffed, and challenges are swelling. Our public health systems are woefully unprepared to address future challenges lurking around the corner, including wildfires and extreme heat threats, rising rates of chronic and communicable diseases, and persistent health inequities. This includes data surveillance systems and equipment, which in many cases have not been upgraded in years and were not built to handle the volume of cases a pandemic would bring.

Inadequate funding for public health departments is a grave threat at a time when the essential services they provide are absolutely critical. LHDs cannot turn these services on and off during times of emergency. COVID-19 demonstrates the real risks a pandemic has to public safety, the economy, and national security, and the serious impacts on the most impacted populations already experiencing the most significant health inequities. There is a need for a transformative "New Deal" type investment and sustainable model moving forward. Coming out of this pandemic, the United States has a unique opportunity to invest in building a robust, and resilient statewide public health system to support LHDs. It is important that LHDs are able to perform their core functions and provide essential services that protect the health and safety of the communities they serve at all times, not just during a pandemic. They need sufficient funding and resources to provide for everyday, ongoing public health needs, as well as to prepare for future public health emergencies related to infectious disease outbreaks, climate change, natural disasters and other events. There is currently an opportunity to create a national system that is prepared for the future and works daily to not just ameliorate threats, but work to eliminate health inequities and create healthy communities that allow everyone to live to their full potential.

It is also important that other sectors coordinate with local public health departments to align their investments toward improving health and equity. This includes government agencies, healthcare, community development, community-based organizations, and the business sector. Community investments can occur along a continuum of care and with collective impact in mind, with everyone coordinating, aligning and leveraging each other's resources to promote better health outcomes. The public health sector also needs to think more innovatively about how to finance its operations, as well as broader health equity-promoting community investments. Traditional models alone will not backfill the public health funding deficit. The public health system must be rebuilt in partnership between local and state public health departments, other sectors, and the community. It must be rebuilt with more innovation, and with equity front and center. The partnerships that have been established between LHDs, other sectors and community-based organizations during the pandemic need to be sustained, and new ones established, so that the most impacted communities are not left behind again.

To assist with laying out the roadmap for these investments, California needs a statewide resilience plan that identifies the magnitude of this need and identifies the universe of potential funding sources that could fund public health departments, communities and other sectors. Together, California's public health community can seize this opportunity and create a system that is prepared for the future and works daily to not just ameliorate threats, but work to eliminate health inequities and create healthy communities that allow everyone to live to their full potential.

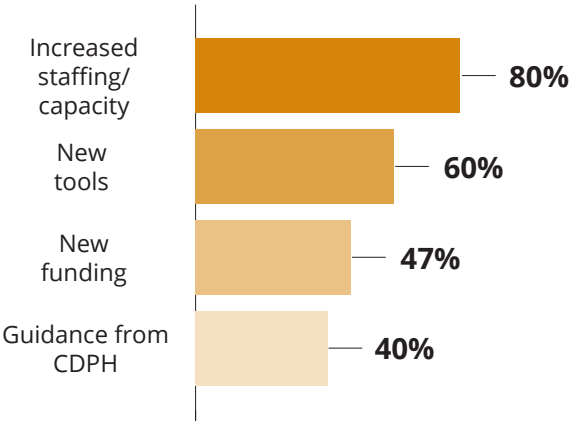
CHALLENGES

1. Public health departments have been chronically underfunded for decades, and the shift to pandemic response had major impacts on LHD capacity and funding to protect the health of communities most impacted by inequities
2. Lack of resources and investments for community-based organizations to address the response and recovery
3. Pandemic funding has focused on addressing short-term immediate needs, not long-term needs to build a more sustainable system, and to address root causes and the social determinants of health
4. Pandemic funding has had challenging requirements that have hindered an equitable response
5. Multi-sector partnerships between LHDs, CBOs and other sectors were stalled or slowed by the pandemic due to a lack of capacity

1. Public health departments have been chronically underfunded for decades, and the shift to pandemic response had major impacts on local public health department capacity and funding to protect the health of communities most impacted by inequities

When the pandemic unfolded in early 2020, LHDs were already underfunded for their core functions. When they quickly had to pivot to address the growing threat of COVID-19, **89% stated that funding was a barrier to addressing the response, with a quarter stating it was a major barrier.** In addition, the categorical nature of public health funding has made it difficult to shift existing funding to address COVID-19, and LHDs shared that the State and federal government did not provide much flexibility. Some categorical work had to stop because of redeployed staff, but the funding tied to it still required the work be done or LHDs risked losing funds. LHDs also described in this report's surveys and interviews that their existing data surveillance systems and equipment were not set up to handle a pandemic of the magnitude of COVID-19, which affected their ability to collect data, do case investigation and contract tracing, and other core functions of tracking an infectious disease. **In this report's LHD data survey, these systems did not improve until additional resources were provided.**

FOR THOSE THINGS THAT IMPROVED, WHAT CONTRIBUTED TO THE IMPROVEMENT?



For close to 20 years, political leaders at all levels have cut almost all funding sources for LHDs, at the same time that threats to public health are increasingly growing. **Over the past decade alone, local and state health departments lost 20% of their workforce, and LHD budgets shrank by as much as 24%.** State and federal decisions have led to California's LHDs receiving $177 million less in total funding in 2018-2019 versus 2007-2008. Eleven local public health labs in California closed over the past 15 years because of funding cuts, limiting the capacity during COVID-19 to scale up testing and staffing needed to adequately meet the State's phased reopening goals. County general funding remains flat and LHDs have to compete with other agencies for funding. For example, in Riverside County, the health department has a budget of approximately $100 million per year, and the Board of Supervisors allocates $12 million from the County General Fund, but this amount has been flat for years amid competing priorities while public health threats are growing. As a result, Riverside has had to cut its LHD staff by about 60% over the past decade. For more statistics on LHD funding cuts, see the Public Health Alliance's *Investing in Our Local Public Health Departments Brief.*

Altogether, this chronic underinvestment had a significant effect on LHD operations during the pandemic and left them not as prepared as they could have been to protect the health and safety of their communities, especially groups most impacted by inequities.

"Over the past decade alone, local and state health departments lost 20% of their workforce, and LHD budgets shrank by as much as 24%"
LHD respondent

Best Practices

- Additional funding did become available to LHDs from the federal government through the Coronavirus Aid, Relief and Economic Security (CARES) Act, the Center for Disease Control and Prevention's (CDC) Epidemiology and Laboratory Capacity (ELC) funding, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities, American Rescue Plan Act (ARPA), and other sources. The State of California established several equity-focused metrics to guide investments in the most impacted communities. This includes the **Health Equity Metric** of California's Blueprint for a Safer Economy (announced in October 2020), and the **Vaccine Equity Metric** (announced in March 2021). As part of the Health Equity Metric requirement, LHDs were required to develop **Targeted Investment Plans** that allocated resources to the lowest HPI quartile in each jurisdiction. Altogether, $272 million in local public health department CARES and ELC funding was directed to the most impacted communities, defined as those in the lowest **Healthy Places Index** quartile. The CDPH Office of Health Equity also directed $5 million in funding for community-based organizations to implement **Health Equity Pilots** within these communities. The Vaccine Equity Metric allocates 40% of vaccine doses to communities most impacted by COVID-19, also utilizing a combination of the Healthy Places Index and CDPH-derived scores. More details about both metrics are provided later in this report.
- Several funders pooled resources to boost local health department capacity to address the needs of communities most impacted by inequities, including the following two initiatives that the **Public Health Institute** is fiscally administering:
  - **TRACING HEALTH:** In August 2020, Kaiser Permanente announced a $63 million investment in **Tracing Health**, which provides contact tracing supports to LHDs within their network in California. Modeled off a successful contact tracing program in Washington and Oregon, the Tracing Health program has hired, trained, and deployed an estimated 500 full-time team members to provide culturally and linguistically competent contact tracing support to LHDs in California, with a focus on the most impacted communities. These contact tracing resources were flexible enough to be able to be used to support multiple communities. Collectively, Tracing Health has the capacity to contact up to 5,550 people per day.
  - **TOGETHER TOWARD HEALTH:** A group of more than 18 funders invested over $30 million in an initiative to connect community-based organizations with LHDs to support outreach, education, and communication activities to groups most impacted by inequities. The goal was to develop a culturally and linguistically competent workforce development pipeline for communities most impacted by COVID-19 and support LHDs in reducing spread of the virus. Together Toward Health (TTH) has funded more than 270 community-based organizations across the State. A full list of the funded CBOs and their focus is available on the **TTH website**. The funders include: the Ballmer Group, Blue Shield of California Foundation, the California Health Care Foundation, Crankstart Foundation, Genentech, the Gordon and Betty Moore Foundation, the Conrad N. Hilton Foundation, the Heising-Simons Foundation, the James Irvine Foundation, Medtronic Foundation, the David and Lucille Packard Foundation, the Sierra Health Foundation, Sunlight Giving, the California Endowment, the California Wellness Foundation, Tipping Point Community, the Chan Zuckerberg Initiative, and the Weingart Foundation.

2. Lack of resources and investments for community-based organizations to address the response and recovery

Community-based organizations serve as trusted messengers in communities most impacted by inequities. They have played a significant role in providing outreach, education, communication, and other essential services to these most impacted communities during the COVID-19 pandemic. This has been in addition to their everyday activities to support community members, which has put a financial strain on many of them. **In this report's CBO survey, conducted between October 2020 and January 2021, 85% indicated that they would most benefit from general operating support in order to make the greatest impact during COVID-19 and other public health and climate emergencies.** When asked about their top three supports during the COVID-19 public health crisis, 77% listed funding, grants, and other types of emergency aid as their top support.

Local public health departments were able to deploy more resources to CBOs in later stages of the pandemic, but the process was gradual and started slowly. **When we surveyed CBOs between October 2020 and January 2021, nearly three-quarters (70.4%) stated that they had not yet entered into any contracts with LHDs or other local government agencies** in order to support the communities they represent and/or serve. For those that had entered into agreements, LHDs were three times more likely to initiate contract conversations with community organizations with whom they had a previous non-COVID-19 related agreement or relationship. Approximately 68% of respondents indicated that they can navigate local governmental contracting processes without, or with very little, difficulty. Only one respondent replied that they cannot navigate government contracts at all. **But nearly half (48%) of respondents indicated that technical assistance (TA) around contracts and procurement would at least somewhat or strongly impact their ability to quickly apply for funding.** While LHD resources and contracts with CBOs did improve over time, the slow start is an important challenge to consider for future pandemics and public health emergencies, so that the most disproportionately impacted communities receive resources and supports as early as possible.

Best Practices

- To facilitate the contracting process with CBOs, LHDs were able to utilize and coordinate with fiscal intermediaries such as local community foundations to allocate funds more quickly and to smaller, less traditional partners to assist with the response. For example, Riverside County utilized the Desert Community Foundation, and Sacramento County relied on the Sierra Health Foundation to contract with some CBOs. The **LA County COVID-19 Community Equity Fund** selects grassroots CBOs with some cultural and linguistic expertise in highly impacted communities.
- As an intermediary to **First 5 LA**, Prevention Institute worked closely with 7 high-capacity community-based organizations to address inequities in the built environment related to parks and open space, food access, and transportation with the aim of improving supports, resources, and opportunities for children 0-5. They learned from the grantees (via ongoing conversation and peer-learning sessions) that they were adapting their policy advocacy and community engagement strategies in response to COVID-19 in creative, yet resource-intensive, ways. They partnered with First 5 LA to allocate additional resources to these grantees to accommodate the additional needs to adapt their policy advocacy campaigns and resident engagement strategies during COVID-19.
- Philanthropy played a major role in supporting community-based organizations during the COVID-19 response. Many funders were able to make quick shifts in their grantmaking to support rapid response, as well as turn restricted grants meant for a particular project or purpose into more general and flexible core support grants, and/or augment support. Because the pandemic happened early in the year, many funders were still early in their grantmaking for the year. Many investments were rapid, and at the beginning, funders thought addressing COVID-19 would be a short-term response. As the pandemic wore on, funders had to increasingly pivot and figure out how to best support grantees. In this report's interviews with funders, they stated that they may make longer term shifts in their grantmaking based on how the process went, including more flexible application and reporting processes, and changes to their program priorities. They have also been able to build new partnerships with existing and new grantees, and recognize the importance of making investments in public health.
- Other funders pooled their resources into local rapid response funds to support a range of community needs. Examples are below (administering foundations in parentheses), and a full list is available at **Philanthropy CA**
  - » **LA County COVID-19 Response Fund** (California Community Foundation)
  - » **Northern CA COVID-19 Response Fund** (Sierra Health Foundation)
  - » **Central Valley** (Central Valley Community Foundation)
  - » **San Diego** (San Diego Foundation)
  - » **Silicon Valley** (Silicon Valley Community Foundation)
  - » **Just East Bay** (East Bay Community Foundation)

"We used $45M in just a period of 4 months. Why did we have to wait for a pandemic to get this? Wish there would be a more long-term investment so we can rebuild our infrastructure and get ourselves ready so that when another crisis hits, we just pull out our plans and we are ready to go." LHD respondent

"We are always playing catch up. And once the funding goes away we can no longer support the needed efforts."
LHD respondent

3. Pandemic funding has focused on addressing short-term immediate needs, not long-term needs to build a more sustainable infrastructure and address root causes and the social determinants of health

At the time of our survey (October 2020 to January 2021), 40% of LHD survey respondents felt that the funding received throughout the pandemic was inadequate. Of the LHDs that found it was adequate, there were concerns about the fact that it was focused on immediate needs. This funding was helpful for short-term emergency response needs such as scaling up testing, contact tracing and vaccinations, but it was insufficient for addressing more long-term LHD needs and rebuilding a more sustainable public health infrastructure. Many LHD interview respondents stated that this always happens during a public health emergency – that they receive one-time temporary allocations that help with the immediate response, but leave them without the staffing and resources to prepare for the next emergency. LHDs need to recruit and retain a well-trained workforce, and one-time funding undermines that critical goal. The lack of sustained funding significantly limits the ability of LHDs to perform their essential core functions and build up their infrastructure to cover the foundational capabilities and core areas.

There was also uncertainty at many points during the pandemic about the longevity of emergency funding. The CARES Act expired in December 2020, and was renewed at the last minute, leaving many LHDs without resources to continue providing critical COVID-19 functions into 2021. Subsequent federal relief bills did address these needs, but the timing of votes and receipt of funds did not always coincide with when the money was actually needed, and put LHDs in the position of having to identify other funding sources to continue essential programs in case federal funding did not come through.

In addition, while pandemic funding did address short-term community needs due to economic loss and other social determinants of health, it has not addressed the root causes of these issues and only serves as a temporary fix. LHDs have done their best to support and protect the health of their communities, but they expressed a need for greater investment to address these issues over a longer term.

How Does California Compare?

The Trust for America's Health publishes state-by-state comparisons of public health spending in its annual *Ready of Not* and *Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020* reports. Both reports highlight that while overall public health funding has decreased over the past 20 years, it has started to stabilize in many states as a result of emergency funding for the pandemic. Though the reports also caution that emergency funds historically ebb and flow, and do not allow for building long-term infrastructure to protect against future emergencies. Some states appear to be making investments in long-term public health infrastructure as a result of COVID-19, but the future outlook remains uncertain in many states. California falls in the middle tier of state emergency readiness.

4. Pandemic funding has had challenging requirements that have hindered an equitable response

In this report's interviews with LHDs and community-based organizations between October 2020 and January 2021, while everyone was grateful for the pandemic funding received, there were concerns raised about challenging requirements. These included the following:

- Certain activities not being eligible for FEMA reimbursement (e.g., community-based organization outreach and education)
- Work plan and spending plan requirements were not always coordinated
- Direct reporting requirements. One LHD reported having to hire an additional staff person to oversee CARES and ELC funding administration and reporting
- Monthly compliance checks
- Funding was not always made available to use right away
- Pandemic funding was not consistently allocated within city/county governments, and funding for other sectors was not always aligned with public health (e.g., public health funding falling under the umbrella category of "public safety" along with law enforcement)
- Duplication of benefits requirements preventing the most impacted community members from accessing services. This was especially true with the Great Plates Delivered program:

The **Great Plates Delivered** program provided seniors with three home-delivered, restaurant-quality meals per day. However, the program excluded seniors already receiving other nutrition assistance like CalFresh/Supplemental Nutrition Assistance Program (SNAP) or Meals on Wheels. This essentially denied enhanced nutrition benefits to those who need them most. Seniors with higher incomes who are not currently accessing nutrition assistance programs were able to access $66 per day, while their lower income counterparts were excluded from this program, receiving the maximum benefit of only $6.26 per day under the CalFresh expansion and left to navigate a rapidly-evolving emergency food system:

NUTRITION ASSISTANCE BENEFIT COMPARISON

NUTRITION ASSISTANCE PROGRAMS	MAXIMUM DAILY BENEFIT AMOUNT PROVIDED	DAILY MEALS PROVIDED
Seniors on Existing CalFresh	$6.26	1+ meal
Seniors on Proposed CA Great Plates Delivered Program	$66.00	3 meals
Difference in Benefits Received	$59.74 less benefits/day for seniors currently on CalFresh than seniors on the Great Plates Delivered Program	

The eligibility requirement essentially established a two-tiered benefits system, in which CalFresh recipients with the highest need were set-up to receive less than 10% of the benefits that new higher-income enrollees in the Great Plates Delivered Program were set to receive. This is a serious injustice that exacerbated structural disadvantages along socio-economic lines and failed to meet the fundamental needs of countless seniors across California. In the future, it is critical to ensure that all seniors and high-risk individuals are guaranteed access to expanded supportive services to address food insecurity and that they are not excluded from higher benefits, simply because they were accessing smaller benefits that they are eligible for, and entitled to, under current guidelines. Increased nutritional access will help mitigate seniors already heightened risk of morbidity and mortality due to COVID-19.

5. Multi-sector partnerships between LHDs, CBOs and other sectors were stalled or slowed by the pandemic due to a lack of capacity

Local public health departments are part of many multi-sector efforts with other government agencies, healthcare, community-based organizations, businesses, and other sectors to elevate health equity and an upstream prevention approach to decision-making. Due to COVID-19, LHDs had to step back from many of these efforts, which stalled and slowed their progress on important existing and ongoing work. In the interviews conducted as part of this report, LHDs reported being unable to continue their health equity, climate change, healthy communities, and other multi sector work because staff was redeployed to COVID-19 emergency response functions. Community-based organizations also reported having to shift to addressing COVID-19 and putting their core work on hold.

Best Practices

The **California Accountable Communities for Health Initiative** (CACHI) sites were able to quickly pivot to supporting the COVID-19 response because of their robust, established partnerships between public health, healthcare, and the community. Their **COVID-19 brief** outlines how they were able to convene partners, coordinate action and disseminate information, deploy staff and resources, and train key staff and volunteers to ensure an equitable response and recovery. These sites played an important role because they were trusted conveners and already exploring and implementing ways to fund community health needs. For example, the **East San Jose Wellness Fund** was already set up and able to give direct payments to people ineligible for federal stimulus payments (e.g., undocumented populations). They were able to raise $600,000 and support 700 families.

"The impacts of COVID are so much greater than the narrow response efforts that the funding is targeted to support. Funding is too restrictive to infection control efforts and not broader public health and social impacts of COVID."
LHD respondent

"Funding sent directly to public health departments has been helpful, but the reporting requirement for all funding (including CARES) has been extremely taxing."
LHD respondent

RECOMMENDATIONS

Significantly increase funding for local public health departments

There is a significant need for more funding from local, regional, state and federal sources to be dedicated to local public health departments. It is important that this funding is flexible and allow for the hiring of critical staff, purchasing new and modernizing existing equipment and facilities, acquiring critical supplies, developing plans and strategies for addressing important public health challenges and emergencies, and partnering with other sectors and community-based organizations to advance health equity. In addition, COVID-19 has resulted in LHDs taking on and responding to the immediate needs necessary to respond to the pandemic, and funding needs to be provided for back funding and loan forgiveness for costs incurred while responding to this crisis. Finally, it is important that this funding maintain and enhance existing health equity supports, including enhanced funding for dedicated equity staff at the local level.

There are five important strategies for investing in our local public health departments:

1. **Increase Non-Categorical Funding:** LHDs need flexible funding to allow them to develop a cross-cutting workforce that can be trained in multiple skills and functions. Less than 5% of current LHD funding is flexible, which limits ability to hire staff trained in multiple disciplines and pivot as public health emergencies arise. By providing more flexible funding for local public health departments, they will be more able to have the resources they need to respond to a range of issues and threats, including health equity and climate change, in a more sustainable way.

2. **Provide Greater Allowances Within Categorical Funding:** Loosening the requirements on many categorical funding streams will allow greater flexibility. In the absence of a significant infusion of new funding, this will allow LHDs to be more innovative in how they use their funding to address important public health issues. It provides an opportunity to shift the paradigm of emergency preparedness from "break the glass in case of an emergency" to an "always on" system that is proactively ready to respond. For instance, in times of emergency, there could be a state or federal policy that LHDs can shift a certain percentage of their categorical funding to address the emergency response.

3. **Enhance Categorical Funding for High-Need Positions:** There are high demand functions, such as epidemiologists and public

health nurses, that require sophisticated skill sets and certifications. It is important that enhanced funding be provided to LHDs to ensure adequate staffing, training and retention of workers with these technical capabilities.

4. **Establish Sustainable Funding:** LHDs need long-term funding to be able to build and strengthen their workforce and systems to address everyday public health threats and more proactively prepare themselves for future emergencies. It is common for LHDs to receive one-time infusions of funding for public health emergencies such as COVID-19, but these temporary solutions only address current needs. Longer-term, more sustainable funding is necessary to ensure LHDs have the staffing and resources they need for all situations.

5. **Enhance Data Platforms to Provide Real-Time Disease Surveillance and Facilitate Data Sharing:** LHDs need funding to modernize and upgrade their data collection and reporting systems. These are important to conduct real-time disease surveillance, detect the spread of COVID-19, collect various data points, and monitor public health threats. It is important that these systems are integrated within LHDs and across other agencies at the local, regional, state and federal level to facilitate greater data sharing; and that these systems have the ability to collect and disaggregate demographic data, including race/ethnicity, income, geography, and the social determinants of health, to address health equity concerns. Staff also need support in understanding and being able to link the data to the historical and current contexts that lead to racial inequities. There are also many examples of LHDs unable to access data from divisions within their own department, such as being unable to obtain mortality data, as well as across other agencies at the local, state and federal level, such as barriers to accessing Section 8 housing data. To address this, it is important that investments are made in developing data sharing agreements and other legal documentation that addresses privacy and confidentiality issues while also providing the information LHDs need to make informed decisions.

There are various approaches that have been put forward at the state and federal levels to increase funding for local public health departments. The following were either enacted or under consideration in the time between October 2020 and July 2022:

- The U.S. Centers for Disease Control and Prevention (CDC)'s National Initiative to

"Sustainable funding is essential now to ensure that a robust public health safety-net is in place to contain and minimize not only the next outbreak or emergency. Additional sustainable funding will also ensure that we can confront the smaller, yet daily devastating waves of infectious and chronic diseases, which contribute to premature mortality and crippling morbidity in many regions and underserved communities."
California Can't Wait Campaign $200M general fund ask letter

Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities, which offered $2.25 billion over two years to local and state health departments to reduce COVID-19 related health inequities.

- The California Can't Wait Campaign, led by the California Health Executives Association of California (CHEAC), which has been working to secure an ongoing State of California General Fund investment for public health department and workforce needs as well as other asks from budget surplus funds, such as the Health Equity Readiness & Opportunity (HERO) initiative.
- The California Alliance for Prevention Funding's efforts to establish a Health Equity and Racial Justice Fund.
- The federal Public Health Funding Prevents Pandemics Act, which would restore funding for the federal Prevention and Public Health Fund to its originally authorized level of $2 billion, starting in FY2021 and for each year thereafter.
- Trust for America's Health push for a federal public health funding bill as part of a comprehensive infrastructure package
- Improving Social Determinants of Health Act of 2021 which would create a social determinants of health program at the CDC.
- Health Force, Resilience Force, and Jobs to Fight COVID-19 Act of 2021, which would establish a national standing workforce to respond to the COVID-19 pandemic in their communities, provide capacity for ongoing and future public health needs, and build skills for new works to entire the public health and healthcare workforce.

THE MEDIA HIGHLIGHTS DISINVESTMENT IN PUBLIC HEALTH INFRASTRUCTURE

USA Today, March 2, 2020
'This is not sustainable': Public health departments, decimated by funding cuts, scramble against coronavirus

San Francisco Chronicle, March 16, 2020
Even before coronavirus, infectious disease was on rise in California — but spending got cut

LA Times, March 20, 2020
Officials long warned funding cuts would leave California vulnerable to pandemic. No one listened.

Detroit Free Press, April 4, 2020
Panic, then neglect: Prior pandemics gave us lessons to fight the coronavirus. But funding dried up.

NY Times, April 9, 2020
The U.S. Approach to Public Health: Neglect, Panic, Repeat

Los Angeles Times, June 15, 2020
Public health funds are needed more than ever but lack 'lobbying muscle' in California

Invest in Communities In Ways That Support Public Health and Addresses Health Inequities

There is a need for a new path forward for investing in the most impacted communities beyond the COVID-19 recovery. Sustainable investments need to be made in communities to address longstanding health inequities, community conditions, and structural racism, and in coordination with local public health departments. It is important that these investments are made more proactively and over a longer term, and not just in response to the COVID-19 pandemic or other future emergencies. Investing in communities goes hand in hand with investing in our public health departments. California will build a stronger, more equitable, and resilient public health system if structural barriers to optimal health are eliminated. It is important that any resources made available for COVID-19 recovery and rebuilding public health systems dedicate a portion of funding for investments in the communities most impacted by COVID-19, and those most at risk for impacts by future threats. For example, as part of the California Blueprint for a Safer Economy's Health Equity Metric requirement, LHDs developed Targeted Investment Plans that allocated resources to the lowest HPI quartile in each jurisdiction. Altogether, $272 million in CARES Act and ELC funding was directed to the most impacted communities, defined as those in the lowest Healthy Places Index quartile. The CDPH Office of Health Equity also directed $5 million in funding for community-based organizations to implement Health Equity Pilots within these communities. Outside of COVID-19, the California Climate Investments initiative is a statewide model for how to set aside dedicated funding to the most impacted communities. This program has legislative requirements (SB 535 and AB 1550) to allocate at least 35% of all grant funding to projects within and benefitting disadvantaged and low-income communities. Another model is the Together Toward Health initiative, where community investments incentivize and encourage partnerships between LHDs and community-based organizations that represent the most impacted communities, to work together on addressing health equity. These investments are necessary and complementary to investments made in public health departments.

Infuse a Health and Equity in All Policies approach with investments from other sectors

Beyond community and LHDs, it is important for other sectors to play an active role in supporting an equitable and just response and recovery. Social and economic factors such as access to safe and affordable housing, good-paying jobs, quality educational opportunities, healthy food, and convenient transportation options have a greater impact on health than genetics. It is important that investments by other sectors, including housing, economic development, employment, transportation, criminal justice, and more, are made with the social determinants of health and health equity in mind. This means taking a multi-sectoral Health and Equity in All Policies Approach. Non-health sectors can integrate health and equity principles into their planning and programming, and fund public health-supportive investments. They can also incorporate health equity metrics into their planning and investment, similar to the model the CDPH deployed for the Health Equity Metric and Vaccine Equity Metric. If not doing so already, these sectors could also explore partnering with CBOs to assist with their work, and providing set-asides within their funding to support investments in the most impacted communities, similar to the model used by many transportation and climate programs under the guise of "disadvantaged communities." They can also expand eligibility for LHDs and community partners to apply for their funding, especially in partnership with each other. For example, LHDs can apply to the California Transportation Commission's Active Transportation Program grants to promote walking, bicycling, and Safe Routes to School, but there are many other grant programs, including most of the California

Climate Investment programs, where they are not eligible or are only identified as recommended partners in project implementation, without funding attached for their participation. When LHDs receive this kind of funding, they are often able to bridge silos, bring in multi-sector partners, and pass through the funding to community-based organizations that are led by those who are most negatively impacted by health inequities. Expanding eligibility to include LHDs and allowing funding to be used for their participation in multi-sector projects can encourage greater community and multi-sector collaboration, and a Health and Equity in All Policies Approach to government-funded investments.

Promote innovative community investment strategies to address community health and equity

Traditional funding sources alone will not provide sufficient funding to address health inequities for the most impacted communities, let alone in a public health emergency. There are innovative financing strategies being implemented across the United States that supplement the resources available to communities and LHDs. This includes strategies like blending funding with sources from other sectors like healthcare and community development, creating a Wellness Fund, developing an Accountable Communities for Health model, exploring anchor institution strategies, and partnering with community development financing institutions and other sectors to leverage funding sources. The Public Health Alliance has created a comprehensive research report outlining these innovative community investment strategies, which provides more information on best practices and recommendations for greater implementation and inclusion of LHDs in these investment efforts.

The California Governor's Office of Social Innovation has catalyzed these models through 27 public-private partnerships that have leveraged $3.9 billion in corporate and philanthropic investments before and during the COVID-19 pandemic. The CACHI model mentioned above is bringing together public health, healthcare, and community partners in 13 sites around California to work together and explore financing models including wellness trusts and blending and braiding of funding. There are also efforts to set up a State Wellness Trust or Health Equity Fund to support both LHD and community needs. The benefit of many of these models is their greater flexibility from traditional public health funding. They also can have a distributed leadership model where the backbone is not one single entity and everyone has a role to play in implementation. There are also community ownership models such as the Funders Forum concept of Response and Resilience Accountability Councils (also known as Recovery and Equity Councils) that could be explored to ensure greater accountability of government response to the community, as well as

efforts to put safeguards and "guardrails" in these mechanisms to ensure they meet the needs of those they are intended to serve and provide effective stewardship of public funds.

Ensure Healthcare Funding Streams Include Investments in Public Health and Community Needs

Given that an estimated $3.6 trillion is spent annually on healthcare, but less than 3% of that is spent on public health and prevention infrastructure, there is a significant opportunity to leverage healthcare expenditures to improve public health infrastructure and support the community health needs of groups most impacted by inequities. This is especially important because LHDs provide many basic healthcare services covered by Medi-Cal and Medicare, often with little to no reimbursement. Many LHDs do not have the billing systems set up to properly account for and be reimbursed for all the services they provide under Medi-Cal. They also lack the capacity to track all the state and federal policy changes that impact their work, including the complex Medicaid waiver processes. There needs to be greater collaboration between the healthcare and public health sector, and incentive mechanisms need to be put in place to ensure this happens in a meaningful way. For example, California's CalAIM proposal, if approved, will provide stronger incentives for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management and in lieu of services. Efforts are cost containment can also be leveraged to provide funding for public health departments and community investments.

Develop a statewide equitable public health infrastructure resilience plan

To address all of the above and put together a holistic, comprehensive roadmap to rebuilding California's systems in a way that supports public health, other sectors and the communities they serve, there is a need for a statewide resilience plan that can guide investments and policy. The aim of this plan would be to identify where systems were overwhelmed in the COVID-19 response, with goal of strengthening the entire public health system to withstand and prevent the community impacts that resulted from a lack of preparedness. This plan would be similar to other statewide comprehensive plans in that it would have a public process and be used as a framework for guiding all investments. The community engagement process would need to ensure that those most impacted by COVID-19 were able to participate. Specific elements of this plan would include identifying funding needs and scale of need (including everything mentioned above in this Recommendations section), recommendations for meeting these needs, and potential funding opportunities, workforce needs (detailed more in the section below). Recent legislation, AB 240 (2021), which would have created a LHD workforce assessment, is a good example of how to advance this approach, but there is a need for a large-scale comprehensive planning effort that also addresses community needs and a focus on equity.

2

Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century

RECOMMENDATIONS

- Establish Programs and Funding to Advance a Community-Centered Public Health Workforce
- Adopt and Implement Structural Changes to Internal Policies to Retain, Support, and Promote Staff, with a Specific Focus on Communities Most Impacted by Inequities
- Establish Standing, Funded Community-Based Partnership Programs to Strengthen the Public Health System
- Increase Cross-Training for Public Health Staff to Strengthen and Support a More Nimble Workforce
- Coordinate with State and Federal Public Health Agencies and Leaders to Establish Incentives to Draw and Retain a Robust Public Health Workforce
- Establish a National Public Health Reserve Program to Rapidly Expand the Public Health Workforce During Emergencies
- Develop a Statewide Public Health Workforce Resilience Plan

OVERVIEW

As the only local agency tasked with protecting the health and wellbeing of California communities, local public health departments are on the frontlines of responding to innumerable community health concerns, from the COVID-19 pandemic and climate change impacts, to childhood asthma prevention and food safety enforcement. In order to effectively and equitably carry out the core functions of public health, local public health departments (LHDs) need a robust, nimble, community-centered workforce.

Persistent budget cuts and a high ratio of retirees to incoming public health professionals, have left the local public health system with a significant shortage of workers. Between 2008 and 2017, local and state health departments lost 20% of their workforce, a loss of over 50,000 public health workers across the country. In 2008, the Association of the Schools of Public Health estimated that there would be a shortfall of at least 250,000 public health workers, leaving the system largely understaffed for routine activities, let alone a crisis of the magnitude of COVID-19. Due to this ongoing disinvestment in state and local public health departments and their workforces, when the COVID-19 emergency struck, LHDs had to scramble to redeploy program staff indefinitely, rapidly hire temporary staff, and coordinate across counties to share specialized staff and facilities in order to respond to the emergency.

Despite staffing shortages, especially in specialized positions like public health nurses and epidemiologists, and an overall lack of staff representative of the communities most disproportionately impacted by COVID-19, LHDs worked tirelessly to meet the crisis. Local health departments leveraged existing relationships and forged new partnerships with other sectors, community-based organizations, and regional collaboratives to create a more expansive system of public health. Community-based organizations (CBOs) in particular stepped beyond their normal scopes and missions to meet the needs of their communities, including with providing access to basic needs, helping navigate government and other benefit programs and systems, and advocacy efforts. The CBO response to COVID-19 demonstrated the critical need for standing, funded CBO network across the State to address inequities and elevate community priorities.

In order to meet the current and emerging public health needs of the 21st century, including climate change inequities and injustice, California must prioritize a nimble, community-based, equity-centered public health workforce. In alignment with the Federal Health Force Act, meeting this goal will require policy action and programmatic changes at the state and local level.

CHALLENGES

1. The COVID-19 emergency exacerbated existing chronic staffing shortages
2. Staff often do not reflect communities most burdened by inequities and disproportionate health impacts
3. Lack of specialized staff, including epidemiologists, public health nurses, and health equity experts
4. Diversion of staff from other critical public health programs that provide support to vulnerable populations
5. Local health departments are frequently in crisis response mode, therefore many departments are unable to prioritize health equity, the social determinants of health, and structural racism

1. The COVID-19 emergency exacerbated existing chronic staffing shortages

The COVID-19 emergency exacerbated decades-long staffing shortages in LHDs, with nearly 60% of LHDs reporting that staffing was insufficient to respond to the needs of communities most impacted by the emergency. Many LHDs reported they were unable to meet the needs of their communities prior to the COVID-19 emergency and have been continuously operating from a deficit throughout the response. While CARES and ELC funding enabled rapid hiring of many temporary staff, LHDs will return to a state of chronic understaffing without an infusion of sustained non-categorical funding. Despite nearly half (47%) of October 2020 – January 2021 survey respondents indicating that internal human resources (HR) policies did not facilitate an effective COVID-19 response in terms of rapid hiring, several LHD representatives described significant improvements over time, with one stating that "it was very difficult early on, but there were some changes in HR policies and practices during the middle of COVID that helped expedite hiring" (LHD respondent).

"We do not have enough staffing to support COVID nor the other emergencies we are facing such as the equity crisis, fires, public safety power shutoffs, extreme weather, economic stress, and the mental health crisis" LHD respondent

Best Practices

RAPID HIRING

In order to meet the urgent need for staff to support the COVID-19 response, LHDs worked quickly to rapidly hire and on-board staff, including case investigators, contact tracers, nurses, and others. Department managers worked with internal human resources and hiring departments or private temporary employee services to increase staff numbers and department capacity as quickly as possible. For example, the Shasta County Health and Human Services Agency hired over 80 temporary staff to support COVID-19 response activities, while the Riverside Health System hired 360 new employees in 7 weeks. Some LHDs described strategies to increase the diversity of hired staff, by working closely with hiring managers to prioritize hiring multicultural and multilingual staff reflective of the communities most impacted by COVID-19.

COMMUNITY HEALTH WORKERS & PROMOTORES

Local public health departments, in partnership with community-based organizations, drew upon and facilitated the expansion of networks of Community Health Workers (CHWs) and "Promotores" (community health workers working in Spanish-speaking communities) to increase outreach to and support for impacted communities. Including Promotores and **CHWs in public health and healthcare systems** has been shown to reduce healthcare costs and **improve health outcomes** for individuals and communities with chronic health conditions. Promotores and CHWs are trusted members of the community, often with shared lived experience to the individuals whom they are serving. Given the history of racism in healthcare and government systems, as well as the fear, stigmatization, and marginalization many communities have experienced throughout the COVID-19 emergency, employing Promotores and CHWs has proved to be a vitally important strategy. As a component of the **Fresno Equity Project**, Fresno County Public Health partnered with over 20 CBOs and California State University, Fresno to launch a CHW effort specific to the COVID-19 response. The LHD contracted with CBOs to hire and train CHWs, who are paid a living wage and provided training in skills that can be applied beyond the COVID-19 pandemic.

87%

of LHD respondents said knowledge of community engagement and partnerships was the most critical staff skill in the COVID response

2. Staff often do not reflect communities most burdened by inequities and disproportionate health impacts

Many LHD directors reported that in addition to insufficient staff overall, there were very few, if any, staff that were from the most impacted communities or from a similar racial/ethnic or cultural background. Local public health department directors and managers described lack of multicultural and multilingual staff as a significant barrier in rapid response efforts, including with: developing and translating informational materials; outreach to new community-based partners from impacted communities; and building trust between communities and the LHD. One LHD representative shared that there was "no targeted outreach to impacted communities to ensure hiring from these communities." Another described an important partnership to try and meet this need: "… We would not have been able to quickly develop a culturally competent workforce, so we contracted with the FQHC [Federally Qualified Health Center] in the most vulnerable areas of the county to do outreach, education, testing…" While many LHDs made a concerted effort to hire contact tracers from impacted communities early on, as described above, those efforts could not take the place of a diverse community-based permanent staff or long-standing partnerships with CBOs.

"Our workforce looks nothing like the most vulnerable people we serve" LHD respondent

Best Practices

FARMWORKER RESOURCE CENTERS

The Ventura County Human Services Agency established the **Farmworker Resource Program** in 2019 for the express purpose of building trusting relationships among the agricultural community, connecting community members to resources, and navigating workplace issues. The program team includes multiple staff who speak Spanish and Mixteco, and are experts in farmworker issues. The Farmworker Resource Program has been a critical partner in responding to the COVID-19 emergency, which has disproportionately impacted Latinx and Indigenous communities as well as agricultural workers. While many LHDs struggled to find adequate translation services and community partners in the agriculture sector, the Farmworker Resource Program enabled Ventura County to rapidly translate **COVID-19 educational materials**, conduct outreach to farmworker communities, share information on testing and basic needs resources, and elevate community priorities during the response. In fact, this model has been so impactful that legislation has been introduced to expand this model across the State. **AB 941 (2021)** requires the Department of Community Services and Development to establish a grant program for counties to establish farmworker resource centers, which would provide information and access to essential services such as health, housing, and worker rights. The program stipulates the following eligibility criteria:

- The county entity must work with community-based organizations to develop the center
- Provide 25% of the center's program funding
- Provide service in at least English and Spanish

COMMUNITY ORGANIZERS IN LHDS

Well before the COVID-19 emergency, the Shasta County Community Action Agency established several community organizer staff positions, supported through public health realignment funds. The Community Organizers are tasked with working directly with community members, formal and informal leaders, and CBOs, to identify community assets, needs, and priorities to advance policy, systems, and environmental changes. In order to reduce barriers to employment, the positions do not have educational requirements and give preference to applicants who are bicultural or bilingual, are from impacted communities, or have worked with marginalized communities. Shasta Public Health Services leadership described these staff and their role as a trusted partner and advocate as one of the County's greatest assets in responding to the COVID-19 emergency, and noted Shasta Public Health Services' ongoing commitment to hire more staff from impacted communities.

"Hiring of any kind of technical position is very challenging. We are trying to hire public health nurses and getting no applications..." LHD respondent

3. Lack of specialized staff, including epidemiologists, public health nurses, communicable disease specialists, and health equity experts

Many LHDs, especially those in smaller and more rural jurisdictions, described lack of specialized or technical professionals as a major hurdle in the COVID-19 response. LHD representatives most frequently described insufficient numbers of public health nurses, epidemiologists, and communicable disease experts, as well as staff specially trained in health equity. Smaller jurisdictions described difficulty hiring and retaining specialized staff due to the part-time nature of many of these positions and lengthy application and hiring timelines, with one LHD Director stating, "…many times they [nurses] get hired elsewhere before they make it through the hiring process." Even larger, more well-resourced jurisdictions noted challenges competing with or matching salaries provided by the private sector or large healthcare providers. This acute shortage during the COVID-19 emergency is merely a snapshot of a larger trend: 25% of public health nurses reached retirement age in 2016, and over one million American nurses are expected to retire in the next 10 to 15 years.

4. Diversion of staff from other critical public health programs that provide support to vulnerable populations

The diversion of LHD staff to COVID-19 response activities significantly impacted provision of other services and core programs. On average, LHD survey respondents indicated that anywhere from 50-70% of their staff were diverted to the COVID response, while some shared that 100% of public health staff were diverted during the surges. Over 80% of survey respondents stated that diversion of staff resulted in gaps in critical department functions and programs, and impacted their ability to conduct community outreach and engagement. Additionally, 60% of survey respondents stated that diversion of staff caused administrative delays impacting service delivery for impacted communities. While LHDs have worked tirelessly to respond to the impacts of COVID, particularly in low-income and communities of color, the diversion of already limited staff from public health, social services, and other community-serving agencies will likely have significant adverse outcomes later on. Local public health department staff described lack of home visiting services and programs in schools as major concerns for maintaining the health and wellbeing of communities. Despite the significant challenges posed by staff diversion to the COVID-19 response, some LHD representatives shared silver linings. One LHD manager described that throughout the response effort, some line staff have emerged a major assets and future leaders in the department.

82%

of survey respondents stated that diversion of staff resulted in gaps in critical department functions and programs

"We have been able to pull staff over from existing programs, but those programs are often equally or more important than COVID response have suffered tremendously. COVID response should not trump other important work in vulnerable communities" LHD respondent

5. Local public health departments are frequently in crisis response mode, therefore many departments are unable to prioritize health equity and the social determinants of health

The decades-long disinvestment in public health departments and their and workforces, and the limiting nature of categorical funding (see "Bolster Resources and Investments in Public Health Infrastructure") undermines LHDs' ability to prioritize ongoing structural and social determinants of health work in partnership with impacted communities. Furthermore, lack of resources and staff can limit emergency prevention and preparedness activities, requiring LHDs to rapidly shift to crisis response mode in the event of an emergency. As the frequency of emergencies increases, from climate change-related wildfires and Public Safety Power Shutoffs to infectious diseases outbreaks, LHDs are required to pivot from emergency to emergency while maintaining categorically funded programs. This pattern leaves little capacity to advance the broad and deeply collaborative policy, systems, and environmental changes needed to promote health equity and social justice. The COVID-19 emergency has laid bare the glaring social, economic, and health inequities across the State and taxed California's public health system, and yet local governments and LHDs have demonstrated their continued commitment to health equity throughout the response.

Best Practices

Local governments, in partnership with LHDs and other sectors, passed critically important policies and programs to help protect and support communities disproportionately impacted by COVID-19. Policy areas addressed include housing, economics, education, and access to services. See examples below.

- Los Angeles County established **Medical Sheltering** sites for those experiencing homelessness or those unable to safely or effectively quarantine or isolate at home.
- **Santa Barbara County** issued a health order requiring daily temperature checks and health screenings in employer provided housing for H-2A status temporary agricultural workers, to mitigate the spread of COVID-19 among migrant workers.
- The City and County of San Francisco enacted an **eviction moratorium**, prohibiting residential evictions and providing 6 months for renters to repay accumulated rent.
- The City of Oakland expanded protections and benefits under the **Emergency Paid Sick Leave Ordinance** to improve access and increase pay rates.

For more examples see the California Department of Public Health's **COVID-19 Health Equity Playbook for Communities**.

"We have been successful in recent years working with advocates for policy change that impacts vulnerable populations. However, [we are] significantly behind other areas of the state in policies that reduce health inequities. This has significantly impacted COVID outcomes for vulnerable populations in the Valley – specifically as it pertains to crowded housing, ag workers, the undocumented, and worker protections" LHD respondent

RECOMMENDATIONS

In order to meet growing public health needs, local, state, and federal entities must invest in a robust public health workforce that promotes community priorities and advances health equity. The COVID-19 emergency devastated--and continues to leave long-term impacts on--families and communities, especially those already experiencing inequities prior to the pandemic. As such, it is critical for public health leaders and elected officials to seize this moment to invest in California's community and public health infrastructure. Young people and students have felt the call to action: the Association of Schools and Programs of Public Health tracked a 20% increase in applications to master's in public health programs. It is the responsibility of local, state, and federal public health entities to meet this motivation with policy and process changes to support a prepared, diverse, and resilient public health workforce. The Federal Health Force Act (2021), introduced in 2021, would have established a grant program through the Centers for Disease Control and Prevention (CDC) for States, localities, territories, and Tribal entities to "recruit, train, and employ a standing workforce of Americans to respond to the COVID-19 pandemic in their communities, provide capacity for ongoing and future public health needs, and build new skills for new workers to enter the public health workforce." In order to fully realize this change, local and state public health departments must commit to hiring people representative of impacted communities and developing funded standing partnerships with CBOs. Below are recommendations to advance these goals.

Establish programs and funding to advance a community-centered public health workforce

The California Future Health Workforce Commission identified the expansion of "pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers" as the number one priority in their 2019 assessment of California's health workforce needs. The COVID-19 emergency underscores the need to ensure the LHD workforce is reflective of the communities they serve and prioritizes hiring people from these communities. It is important that LHDs adopt and implement the following practices to increase diverse local hiring practices.

- Implement standard policies to prioritize hiring staff, at all levels, who are from the communities served, and decrease barriers to enter the public health workforce. Policies can include the following;

  - » Changing and/or removing language requirements and formal education minimums
  - » Prioritizing lived experience and community knowledge
  - » Removing questions related to criminal background and documentation status
  - » Removing Driver's License requirements
- Partner with CBOs, high schools and community colleges, re-entry programs, social services, and other workforce development programs to establish paid public health internship and mentorship programs, and career pathways
- Collaborate with diverse stakeholders to develop and establish a Public Health Corps program and funding stream to support young people, people from local communities, and people from communities most impacted by inequities to enter LHDs

- Expand the role of CHWs and Promotores to more actively include these critical workers in decision-making, organizing and civic engagement
- Develop and provide certification programs for CHWs and Promotores, people to assist in navigating various benefits and systems programs, home visitation workers, and others to increase acquisition of employable skills
- Establish community organizers as standard positions in LHDs

Adopt and implement structural changes to internal policies to retain, support, and promote staff, with a specific focus on communities most impacted by inequities

Complementary to the hiring recommendations outlined above, it is important for LHDs to implement changes in internal policies and processes to retain and support staff, especially staff of color, and staff from communities impacted by inequities and other marginalized communities. Local public health departments can implement policies to cultivate a culture of equity, transparency, and accountability, including: salary transparency and equity policies to mitigate pervasive gender and race/ethnicity wage gaps; and policies that provide clear and supportive mechanisms to report and address discrimination and harassment. It is critical that LHDs adopt transparent promotional practices and prioritize promoting staff of color and from impacted communities to management and leadership positions. The Local and Regional Government Alliance on Race and Equity has developed many resources to help local government agencies institutionalize racial equity, including Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action.

Establish standing, funded community-based partnership programs to strengthen the public health system

A truly equity-centered, community-based public health system requires two critical elements: a diverse community-based workforce (as described above), and long-term, funded partnerships with a network of CBOs that are coordinated with local public health departments. In order for the public health system to authentically identify, uplift, and address community priorities and advance health equity, communities must be represented within the LHD and be well-resourced to engage with and hold the department accountable. Throughout the COVID-19 pandemic, LHDs with longstanding, trusting partnerships with CBOs have been better positioned to equitably respond to the needs of disproportionately impacted communities in a rapidly shifting environment. Community-based organizations, often with little or no financial support, have expanded their scope and stepped into entirely new roles to protect and support their communities; they are a central pillar of the 21st public health system and must be resourced as such.

Local public health departments, and local government more broadly, need to provide on-going funding, not merely project or activity-specific, to a CBO partner network to facilitate continuous partnership and power-sharing in decision-making, policy and program development, and emergency preparedness and response.

Increase cross-training for public health staff to strengthen and support a more nimble workforce

Throughout the COVID-19 emergency, LHD staff have had to adapt to an everchanging landscape and often step into new and unfamiliar roles. However, this necessary flexibility is not unique to responding to this crisis; increasing opportunities for staff to acquire new skills and participate in training in new topic areas will be helpful in standard public health functions and future emergencies. All staff should be trained in foundational equity principles, including implicit bias training, use of equity tools in decision-making, as well as strategies for building authentic, trusted, community-based partnerships. Additionally, staff should have opportunities to develop skills related to culturally-competent messaging, and understanding and communicating data. The COVID-19 pandemic has also underscored the importance of interagency collaboration and coordination in facilitating an all-County or all-government response. Creating opportunities for public health staff to learn about roles, capabilities, and dynamics of other agencies will enable increasingly effective partnerships to address emergencies and ongoing cross-sector issues, such as housing, transportation, land use, and climate change.

See the California Chronic Disease Prevention Leadership Project's Public Health Workforce Imperative for more information and recommendations.

Coordinate with State and Federal public health agencies and leaders to establish incentives to draw and retain a robust public health workforce

In conjunction with internal policy and practices changes, it is important that LHDs coordinate with the California Department of Public Health (CDPH), other state level agencies and partners, the US Department of Health and Human Services (HHS), and other Federal agencies and leaders to implement structural changes to increase the State's public health workforce. As a component of the Public Health Workforce Resilience Plan (described below), it is important the US HHS and CDPH conduct an assessment of salary ranges across the private and public sectors, as well as cost of living fluctuations and variations to ensure LHDs are able to offer competitive salaries, particularly for highly-trained specialized positions. Additionally, local and state agencies can explore and advocate for more robust loan forgiveness programs for public health professionals at the state and federal level, reducing

the financial burden of higher education, especially for low-income and communities of color.

Establish a national public health reserve program to rapidly expand the public health workforce during emergencies

Lack of specialized staff within LHDs has been a significant challenge throughout the COVID-19 emergency. In order to increase public health preparedness for the next emergency, CDPH and the California Department of Health and Human Services can collaborate with the US HHS and other state health departments to establish a National Public Health Reserve Program. A Public Health Reserve Program could be modeled off of the Medical Reserve Corps, and could include retired public health professionals (e.g., public health nurses, epidemiologists, etc.) as well as public health professionals working outside of the government public health system. In alignment with the Federal Health Force Act, creating a national program would enable mutual public health aid across states to respond to local and regional emergencies, while increasing the resilience of the country's public health system as a whole.

Develop a statewide public health workforce resilience plan

In order to effectively and equitably, plan, fund, and implement the above recommendations, it is important for California to develop a statewide public health workforce resilience plan in alignment with the Public Health Infrastructure Resilience Plan (see Resources & Investment chapter). Recent legislation, AB 240 (2021), laid the foundation for this plan by proposing to create a LHD workforce needs assessment, including recommendations for future staffing, workforce needs, and resources. If this bill or a future iteration moves forward, it is critical that the development of the needs assessment and the workforce resilience plan includes community representatives throughout the process to ensure that community priorities are elevated throughout, with particular attention to the development of a community-based workforce pipeline and strengthening the CBO network as a pillar of the State's more expansive public health system.

3

Embed Equity throughout Local Public Health Department Emergency Planning, Response and Recovery Processes

RECOMMENDATIONS

- Support the Creation of a Robust, Structurally Funded Equity Team within Each Local Public Health Department
- Build and Activate Community Partnerships for Transformative Equity Solutions
- Embed Equity into Emergency Response Structures and Processes
- Incorporate an Equity Metric into All Emergency Response and Recovery Processes
- Fund Community-Based Partners to Conduct Culturally Informed and Relevant Outreach and Engagement
- Prioritize Hiring Community Members from Disproportionately Impacted Communities
- Integrate Equity into All Recovery Planning and Implementation Processes

OVERVIEW

COVID-19 has compounded the impacts of underlying inequities that have negatively impacted low-income communities and Black, Indigenous, and People of Color (BIPOC) communities for centuries. Rooted in historic and contemporary structural racism and discriminatory policies and practices, low-income communities and communities of color, particularly Black, Latinx, Indigenous, and Native Hawaiian, and Pacific Islander communities,[1] have been disproportionately impacted by COVID-19 infections and deaths. They are also frequently on the front lines of exposure as essential workers.

The pandemic has also made clear that public health emergencies are complex and resource-intensive and can rapidly overwhelm government systems designed for routine operations—which can make it difficult to implement equitable principles and practices. This is especially true when equity has not already been embedded into local emergency response protocols. For many jurisdictions, COVID-19 created a critical opportunity to integrate equity more formally into local emergency operations and throughout the COVID-19 response. Jurisdictions with funded equity staff in place, were able to do so more formally (through shifts in emergency response structures). Jurisdictions who were able to integrate equity more formally into the emergency response, as well as leverage already existing and authentic partnerships with community-based organizations (CBOs) and trusted community thought leaders, were better able to develop and implement equitable response solutions. In addition, those jurisdictions who were able to financially support community-based outreach, engagement, and education efforts throughout the response, have also been more successful in leveraging those community relationships in vaccine distribution and prioritization efforts.

The development of the State of California's first in the nation Health Equity Metric for reopening, also allowed many jurisdictions, some for the first time, to explicitly prioritize disproportionately impacted communities during the COVID-19 response and during vaccine prioritization and distribution. This intentional focus on equity has allowed many local public health departments (LHDs) to rethink their policies and processes for working in and with communities most impacted by inequities, both during COVID-19 and beyond.

1 There is also evidence to suggest that some Asian American subgroups have also been disproportionately impacted by COVID-19 infections and deaths, however, a lack of disaggregated race/ethnicity data for Asian Americans have led to an incomplete picture of the disproportionate impact of the COVID-19 pandemic on the Asian American community.

Local public health departments and community partners agree that in order to prevent further exacerbating inequities during the COVID-19 response and recovery process, it is important that those communities most impacted by inequities play a leadership role in the development and approval of all response and recovery-related decisions. A focus on cultivating equity in emergency response processes, both in formal management structures and more informal decision-making processes, can help communities respond to and recover from the health and economic impacts of COVID-19 and future public health and climate change-related emergencies. Equity-centered practices and processes must receive ongoing support (both financially and politically) in order for California to emerge from the COVID-19 crisis more just and equitable.

CHALLENGES

1. Many jurisdictions did not have structurally funded or sufficient equity staff in place to help lead efforts throughout the response
2. A model/uniform approach for embedding equity into emergency response did not exist; this led to inconsistent processes for addressing disproportionate impact
3. Community-based partnerships were critical in reaching those most impacted throughout the crisis; jurisdictions without strong partnerships in place were less able to respond equitably to the crisis
4. There have been inconsistent opportunities to fund community-based partners throughout the crisis; when funding has been available, internal governmental contracting/procurement processes created barriers to accessing funding for some community-based organizations
5. There have been ongoing challenges in creating culturally relevant and effective public health messaging for communities most impacted by the COVID-19 crisis
6. There have been difficulties finding effective ways of reaching disproportionately impacted community members throughout the crisis

1. Many jurisdictions did not have structurally funded or sufficient equity staff in place to help lead efforts throughout the response.

In both survey responses and interviews, LHDs reported there were varying levels of equity capacity when it came to funded equity staff. This also led to inconsistent local approaches to addressing priority health and economic inequities that emerged throughout the crisis.

In the Community Survey:

- 59% of respondents indicated that they do not have funded equity staff – of those, 83% believe additional funding for dedicated equity staff would better support their department's COVD response.

Many LHDs described a local funding environment that makes it difficult to hire and retain dedicated health and racial equity staff in their departments, despite a near universal consensus among interviewees that this dedicated staffing would support their broader efforts to advance equity internally and in partnership with the communities they serve.

"We need ongoing funding to support health equity efforts"
LHD respondent

Best Practices

UTILIZING COVID-19 RESOURCES TO ADVANCE HEALTH EQUITY

Multiple jurisdictions worked to secure funding for dedicated equity staff or even formal equity offices throughout the COVID-19 crisis. In September 2020, **Sonoma County** launched a new Office of Equity in response to the disproportionate impact of COVID-19 on Latinx and Indigenous communities in Sonoma. In December, 2020, the **Orange County Health Care Agency** also launched the Agency's first Office of Population Health and Equity. Some LHDs are leveraging COVID-19 funds (specifically federal Environmental Laboratory Capacity (ELC) funds) to hire dedicated equity staff, some for the first time. In Santa Barbara County, ELC funds are supporting the launch of a new Office of Equity, with a focus on internal policy and systems change, and power-building and sharing with community-based organizations, with the goal of improving population health. Likewise, Riverside County leveraged ELC funding to support the onboarding of a COVID-19 equity response staff member. This strategy is one that can be leveraged and considered by health departments across California as additional funding support is identified to improve community health both during COVID-19 and beyond.

LEVERAGING REGIONAL LOCAL HEALTH DEPARTMENT COALITIONS TO PROVIDE CRITICAL EQUITY SUPPORT

Regional LHD coalitions , like the **Public Health Alliance of Southern California (Public Health Alliance)**, the **Bay Area Regional Health Inequities Initiative (BARHII)**, and the **San Joaquin Valley Public Health Consortium (SJVPHC)**, were able to pivot quickly to provide equity-based technical assistance and capacity-building support for their member health departments throughout the crisis. These regional coalitions were also able to elevate priority concerns impacting residents throughout their regions and worked to secure resources and identify gaps in service. Early in the crisis, the regional coalitions elevated the urgent need for communications support to address the multiple inequities that emerged as a result of the crisis. In partnership with public health communications partner, **Berkeley Media Studies Group** (BMSG), regional coalitions responded to local public health departments' need for developing tailored communications support around everything from **Addressing Racism & Xenophobia**, to **communications strategies for putting data into context**. Regional coalitions have consistently elevated emerging and urgent policy and equity priorities at both the State and Federal levels, and have supported local members with **policy and investment priorities**, technical assistance around the State's health equity metric, and **emerging promising practices** for advancing equity throughout the COVID-19 response.

2. A model/uniform approach for embedding equity into emergency response did not exist; this led to inconsistent processes for addressing disproportionate impact

For many jurisdictions, COVID-19 created a critical opportunity to integrate equity more formally and comprehensively into local emergency operations. Jurisdictions without intentional, equity-centered staffing integration and support, were less able to identify and respond to early signs of disproportionate impact.

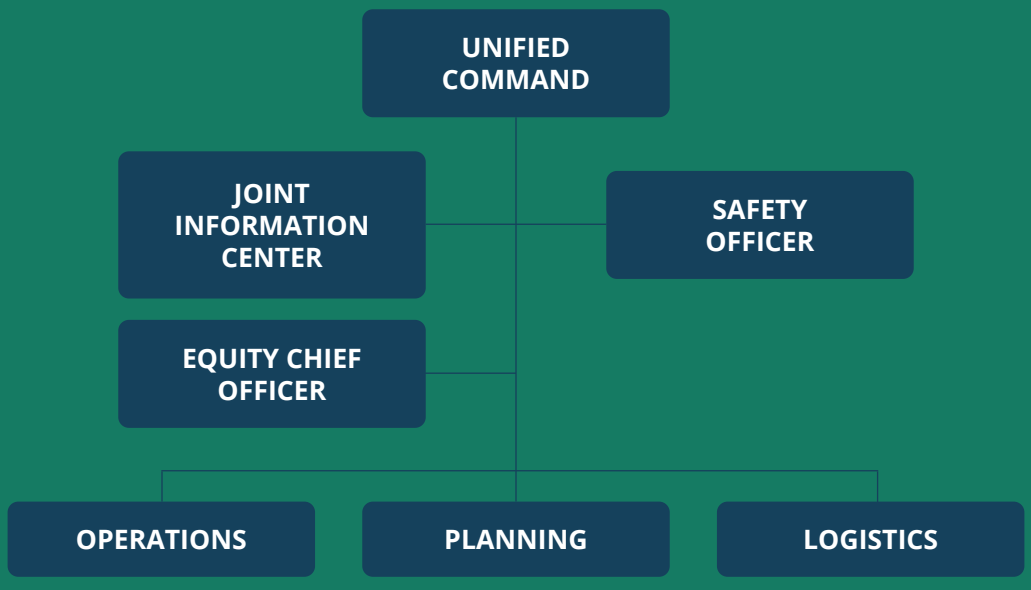
In the LHD Survey:

- Less than 1/3 of LHDs indicated that they always or often used an equity tool in decision-making during the response
- Local public health departments also identified a need for funding to support ongoing health equity efforts both during COVID-19 and beyond
  - » Of those LHDs that had funded equity staff, less than half (43%) were deployed to the EOC

Best Practices

A scan of jurisdictions that were successful in embedding equity into their COVID-19 response found that counties and cities with Equity Officers or dedicated equity staff teams who were actively deployed through the Incident Command Structure (ICS) and Emergency Operations Center (EOC) were best positioned to respond to the disproportionate impacts of the pandemic. These jurisdictions were also better able to collect, report, and track disaggregated demographic data that was initially missing from many public data dashboards.

INCIDENT COMMAND STRUCTURE EXAMPLE



SOURCE: Louisville Incident Command Structure

Best Practices

EMBEDDING AN EQUITY OFFICER IN THE ICS STRUCTURE

The City and County of San Francisco: Less than a week after the first national reports of stark disparities in COVID-19 hospitalizations and deaths among African Americans were released, San Francisco developed and published a map of COVID-19 impacts by ZIP code to help shape the City's response. This fast reaction was made possible by a host of structural and operational actions to embed equity into the City's crisis response framework. San Francisco's EOC began by including community, faith, and private sector organizations into its design and planning processes. The City integrated an Equity Officer position into the EOC structure and appointed the Equity Officer at full-time capacity for emergency response. It also activated a team of City staff to support the Equity Officer in implementing equitable response strategies.

The City of Long Beach: The City of Long Beach Office of Equity works on City-wide equity initiatives, focused on health equity and racial justice. Shortly after the first cases of Southern California COVID-19 cases emerged, the Office of Equity was activated, largely in response to City-wide language access needs. Prior to the COVID-19 response, equity was not officially embedded into the City's EOC structure. After identifying communities facing barriers to information, testing services, and essential protections, the Equity Officer was officially integrated into the EOC structure, reporting directly to the Incident Commander. In addition, the Equity Officer mobilized an equity unit within the EOC, a team of staff focused on responding to critical needs of the most impacted communities. Language Access staff were also deployed to the City's Joint Information Center (JIC) to provide equitable communications support.

INTEGRATING AN ACCESS AND FUNCTIONAL NEEDS COORDINATOR IN THE EOC

Marin County: In recognition of the specific needs of individuals living with access and functional needs (AFN) during an emergency,[2] **Marin County worked to integrate an Access and Functional Needs (AFN) Coordinator position** into the management section of the EOC. The AFN Coordinator works to evaluate planning and operations in the context of people living with disabilities and AFN. The AFN Coordinator also works to ensure that language and disability program access and physical accessibility issues are addressed at all levels of the emergency response.

"The pandemic moved faster than we did. We needed earlier identification of and response to COVID disparities" LHD respondent

2 Individuals living with AFN can include but is not limited to individuals with physical, developmental, mental health or intellectual disabilities, chronic conditions or injuries, older adults, and individuals experiencing homelessness.

"Establishing strong ties with partners helped spread the work that this pandemic needed to be taken seriously and allowed us to rapidly respond to and meet vulnerable communities in appropriate language and formats with our outreach work" LHD respondent

3. Community-based partnerships were critical in reaching those most impacted throughout the crisis; jurisdictions without strong partnerships in place were less able to respond equitably to the crisis.

The importance of community-based partnerships in meeting the needs of disproportionately impacted communities throughout the pandemic cannot be overstated. In nearly every interview conducted with LHDs, community-based partners and the partnership network were uplifted as critical to protecting the health of disproportionately impacted communities, especially Black, Latinx, Indigenous and Native Hawaiian and Pacific Islander, and other disproportionately impacted Asian/Asian American community members. Local public health departments also recognized that many of their partner organizations were going above and beyond the defined scopes of their missions to ensure the populations they serve were getting the assistance and access to resources they needed.

The level of partnership and coordination between LHDs and CBOs varies widely across the State. Some LHDs have built strong, authentic partnerships with their community partners, while others have struggled to build trust and support. Many LHDs worked to build new trusted partnerships in the midst of the pandemic. Local public health departments need sustained staff capacity to support these partnerships during COVID-19 and beyond.

In the LHD Survey:

- Less than half (43%) of LHDs indicated that they "often" engaged community groups/ members most vulnerable to COVID-19 in the decision-making process.

In the Community Survey:

- Nearly 30% of respondents said that LHDs could have done better by acting more quickly and timely to ensure they were responsive to pressing community needs.
- Nearly 60% of respondents either strongly agreed or agreed that the COVID-19 pandemic facilitated new partnerships with LHDs and other government entities that are beneficial to supporting the communities that CBOs serve.
- Over 3/5 (60%) of respondents shared that they are engaged, to some degree, in decision-making processes by their LHD.
- Over 4/5 (82%) of respondents said that preexisting partnerships with LHDs or other local government agencies were very helpful or somewhat helpful in supporting communities that CBOs served.

"The County does not have strong ties to many of the most vulnerable communities. It's part of the reason why they are the most at-risk and vulnerable" LHD respondent

"While existing relationships were not all of the relationships we eventually needed, we leveraged the existing to quickly identify and establish others" LHD respondent

"Partnerships with CBOs were essential to the effectiveness of our outreach program so far and supplemented deficits in culturally informed staffing and linguistic challenges for our department staff. Our outreach efforts were effective because of widespread buy-in from the community partners who work closely with vulnerable groups" LHD respondent

Best Practices

Many examples were shared in the interviews of LHDs partnering with and funding community-based organizations to reach members of their communities most disproportionately impacted by COVID-19. From partnerships with organizations offering services in multiple indigenous languages, to testing and vaccine partnerships with faith-based leaders, to outreach and communications with community health workers and promotores, LHDs demonstrated their ability to authentically partner with communities to reach those most in need of services. The below examples showcase LHDs engaging in robust collaborations:

- **Fresno County COVID-19 Equity Project:** The Fresno County COVID-19 Equity Project brought together multiple County coalitions, connecting the Fresno County Department of Public Health and community-based organizations (CBOs) around unique approaches designed to respond to, and recover from, the pandemic. The project included the Fresno County Department of Public Health, 22 CBOs, and the University of California San Francisco (UCSF) Fresno. The effort incorporated training and deploying community health workers/promotores with proficiency regarding 16 different languages and cultures, and distinct strategies developed for community members that have been most disproportionately impacted by the pandemic. The Fresno Equity Project brought together community partners from three different County coalitions (the Immigrant and Refugee Coalition, the African American Coalition, and the Disability Equity Project) to develop distinct strategies and approaches for the members of the communities they represent and/or serve.
- **Monterey County Coalition of Agriculture (MC-COA):** MC-COA was launched in Monterey County in response to the urgent need to protect the health and safety of the region's large farmworker population. The coalition included representatives and leadership support from the Monterey and Santa Cruz County Health Department staff and clinicians, University partners, Monterey Board Supervisors, key agricultural industry partners (including most major Monterey County grower organizations), and community-based organizations and medical providers that represent and/or serve the region's diverse farmworker population and their families. The coalition worked to address a variety of urgent and emerging issues impacting farmworkers and their families, including the need for increased personal protective equipment, workplace rights and safety, and increased coordination between healthcare providers at hospitals and clinics throughout the Salinas Valley.

Best Practices

- **Sacramento County COVID-19 Collaborative**: The Sacramento County COVID-19 Collaborative (The COLLAB) supports community members and business owners with up-to-date information, guidelines, and resources to stay informed and healthy. The collaborative includes trained Business Navigators and Resource Coordinators who worked in neighborhoods experiencing the worst impacts of COVID-19. The COLLAB is a community partnership supported by the Sacramento County Division of Public Health, The Center at Sierra Health Foundation, and multi-ethnic community-based organizations located in Sacramento County.
- **Sonoma County "On the Move":** Sonoma County Department of Health Services partnered with **On the Move**, a non-profit that works to mobilize emerging leaders to take action in pursuit of social equity. The partnership worked to develop and implement a multi-sectoral, large-scale outreach and education campaign in response to the disproportionate impact of COVID-19 on the County's Latinx and Indigenous communities. The initiative, deployed through On The Move's **"La Plaza: Nuestra Cultura Cura,"** brought together County leaders, partner organizations, and a robust network of community organizations to provide up to date information and guidance on COVID-19, as well as connections to critical health services and other resources.
- **Riverside County Coachella Valley Equity Collaborative**: : The Coachella Valley Equity Collaborative, a partnership with the Riverside County Public Health Department, was formed after the Desert Healthcare District and Foundation (a foundation committed to connecting Coachella Valley residents to health and wellness services and programs) received $1.2 million in CARES Act funds through Riverside County in 2020 to raise awareness and opportunities for testing communities most vulnerable to the COVID-19 pandemic. Those funds were awarded as grants to eight community-based and faith-based organizations that provided outreach to farmworkers and other residents who traditionally lack access to healthcare. The Equity Collaborative's efforts have been featured nationally for their work to reach disproportionately impacted farmworkers throughout the Eastern Coachella Valley in vaccine distribution and administration. The collaborative placed an emphasis on multilingual, community-based partners who work to reach community members through direct outreach at their worksites. The success of these efforts led to the successful vaccination of thousands of farmworkers throughout the Eastern Coachella Valley.
- **Santa Barbara County Latinx & Migrant COVID-19 Response Task Force:** The Santa Barbara County Latinx & Indigenous Migrant COVID-19 Response Task Force is a partnership effort between the **Santa Barbara County Public Health Department** and over 90 cross-sectoral county partners, including the University of California Santa Barbara and trusted community partners, the **Mixteco Indigena Community Organizing Project (MICOP)**, and the **Central Coast Alliance United for a Sustainable Economy (CAUSE)**. The task force launched in March 2020, near the start of the COVID-19 pandemic, in response to early data on emerging inequities by race and place, and worked to identify and address barriers experienced by disproportionately impacted communities throughout the crisis. The task force was formed using a language justice framework, and worked to develop key outreach and communications strategies that specifically accounted for the multiple indigenous languages spoken by residents throughout the county. Task force efforts have also focused on workplace and housing health and safety for farmworkers, specifically those living in **H-2A Housing**.

4. There have been inconsistent opportunities to fund community-based partners throughout the crisis; when funding has been available, internal governmental contracting/procurement processes created barriers to accessing funding for some community-based organizations.

Local public health departments have long recognized the critical need to work with community-based partners to provide critical services and support throughout the crisis. This has ranged from in-language, culturally informed outreach and education services, to supporting individuals with navigating the complicated medical and social services systems, to providing critical food, housing, and legal support. However, despite the recognition that community partners are vital for addressing the disproportionate impact of the pandemic on community members, there have been inconsistent opportunities for health departments to provide financial support to community partners. Both CARES Act and ELC funds have supported departments in funding community partners; however, LHDs expressed concerns related to identifying longer-term, ongoing sources of financial support. In addition, internal contracting and procurement processes created barriers for some community partners in applying for and receiving funding support through local jurisdictions, thus limiting their access to available community-based resources.

In the Community Survey:

- Nearly 3/4 of respondents (70%) have not entered into any contracts with LHDs or other local government agencies during the pandemic.
- Nearly half (48%) of respondents indicated that technical assistance (TA) around contracts and procurement would somewhat or strongly impact their ability to quickly apply for funding.

"We need to be thinking about how to provide support to CBOs on how to contract with government…but government also need to think about the process on their end. [Government] needs to be more flexible and work more cooperatively." LHD respondent

"Really small CBOs don't have the backbone support, financial and administrative, to apply for governmental grants…the requirements are so strict" LHD respondent

"We need to be able to provide capacity building so our community partners can apply for funding to support our departments in our COVID-19 efforts" LHD respondent

Best Practices

ENSURING FUNDS QUICKLY AND EFFICIENTLY REACH COMMUNITY PARTNERS

The Public Health Institute's **Together Towards Health Funder Pool** is a joint program with 18 California philanthropic organizations, supporting more than 180 community-based organizations (CBOs) statewide that serve as trusted experts for COVID-19 education, testing and vaccination access in their communities. This funding pool was stood up in response to the need for quick, easily deployable and flexible resources to support community-based partners doing the critical work to reach disproportionately impacted communities on the ground. The application process was streamlined to ensure minimal barriers for community organizations to apply for and receive funds, and funds were deployed to organizations quickly to support critical outreach, education and communications support. Funds were also often more flexible than established federal funding sources (e.g., Federal Emergency Management Agency (FEMA) reimbursement). In another example, Alameda County worked to rapidly deploy COVID-19 funding support for community-based partners and clinics, **fast-tracking the Request for Proposal (RFP) process**, and ensuring certaina CBOs were eligible to receive at least some amount of funding at the beginning of the implementation of services. This was crucial, as many CBOs were in desperate need of resources to respond to overwhelming community need.

LEVERAGING TRUSTED COMMUNITY PARTNERS TO STREAMLINE CRITICAL FUNDING NEEDS

For many LHDs, the governmental contracting and procurement process created nearly insurmountable obstacles for some community partners (especially those who had not previously received a government contract, or for smaller partners without sufficient staffing to support the application process). Many of these smaller or previously non-government funded community partners, were also critical partners for reaching disproportionately impacted members of the community. Some local jurisdictions worked with a trusted, community-based funding partner to streamline and simplify the funding application process for community partners, as well as provide needed technical assistance and capacity building support. In Los Angeles County, the LHD worked with a non-profit partner, **Community Partners**, to subcontract with 51 community-based organizations to conduct outreach, education, contact tracing and case investigation support in communities hardest hit by the pandemic. In Riverside County, funding support in the Eastern Coachella Valley was provided in partnership with the **Desert Healthcare District and Foundation.**

5. There have been ongoing challenges in creating culturally relevant and effective public health messaging for communities most impacted by the COVID-19 crisis.

The COVID-19 crisis has elevated the critical need to develop in-language outreach, education, and engagement materials. Many jurisdictions were accustomed to providing translation in threshold languages,[2] however, the crisis also elevated the need to provide language support for community members who might not speak a County or City's threshold language. In some jurisdictions, the need for multiple modes of communications became apparent as some community members most impacted by the crisis spoke primarily oral indigenous languages. In addition, community partners identified the need for community members most impacted by the crisis to play a key role in the development of outreach and education materials in order to ensure cultural relevance and understanding. For individuals living with disabilities, ensuring accessibility of information and communications was also elevated as a critical need (see the Center for Health Equity's Recommendations for Improving Accessibility for Individuals Living with Disabilities). Most LHDs did not have this type of holistic communications support available internally when the pandemic hit, making effective outreach and communications difficult, especially in the first few months of the crisis. Effective communications and outreach throughout this crisis have relied heavily on already established, trusted community partners.

Some LHDs also elevated the need for the State to consider specific regional needs/local context when developing outreach and communications materials for diverse communities throughout the state (specifically geographic considerations). This includes considerations for individuals with barriers to accessing technology and services, considerations for individuals who primarily speak an oral, not a written language, and considerations for individuals who may be hesitant to access government services more broadly.

> *"When it comes to being informed, being able to ask questions and communicate directly with public health leaders and officers, our Health Department has done a fantastic job on reaching our underserved communities throughout [the county]."*
> *Community-based partner respondent*

In the LHD Survey:

- Less than 40% of LHDs surveyed indicated that the department's outreach and communications materials were "always" or "often" developed and/or reviewed by community advisors.

In the Community Survey:

- The majority of community partners surveyed and interviewed uplifted consistent and open LHD communications and channels throughout the crisis as one of the top things that have gone well in terms of supporting impacted communities.
    - » More than 1/2 of respondents (52%) indicated that communications was the top thing that went well when working with LHDs, including providing critical information, notifications about surges, exposure notices, and LHDs' efforts to reach the greater public.

2 "Threshold Language" means a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

- However, there were also critical areas of need uplifted by community partners:
  - » 1/4 of respondents identified the need for LHDs to coordinate messaging in a quick, clear, unified, and consistent manner
  - » More than 1/3 of respondents identified insufficient multilingual and culturally informed information/outreach (37%) as a top communications challenge throughout the pandemic
  - » The top communications and/or outreach strategies identified for reaching disproportionately impacted communities were:
    - * LHDs hiring linguistically diverse staff from the communities they serve (95% listed as a top priority)
    - * LHDs hiring outreach workers from the neighborhoods/communities disproportionately impacted by COVID-19 (2/3) and;
    - * LHDs partnering with community-based organizations to conduct outreach and provide additional resources (2/3)

Best Practices

Many LHDs have responded to the need for culturally relevant, in-language outreach and communications support, by partnering with trusted community partners and messengers. Below are examples from across the state of strong, community-informed communications strategies:

The City and County of San Francisco's Outreach Toolkit for COVID-19 includes general communications and information in a variety of the County's threshold languages. The outreach strategy also includes two communications campaigns specifically aimed at reaching the County's Black and Latinx communities: **Together We Heal** and **UnidosCOVID19**. Both campaigns brought together trusted community partners and messengers to lead community-informed outreach and engagement.

Contra Costa County's robust **COVID-19 social media toolkit**, includes a variety of culturally informed and culturally relevant images and messages designed to reach those members of their community most disproportionately impacted by the crisis. Contra Costa County Health Services also launched a paid **Youth Ambassador Program**. The program compensated local youth to design and drive public health social media messages online.

In response to the COVID-19 crisis, the Los Angeles City/County Native American Indian Commission (LANAIC) formed the **LA Native COVID-19 Response Working Group (Working Group).** The Working Group consisted of leadership from Los Angeles County's American Indian and Alaska Native (AIAN) community-based organizations. The working group developed a specific AIAN communications campaign to ensure that the AIAN community was aware of and connected to response and relief efforts related to COVID-19.

The San Diego County **Together Against COVID** Campaign, led by the Multicultural Health Foundation in partnership with a robust group of stakeholders, was developed by and for Black San Diegans. The expert testimonials and educational materials provided were developed and delivered by trusted messengers in San Diego's Black community.

Santa Barbara County partnered with trusted community partners, Mixteco Indigena Community Organizing Project (MICOP), throughout the crisis, to create **in-language outreach and communications materials** designed to reach disproportionately impacted indigenous-language speaking residents.

6. There have been difficulties finding effective ways of reaching disproportionately impacted community members throughout the crisis.

From the interview findings, many LHDs identified the need to develop and implement multiple modes of outreach/communication in order to reach the communities most impacted by the COVID-19 pandemic. Local public health departments have relied on intra-governmental partnerships and robust, community partnership networks to reach their communities most in need of resources and support. Many LHDs also identified the lack of trust and consistent access to technology as barriers to reaching community members throughout the crisis. Finally, both LHDs and community members identified traditional forms of government outreach most commonly used throughout the response (e.g. Facebook, email, etc.) as insufficient for reaching those community members most at risk throughout the pandemic.

In the LHD Survey:

- The top communications challenges identified by over 50% of respondents was that the outlets for communication are not reaching the communities that they represent and/or serve (52%).

In the Community Survey:

- Nearly 30% of respondents said that LHDs could have done better by acting more quickly and timely to ensure that they were responsive to pressing community needs.

Best Practices

Many LHDs, including in **Ventura County** and **Kern County**, leveraged their county's "Reverse 911" systems to send urgent communications related to the pandemic to their community members most vulnerable to the crisis. Partnerships with **211** in counties throughout the state have supported residents with connections to vital resources and medical and mental health supports throughout the crisis.

Many LHDs deployed Promotor(a) or Community Health Worker models to reach members of their communities most vulnerable to the health and economic impacts of the crisis. In San Diego County, the LHD partnered with **Vista Community Clinic** to provide outreach, education, and mobile testing for rural, migrant, and farmworker communities in San Diego County. Their Promotores, or community health workers, worked with County workers to do health education around COVID-19 testing and administer tests through mobile units. Solano County supported a Promotor(a)/Community Health Worker Program to provide culturally-responsive outreach and health education to connect disproportionately impacted communities to resources, tools, and knowledge to prevent the spread of COVID-19, increase engagement with testing, and decrease testing disparities. Many LHDs identified conducting on-the-ground community-based outreach with community-based partners, as being vital to the success of their outreach and engagement efforts.

In Ventura County and Orange County, local community-based radio stations, **Radio Indigena** and **Radio Santa Ana**, are vital resources for many Latinx and Indigenous community members in those communities. These local radio stations provide education in-language and have worked to address issues relevant to local community members throughout the crisis. Both entities have worked to share vital public health communications and resources from their LHDs with their local listeners.

RECOMMENDATIONS

Support the creation of a robust, structurally funded equity team within each local public health department

Local public health departments need dedicated, structurally funded staff committed to building internal and external capacity to advance health and racial equity. A robust equity team can support health departments and broader jurisdictions in advancing equity across all department policies, programs, and practices. Local health departments need funding support to be prioritized at the local level, through annual budgeting processes, with additional support provided by the State (when needed and as available). While many LHDs are utilizing short-term COVID-19 response funding to enhance internal capacity to advance equity, given the time bound nature of that funding, ongoing support at the local and state level will be critical in ensuring institutional capacity to advance health and race equity. Enhancing internal capacity to advance equity before an emergency, will support staff in responding equitably to future public health and climate emergencies.

While there are no universally accepted staffing ratios and/or structures when it comes to enhancing LHD capacity to advance health equity, there is a recognition that dedicated equity staff are critical to operationalizing equity in everyday health department work, as well as the development of resources and trainings to support LHDs in integrating health equity into programs, policies and plans. The 2018 Human Impact Partners Report, "Advancing Health Equity in Public Health Practice: Recommendations for the Public Health Accreditation Board," recommends that LHDs have a "clear "backbone" mechanism or structures for integrating health equity across departments and programs, and that specifically, those mechanisms have the authority and capacity to work across the whole department (e.g. Chief Health Equity Strategist, a Health Equity Coordinator, Health Equity Manager/Officer, etc.). Local public health departments have also recognized that the work of advancing equity cannot just fall to one individual, and that the most effective equity work is often done in a collaborative environment. The Center for Disease Control and Prevention (CDC) in their "Practitioner's Guide for Advancing Health Equity," also elevates the need for organizations to establish an institutional commitment to advancing health equity through the establishment of permanent structures, such as cross-departmental equity workgroups and staffing positions.

Build and activate community partnerships for robust equity solutions

Jurisdictions who were able to leverage existing and authentic partnerships with community-based organizations (CBOs), other non-profits, and trusted community thought leaders, were better able to develop and implement equitable response solutions. For jurisdictions without these types of partnerships already in place, operationalizing equity proved more difficult. It is imperative that LHDs work to build strong, authentic partnerships with the communities they serve before an emergency occurs. It is important that these partnerships also include intentional consideration for community partners LHDs have not traditionally engaged with in the past.

During an emergency, strong partnerships can be leveraged throughout the response structure. This can include institutionalizing community advisory groups into the emergency management structure, incorporating community-based leaders from disproportionately impacted communities into decision-making processes, and planning to provide compensation for community time and resources. Community partnership agreements are strong models for activating just partnerships during an emergency.

A best practice for valuing the time and knowledge of community organizations that serve populations most impacted by inequities is for jurisdictions to provide compensation to community organizations and residents for participation in emergency planning and response activities. Jurisdictions can also work to establish Community Advisory Groups, which are important venues for two-way communications between government and community entities that help create opportunities to identify concerns and provide timely feedback on recent activities and proposed actions. These bodies can be also be critical to help prevent, interrupt, and respond to misinformation or stigma. They can also allow for the creation of joint community-government strategies and initiatives.

Embed equity into emergency response structures and processes

The Public Health Alliance, in partnership with the Bay Area Regional Health Inequities Initiative, produced a brief that outlines priority strategies and recommendations for local health departments to embed equity into emergency operations. Key recommendations in this brief include:

- **The need to create a core equity unit with dedicated equity staff roles in the EOC/ DOC**

  This includes the need to designate an equity staff lead in the core command group of the EOC, preferably an Equity Officer. Other "equity staff" (either formal or informal) should be embedded throughout the EOC/DOC to support work that advances equity during the response. This can also include integration of an Access and Functional Needs (AFN)Coordinator in the EOC. It is important that staff work to incorporate and utilize a health or racial equity tool in all planning, response, and recovery related processes.

- **Provide equity training and capacity-building before and after emergency response activation**

  It is important that staff involved in emergency response receive training in core equity principles. This also includes cross-jurisdictional training for other staff involved in emergency management and response. Staff training can include training in the use of an equity tool or lens in decision-making, along with strategies for creating authentic, trusted community-based partnerships.

- **Incorporate equity into standard and ongoing emergency response planning and processes**

  It is important that equity considerations and training be incorporated into standard and ongoing emergency management processes.

It is also important that equity staff who are integrated into emergency response structures have ongoing equity-based training and preparedness opportunities. In addition, local jurisdictions can work to establish a Community Organization Active in Disaster (COAD) or Voluntary Organizations Active in Disaster (VOAD) group before an emergency strikes to ensure that culturally-responsive strategies, resources, and decision-making structures are in place, and use the COAD or VOAD to inform local equity response strategies, during a disaster.

Incorporate an equity metric into all emergency response and recovery processes

Many LHDs identified the State of California's Health Equity Metric as a helpful tool for supporting their work to advance equity during the COVID-19 response. The metric provided departments with the data needed to justify prioritizing the most disproportionately impacted communities throughout their jurisdictions. Many departments also felt the metric supported their ongoing work to prioritize communities most impacted by inequities in resource and investment allocations. The development of the State's health equity metric supported a more consistent approach to prioritizing disproportionately impacted communities in resource allocation and decision-making.

Low-income communities and communities of color are consistently disproportionately impacted during public health or climate change-related emergencies. For that reason, it is important for the State and LHDs to incorporate health equity metrics into all planning, response, and recovery decision-making processes. The success of the health equity metric for resource and investment prioritization during COVID-19 also reinforces the need to explicitly incorporate an equity tool (e.g., a health equity metric) into ongoing health department and broader jurisdictional operations both during emergency response and beyond.

Fund community-based partners to conduct culturally informed outreach and engagement

Local public health departments worked throughout the pandemic to identify community-based partners with long-standing, trusted relationships in communities most impacted by inequities. Local public health departments also worked to provide funding to support culturally relevant and community-informed outreach and education. It is important that LHDs and broader jurisdictions work to institutionalize the equitable processes and practices developed in response to COVID-19 in order to sustain ongoing, authentic community partnerships and engagement strategies. Community partnership agreements can also solidify these relationships for future emergencies.

During the pandemic, many LHDs also elevated the need to identify and work to address barriers to their contracting and procurement processes, specifically for small community-based organizations. Departments can work to provide technical assistance and capacity-building support to strengthen the network of community-based organizations throughout their jurisdiction. In addition, departments can work to address barriers to contracting and procurement for community-based organizations and businesses most impacted by inequities. The Government Alliance for Race and Equity (GARE) has a guide for local government to advance equity in contracting and procurement that local jurisdictions can utilize to address internal barriers to advancing equity in contracting and procurement.

Prioritize hiring community members from disproportionately impacted communities

As part of their efforts to institutionalize equitable practices and approaches, many LHDs recognized the need to work with and hire community members most impacted by inequities both during COVID-19 and beyond. For many LHDs, the COVID-19 crisis elevated the internal barriers that limit the

ability of departments to hire some members of the community for many departmental opportunities. These barriers often include language requirements, traditional educational requirements that prioritize formal education over lived experience, criminal background restrictions, testing requirements, and even requirements related to the need to obtain driver's licenses. Many LHDs are working to identify and address these barriers to hiring. It is important that developing low-barrier hiring processes that are responsive to community needs remain an ongoing and long-term priority for LHDs.

Many community partners also identified the need for funding to support their own capacity to provide services in partnership with LHDs. Community partners identified the desire to retain qualified staff that can provide critical services (in language outreach, engagement, and other activities), and the need for funding assistance from LHDs to support these services, both during COVID-19 and beyond. Strengthening both internal departmental capacity and community partner capacity to provide services to communities most impacted by inequities, will strengthen the ability of departments to respond to this and future public health and climate change-related emergencies.

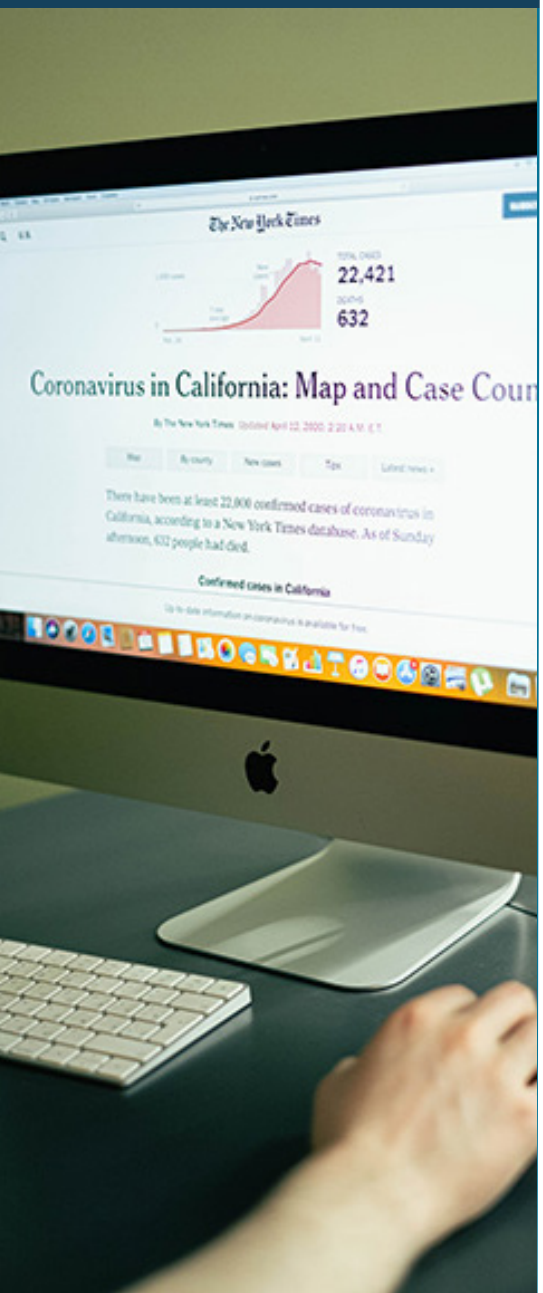
Integrate equity into all recovery planning and implementation processes

In addition to managing the pandemic through vaccine distribution and other measures, local jurisdictions must also identify strategies and approaches for longer-term recovery. Emerging from this crisis a more just and equitable state will require integrating equity into all local and statewide recovery planning and implementation processes. In addition to involving key equity staff involved in the emergency response in recovery planning, community partners representing or serving groups most impacted by inequities must also be central to local and statewide decision-making. It is important these community partners play a leadership role in the development and approval of recovery-related decisions.

It is important that recovery planning also considers the development of specific equity metrics (similar to the health equity and vaccine equity metrics developed during the COVID-19 response), to ensure equity is prioritized, and jurisdictions are prioritizing disproportionately impacted communities throughout the recovery process. It is also important that jurisdictions consider actively advocating for key policy priorities (local, state, and federal) essential to both short- and long-term just recovery strategies. Policy priorities central to a just recovery should be community-informed and work to strengthen both individual and community health and well-being (for more on advancing community-informed policy priorities, see our chapter on "Advance Health Equity & Strengthen Resilience Through Ongoing Community-Informed Policy and Practice Changes").

4

Catalyze Transformative Shifts in Utilizing Data



RECOMMENDATIONS

- Support Development of a Modern Public Health Data Infrastructure
- Integrate Local Public Health Department Stakeholders in State Governance of Data for Policies, Practices, and Metrics
- Institute “Health Equity Metrics” Across State and Local Government Operations and Investments
- Expand and Improve Collection of Demographic Data
- Standardize Data Practices Statewide, in Collaboration with Local Public Health Departments, to More Effectively Track Disparities
- Support Comprehensive and Transparent Public Reporting of Impact Data
- Develop a Unified, Bidirectional Statewide (HIE) with Interoperability between State and Local Public Health Departments, and Healthcare and Hospital Systems

OVERVIEW

Over the last year, several data challenges have affected the ability of the State and local public health departments to track and respond to the equity impacts of the COVID-19 pandemic.

Without data – collected, analyzed, and publicly reported in close partnership with local public health departments – it is impossible to track the equity impacts of COVID-19. To assess these impacts, data must be collected that reflect key demographic characteristics linked to health inequities, including race/ethnicity, gender, and sexual orientation. It is important to identify population-specific challenges, and design data collection and reporting accordingly. For example, race/ethnicity data are frequently missing, and when not missing, misclassification is a persistent issue. Without processes to address these problems and others like it, impacts to specific groups may not be captured accurately.

Some impacts are tied to community factors, such as household income, housing crowding, and transportation access, in addition to or instead of demographic ones. It is equally important to collect and report data at the smallest possible geography, while adhering to reasonable standards of privacy. A balance must be struck between actionable data and the risk of individual identification.

To establish and keep the public trust, alignment of State and local data reporting is necessary. A State commitment to transparency and collaboration in the development of data collection, analysis, and reporting processes, as well as in the creation of tracking metrics tied to direct impacts (including funding and other resources) on jurisdictions are crucial to this end. This commitment could take the form of policies mandating the collection of key demographic measures, creation of formalized processes for developing metrics that include input from local public health departments, and timely, complete publishing of methodologies used to track health outcomes or calculate metrics.

The recommendations in this chapter describe improvements to existing data practices, towards development of systems that capture health inequities and prioritize the response to the most affected communities.

CHALLENGES

1. Missing, incomplete, or inaccurate demographic data – particularly by race/ethnicity, alone or as a stratification variable for other outcomes – impede monitoring and addressing equity impacts
2. Outdated and inflexible data systems paired with a lack of data standards failed to meet demands of COVID-19 response
3. Missing or incomplete methodology provided for State reopening and reporting metrics
4. Communicating data to communities

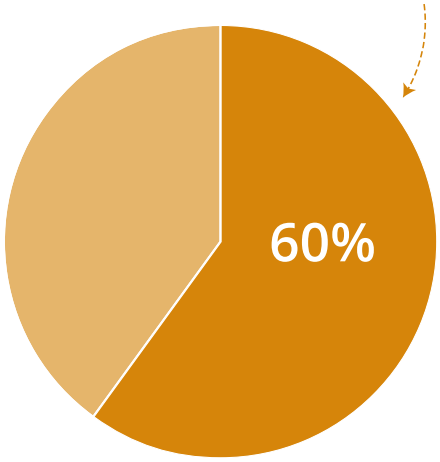
1. Missing, incomplete, or inaccurate demographic data – particularly by race/ethnicity, alone or as a stratification variable for other outcomes – impede monitoring and addressing equity impacts

There have been ongoing issues of missing data, specifically related to demographic characteristics, and particularly from testing, lab reports, and point-of-care. State and local public health departments have internalized these reporting issues, when it is in fact a result of incomplete collection or pass-through of data from labs, clinics, and other healthcare providers. Put simply by one respondent to the LHD Data Survey (December 2020), "race/ethnicity and SOGI [sexual orientation and gender identity] are a challenge to collect." Even with State collection mandates, LHD staff during one California Conference of Local Public Health Data Managers and Epidemiologists (CCLHDME) meeting reported that providers commonly input "other" or "unknown" for race and/or ethnicity:

"As long as healthcare can report 'unknown race/unknown ethnicity' we won't get good data – and can't track if vaccinations are being equitably distributed." LHD respondent

In September 2020, during a California Association of Communicable Disease Controllers (CACDC) meeting, one jurisdiction reported that the "unknown" and "other" categories selected for race comprised nearly 60% of their reports.

MORE THAN HALF OF PROVIDER REPORTS SELECTED "UNKNOWN" OR "OTHER" FOR RACE/ETHNICITY



During periods of surging COVID-19 infections, respondents to the LHD Data Survey noted that the "unprecedent volume of cases and lab results" contributes to challenges in data collection – and "reaching enough cases to collect race/ethnicity is especially challenging in regards to health equity." One jurisdiction wrote that this is "frustrating… as [staff] attempt to prepare a comprehensive report on disparities suffered in some zip codes."

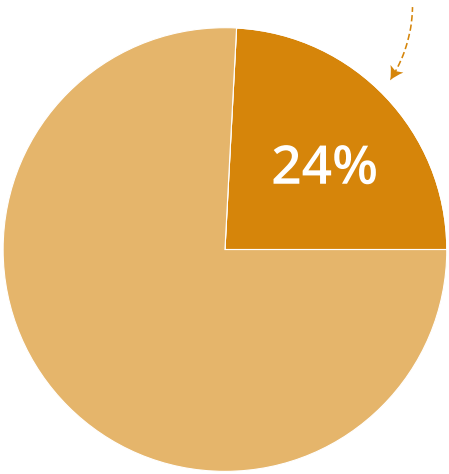
Missing data only represents the most visible challenge. Race and/or ethnicity misclassification, telegraphed through the preponderance of the "other" category in demographic tracking, makes accurately capturing inequities in COVID-19 metrics difficult, if not impossible. Smaller communities, such as Native Hawaiians and other Pacific Islanders (NHPI), and American Indians and Alaska Natives (AI/AN), are particularly impacted either in their undercounting (when they are systematically misclassified into other groups) or in potential exaggeration (when non-NHPI or AI/AN individuals are classified as such) of disparities. In either case, bias from those inputting data interferes with being able to accurately measure the impacts on these communities.

Over the course of the pandemic, and based on ongoing monitoring of publicly reported COVID-19 data by the Public Health Alliance, many jurisdictions have experienced this issue. In a late May 2020 CCLHDME meeting, LHD epidemiologists openly discussed the specific impacts in their jurisdiction. Many noted that there have been differences between what appears in the State's reportable disease surveillance system for race/ethnicity compared to what is reported on death certificates. Because vetting of data on death certificates is more thorough than vetting of the data collected of cases, it is surmised that data on cases may be most affected by this bias compared to data on deaths. There have been periodic re-classifications of NHPI, Other, and AI/AN cases and deaths on local public health department data dashboards; but it is unclear how reconciliation of data discrepancies is occurring, whether in a systematic way or a piecemeal fashion. One Bay Area county reported that they resorted to calling people to clarify. This solution may work when case/death rates are low, but impossible during surges without significant increases in LHD staff capacity.

Underlining the challenges faced by AI/AN communities, the Urban Indian Health Institute published a report card assessing the quality of each state's COVID-19 reporting. Citing a surfeit of incomplete or missing race/ethnicity data, California was awarded a "C" grade for AI/AN data collection overall. The pandemic response showed that current data collection practices were insufficient in meeting the needs of California's diverse communities.

Beyond race/ethnicity, jurisdictions do not have the capacity, staff, or data to accurately or thoroughly track equity impacts along other dimensions, including place-based factors. Just under one-quarter of local public health departments responding in the LHD Data Survey (24%, n = 17), tracked indirect COVID-19 impacts, such as job losses or housing or food insecurity in their vulnerable communities. When asked what data would be helpful for their COVID-19 response among these communities, LHDs listed a broad array of factors including income, access to care, medical mistrust, employment, housing insecurity, and household size, along with more accurate population denominators. At the level of local public health departments, the will to more inclusively track equity impacts is there, but the data and capacity are not.

JUST UNDER ONE-QUARTER OF LOCAL HEALTH DEPARTMENTS TRACKED INDIRECT COVID-19 IMPACTS



Best Practices

Both the State and local public health departments have taken action to address aspects of the challenges outlined above. While much work remains to be done, it is important that the practices listed here are uplifted; improving data collection practices is critical to supporting communities and identifying health inequities.

At the state level, **California took regulatory action** in July 2020 to mandate the collection of race/ethnicity and sexual orientation and gender identity data. Action at this level has the ability to create wide-reaching impacts, but it must be implemented thoughtfully. While collection of these data is now mandated, it does not prevent data reporters from entering "unknown" or "other" in any required field. Systematic, institutional change is necessary to truly improve data collection across the board.

This can start with outreach to communities. **A report on race/ethnicity disparities in COVID-19 outcomes** spurred the Los Angeles Department of Public Health to create an Asian & Pacific Islander Task Force. One focus of this Task Force is improvement of disaggregated data collection and reporting among the Asian American, Native Hawaiian, and Pacific Islander communities in Southern California.

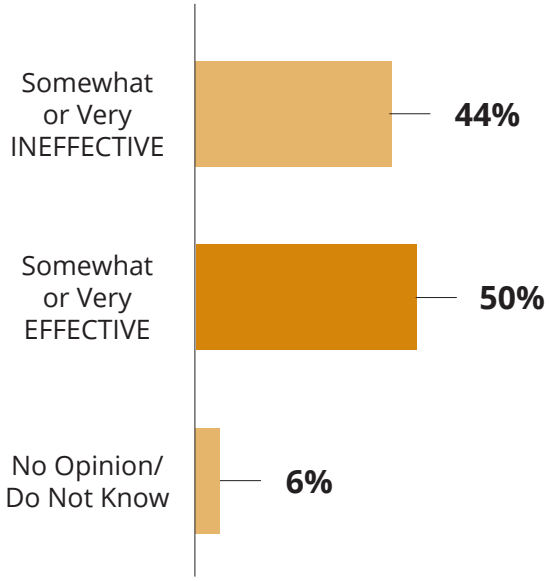
In August 2020, the Urban Indian Health Institute similarly published a detailed set of **best practices for American Indian and Alaska Native data collection**. In addition to a collection mandate, they include linking data sets to correct misclassification, ensuring data collection instruments allow for the selection of multiple races, and disaggregating data wherever possible when reporting.

2. Outdated and inflexible data systems paired with a lack of data standards failed to meet demands of COVID-19 response

When surveyed about the condition of their data systems (in place prior to, and at the beginning of, the COVID-19 pandemic), nearly half (44%) of local public health department leadership rated their data systems as "somewhat" or "very" ineffective. Respondents identified collection of demographic data, hospital data, and case reporting, investigation, and management as the top challenges presented by the existing data infrastructure. Collection of lab data and production/reporting of State-required metrics were identified by respondents as lesser but still impactful issues.

As COVID-19 cases surged, limitations of the existing data infrastructure impeded the response of LHDs, including a reliance on faxed and paper records and insufficient data standards that limited efficient, timely, and complete data exchange between healthcare providers, the State, and local systems.

HOW EFFECTIVE HAVE YOUR EXISTING (IN PLACE PRE-COVID) DATA SYSTEMS/ SURVEILLANCE BEEN IN SUPPORTING COMMUNITIES MOST VULNERABLE TO THE IMPACTS OF COVID-19 THROUGHOUT YOUR RESPONSE?



The California Reportable Disease Information Exchange (CalREDIE) is a tool provided by the State to local public health jurisdictions for electronic disease reporting and surveillance. Launched in early 2010, all California counties, with the exception of San Diego and Los Angeles, use CalREDIE as an integral component of their communicable disease programs. Per the California Department of Public Health, the vision of CalREDIE is to "improve the efficiency of surveillance activities and the early detection of public health events through the collection of more complete and timely surveillance information… It maximizes prevention efforts by allowing public health information from physicians and laboratories to be tracked and analyzed by the Division of Communicable Disease Control (DCDC) and LHDs."

As shared by our survey respondents, CalREDIE fell short of this vision during the COVID-19 pandemic:

"CalREDIE… make[s] managing high volumes of data near impossible, because steps require so much human input. When comparing to an EHR [electronic health record], things that should be simple are just not developed… A simpler and more systematic workflow is needed to streamline and allow for voluminous data flow."
LHD respondent

Among several issues identified by the LHD survey respondents, two have significant equity implications and are highlighted here.

The first is limited functionality to add new fields, which would allow LHDs to rapidly collect information on emerging risk groups, populations, occupations, and more. For example, early in the response there was no easy way to identify incarcerated, skilled nursing facility, or other congregate setting cases. Jurisdictions were required to manually track variables of this type. After LHDs shared this concern to the State, CalREDIE was updated to support the addition of user-defined fields to the person under investigation tab to capture these data.

The second concerns the built-in geocoder (a tool used to convert addresses to points on a map). Geocoded case data is an invaluable tool for LHDs to identify geographic "hot spots," and track the spatial spread of a disease. CalREDIE's geocoding function, per local public health department experience, has limited functionality. Small LHDs may not have the capacity or expertise required to manually geocode and map case addresses, which could lead to missed clusters of disease, hamper outbreak investigation, and make it difficult to identify the most impacted communities.

Because CalREDIE was "cumbersome and slow" (per one respondent to the LHD Data Survey) when faced with the demands of pandemic reporting, the State stood up an auxiliary system –CalConnect– over summer 2020 to support case investigation and contact tracing. CalConnect interfaces with CalREDIE, and is designed to seamlessly transfer data between the two systems. LHD staff responding to the LHD Data Survey found CalConnect did not meet expectations, at least initially:

- "Case data management is a challenge especially with cases being locked in CalConnect."
- "We struggle with functionality of CalConnect for us and our staff."
- "CalConnect is so complex that the data is poor because it is so easy for staff to miss entering info especially in re: exposure events and linking cases to exposure events, and referral for resources."

The issues with CalREDIE and CalConnect highlight a broader challenge related to State and local public health data systems: they are not setup to communicate with each other or with key healthcare and lab partners. Ideally, providers, labs, and LHDs could share data electronically, seamlessly, and instantaneously between themselves and the State. In practice, it is much different.

State and local public health department data systems were not designed, at the outset, to handle the volume of data generated by, and reporting required in, response to the pandemic. During one LHD interview, staff noted a fundamental mismatch in data systems: as the pandemic ramped up, some partners were still recording data on paper. Based on an interview with a health plan in Southern California, LHDs were not prepared to effectively share data outside of their internal systems, and said it was easier for them to get data directly from testing companies, like LabCorp and Quest. One county echoed this from the perspective of the local public health department during an October CACDC meeting, noting that "providers are to the point where they can export a lot of info from their EHRs, but LHDs have no way to get it into CalREDIE in a timely way." In this same discussion, it became evident that CalREDIE lacks an automated import or bulk upload function for clinical partners, and many jurisdictions do not have the capacity to support manual data entry. This results in delayed communication between LHDs, the State, healthcare providers, labs, and, ultimately, COVID-19 cases and contacts.

Overall, inefficiencies within five primary data sharing pathways were identified:

1. PROVIDERS (HOSPITALS, LABS, CLINICS) → LHDS VIA PAPER OR FAX REPORTING

This requires manual input by LHD staff – already limited in capacity - into CalConnect or CalREDIE.

2. PROVIDERS → LHDS VIA ELECTRONIC REPORTS

CalREDIE's Provider Portal and confidential morbidity reports (CMRs) allow providers to directly submit to CalREDIE. While these streamline provider reporting, LHDs have noted that providers frequently submit incomplete reports, requiring staff to follow-up –if they are used at all. According to one respondent to the LHD Data Survey, "many providers are not reporting via CMR and/or CMRs are barely filled in."

Outside of CMRs and the Provider Portal, electronic spreadsheets are another mode used by outside entities to transmit data to health departments. In early August 2020, CDPH required labs to submit spreadsheets directly to LHDs with COVID-19 test results,. This process change came without enough details for LHDs to efficiently operationalize this reporting shift, as discussed in an August post on the CCLHDME forum. Functionally, electronic spreadsheets and faxed or paper records are much the same to LHDs: they require manual input into CalREDIE.

"The hospital data from hospitals is often messy or doesn't make sense. it would be great to know the age make-up of each of our COVID hospitalizations for modeling purposes. But, this data is either missing or doesn't add-up."
LHD respondent

3. MULTIJURISDICTIONAL HOSPITALS AND HOSPITAL SYSTEMS → LHDS VIA MULTIPLE SYSTEMS

Entities that work across jurisdictional boundaries are required to submit reportable conditions (e.g., COVID-19 outcomes) to all local public health departments in the jurisdictions they serve. With limited coordination, each LHD sets its own preferred format for, and method of receiving, reports. As a result, hospital systems can be required to produce multiple versions of the same report and transmit them in multiple ways, including via fax, secure email, or secure file transfer protocol (SFTP). This places a burden on the reporting hospitals that can result in poor quality data.

4. LHDS → CDPH VIA PAPER REPORTS

Case investigation (CI) and contact tracing (CT), particularly in smaller jurisdictions, is sometimes done on paper. A jurisdiction responding to the LHD Data Survey reported that "CI/CT is easier done over the phone with paper forms, but that makes State required reporting very time consuming when resources are stretched thin." Paper forms must be input into CalREDIE (or CalConnect, then synced with CalREDIE) by LHD staff, essentially a duplication of work when capacity is already extremely limited.

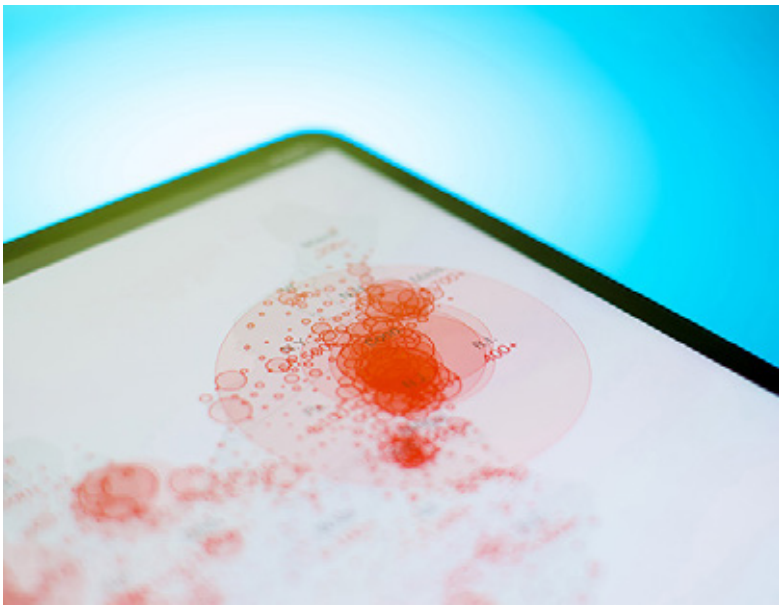
5. LHDS → CDPH VIA ELECTRONIC REPORTS

Electronic CI/CT reports, taken through CalConnect, must still be input into CalREDIE. This is done via an automated process that synchronizes data between CalConnect and CalREDIE. LHDs raised numerous issues with this synchronization system when it launched:

- Not syncing frequently enough for volume of cases (only once or twice per day)
  - » Some jurisdictions resorted to manually entering data in CalConnect and CalREDIE instead of programmatically pushing it back and forth; meaning staff had to enter case and contact data twice.
- Date of death field was frequently cleared
- CalConnect overwrote CalREDIE data, leading to loss of data

An important factor contributing to many of these inefficiencies is that health systems – in contrast to State and local public health departments - received a decade of Meaningful Use incentive payments to modernize their data systems and promote widespread adoption of electronic health records. Lacking the resources to regularly update and upgrade their own systems, it was inevitable that State and local public health departments would fall behind.

Functional data systems are the cornerstone of an effective public health response. They are integral to rapidly identifying impacted communities and responding to their needs. Delays or barriers to data sharing, as described here, can exacerbate, or even miss, serious inequities in health outcomes. Nevertheless, improvements within the pathways outlined above have come piecemeal over the course of the pandemic response – driven largely by emergency infusions of funds from the federal government - but many challenges remain.



Best Practices

Ideally, data are 1) accurately captured at the point of origin once and, 2) successfully passed through to other data systems via standardized protocols. In this case, patient self-identification (for demographic measures), or clinical diagnoses in primary care settings recorded in practice management systems/electronic medical record and sent via secure electronic protocols (e.g., HL7) to other care providers (laboratories) and public health agencies. As revealed by the pandemic and evidenced above, data collection and sharing fell short of these ideals. However, some successful enhancements were made during the pandemic that should be considered in response to future public health emergencies.

When the existing CI/CT infrastructure and reporting pipeline proved insufficient, the **State stood up the CalConnect system** for LHDs. Despite challenges in implementation, detailed above, for many jurisdictions it standardized and streamlined the CI/CT process.

The State also recognized that CalREDIE overall – as a communicable disease reporting system and database – was outdated and lacked many features expected of a modern tool (e.g., bulk uploads, field customization, interoperability). Engaging a contractor (Deloitte), the State sought extensive input from LHDs on data workflows, needs, and challenges through a series of interviews and focus groups. These were used to inform a "CalREDIE 2.0" landscape analysis, capturing the needs of its primary users.

Further, regularly surveying LHDs and developing tools and resources to support local response, like **CDPH's LHD Contact Tracing Program Readiness Survey**, can help identify immediate needs and complement long-term planning.

Among local public health departments, the burden of reporting twice —once to the State, and once to the public— was eased markedly by developing public-facing data dashboards that pull directly from internal tracking tools. One respondent in our LHD Data Survey noted that:

"Connecting our public-facing databases to CalREDIE/CalCONNECT fields makes it easy to maintain. The underlying data is still poor, but there is not a lot of maintenance required." *LHD respondent*

3. Missing or incomplete methodology provided for State-required COVID-19 surveillance and reopening metrics

A keystone component of any disease surveillance system is clear, consistent case definitions. All reporting parties must agree on what constitutes a "confirmed" or "probable" case or death; without this agreement, they are not counting the same thing. This can have significant repercussions in identifying and responding to disparities in COVID-19 outcomes.

Throughout 2020, local public health departments repeatedly voiced concerns about these core measures on CCLHDME and CCLHO calls, and the impact on their workload. LHDs frequently reported that case and death totals did not match those reported by the State. As late as December 2020, there was still no universal agreement on assignment of confirmed and probable deaths based on location of COVID-19 on the death certificate; one attendee of the CCLHDME call where this was discussed stated that "death certificates are going to be the indelible dataset… We really need CDPH to stand up and set a standard for how to count these deaths." Further, no guidance was provided on counting deaths re-allocated from one jurisdiction to another (such as when the decedent is a nursing home resident in county A but their permanent address is in county B). Per a LHD epidemiologist on a CCLHDME call, "I would rather have clear guidelines from the State on this, than to say it is up

to the LHJ." During another October 2020 CACDC call, a jurisdiction shared that: "We're looking to CDPH to tell us how we should report, not the other way around."

Without clear definitions, and precise, reproducible methodology, this created an incredible workload burden for LHDs. Jurisdictions regularly had to troubleshoot mismatched reporting between State and local measures, including "back-engineering" the data. Worse, this troubleshooting often occurred in a vacuum: each LHD had to discover and fix the same problems, independently. One LHD epidemiologist on the CCLHDME message board put it succinctly:

> *"The reconciliation of local data vs CDPH counts has caused so much extra work for our epi[demiology] staff this summer, additionally the data discrepancies have added to more negative press for our PHD/ Epi team." LHD respondent*

Time spent reconciling different data sets is time LHDs did not have to respond to equity concerns, with real impacts on public perception of State and local public health departments.

An illustrative example, from the fall of 2020, concerns reporting of results from SARS-CoV-2 antigen tests. Antigen tests, compared to the "gold-standard" real-time reverse transcription polymerase chain reaction (RT-PCR, or simply PCR) tests, offer an inexpensive, rapid method of COVID-19 testing. Many workplaces and congregate settings requiring repeated COVID-19 tests find antigen tests an appealing alternative to PCR testing for these reasons. However, antigen tests are "generally less sensitive" than PCR tests in detecting SARS-CoV-2, and require careful interpretation to recognize false negative or false positive results. With increasing usage of antigen tests, how the results from these tests are reported (or not) varied dramatically from jurisdiction to jurisdiction, per an October CACDC call:

- One county in Southern California counts them as "confirmed" cases, but separates them out when reporting to the State
- Several others record and report them as "probable" cases
- At least one county is not differentiating between antigen and PCR tests, and reporting all as confirmed
- Many others not yet publicly reporting, but know they will need to start reporting soon

One LHD on the CACDC call noted that they have de-emphasized antigen/probable test reporting because they want to be consistent with what is reported by the State, and that "it would be nice if we had some consistency across counties, and from county to state." Another shared concerns about an eventual public rollout of antigen test reporting, saying they "don't want it be a 'big reveal' to the public… hope there is a thoughtful rollout... including workload & PH communications."

Without consistency in reporting, it has been difficult for local public health departments to maintain trust in the public view. This trust is paramount to effectively tracking and responding to health disparities: without cooperation from impacted communities, it can be challenging to affect change.

In late August 2020, the State released its Blueprint for a Safer Economy (Blueprint) framework. The Blueprint framework includes a series of COVID-19 metrics that dictated the ability of each county to re-open portions of their economy. Because of its impact on businesses and subsequent high profile, Blueprint metrics were subject to additional public scrutiny, leading to further challenges for local public health departments. Of note: missing or incomplete

methodology limiting the ability to replicate State metrics locally, and insufficient engagement of LHDs in the metric development process.

The former has been an ongoing topic of discussion on CCLHDME and CACDC calls since the launch of the Blueprint. Many LHDs found that they could not reliably reproduce Blueprint metrics. According to reports shared on these calls, requests made by LHDs for the State to release detailed methodology, statistical code, or important source data (such as line lists of cases/incident IDs included in the case rate) frequently went unanswered. One jurisdiction, on a September CACDC call, noted that "we are struggling to respond to our PH officers and county boards" due to discrepancies in State and local calculation of Blueprint metrics. Overall, better inclusion of LHDs in the development of these new metrics could have eased these challenges in the rollout.

Best Practices

The State took a promising step towards data transparency by spooling up a Github site to share, with local public health department epidemiologists, the statistical code used by CDPH to generate Blueprint metrics. This had the potential to provide significant clarity on calculation of the metrics, including details of inclusion and exclusion criteria, and precluded the need to "back engineer" metrics.

In addition, CDPH's own CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) grant reporting team modeled a collaborative metric development process. CDPH staff on this team actively sought input from local public health departments, at multiple levels, on the development of ELC reporting metrics. LHDs were given several opportunities to weigh in on proposed measures, and could raise concerns or methodological questions before being asked to adopt brand-new metrics.

4. Communicating data to communities

Over the course of the pandemic, the public has seen conflicting data reported by State and local agencies. Inconsistencies in the measures themselves (such as the definition of a COVID-19 case, or the COVID-19 test positivity rate) is an important problem, but may not be as visible to the public. However, inconsistencies in what is and isn't reported between State and local data dashboards is far more visible, and has led to confusion, mistrust, and frustration.

People are invested in the health of their communities, and often want to be part of the solution to address disparate impacts. Their participation hinges on clear, consistent, and detailed reporting on local public health outcomes, including COVID-19. State and local agencies, attempting to balance privacy and actionability, took different approaches to mixed results.

The State is very conservative in its public reporting, sharing aggregated data at geographies no smaller than county, and only reporting certain measures, such as COVID-19 cases by race/ethnicity, at the State level. This has made it more difficult for the public to be informed about impacts to their specific communities, and limits their ability to engage directly in solutions. It is also counter to recommendations made in the State's Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity: "Data that allows us to see disparities at the level of social determinants of health, and that is disaggregated in ways that make our often- invisible communities visible, has been hard to obtain but is vitally important."

The State's reporting choices are largely informed by the California Health and Human Services Agency's Data De-Identification Guidelines (DDG). CDPH frequently cites the DDG recommendation to report data only at geographies with populations above 20,000 (excluding census tracts, ZIP codes, and even many cities) as justification for this conservative approach.

As a result, communities who sought to understand COVID-19 impacts not only in their county, but in their city or neighborhood, were unable to get detailed data from the State.

Local health departments have often tried to provide more granular data. Some jurisdictions have chosen to report COVID-19 cases aggregated to the level of census tract. Others are reporting at the ZIP code, city, or unincorporated community/ Census-designated place level. Many jurisdictions also report COVID-19 outcomes by race/ethnicity. By providing data at smaller geographies and stratified by important measures like race/ethnicity, these approaches are generally more welcoming to community participation in addressing disparities in COVID-19 impacts.

In some cases, however, this openness and transparency in reporting led LHDs to experience push back from some community members, who felt it was an intrusion. This has been felt particularly in the CI/CT process, which gathers some sensitive demographic characteristics, including sexual orientation and gender identity (SOGI). An attendee of a September CACDC meeting noted that:

"We are already speaking with county residents who feel that the government is being intrusive. This question [on SOGI] adds to that feeling and has a very negative impact on our interviews." LHD respondent

Another shared that "in rural conservative areas, this can really alienate people we are already struggling with." Beyond SOGI, one respondent to the LHD Data Survey wrote that "we see a high rate of non-cooperation with naming contacts, especially with families who have foreign born family members (Hmong and Latinx in our county) but also among white, COVID-deniers. Somehow we need to establish trust and credibility with these populations." Based on these responses, some jurisdictions shared that they don't want to report these data publicly, given concerns about undue bias against certain groups.

State and local agencies must carefully balance data transparency and personal privacy to maintain the public trust and facilitate a collaborative public health response with full participation from communities. Neither the State nor LHDs struck precisely the right mix during the pandemic, and discrepancies in reported data exacerbated this challenge: during an October CACDC call, participants shared that inconsistency between what LHDs versus the State reports has been a significant source of dissatisfaction among the public There has been general feedback from LHDs that improving our public data reporting will help alleviate these frustrations, and ensuring that all parties – the State and LHDs – are aligned in what they report is key. As highlighted in the State's Portrait of Promise strategic plan communication goals, it is important that the State and LHDs center public feedback, and community needs, in the development of a unified reporting approach.

Best Practices

The disparate approaches in collecting and publicly reporting COVID-19 data has resulted in many challenges *and* many successes. Local health departments that chose to release data disaggregated by gender and race/ethnicity, as in **Santa Barbara County's COVID-19 Community Data Dashboard**, enabled the public (including public health researchers and community-based organizations) to monitor disparities in their communities. San Francisco publishes **cumulative case rate maps at the census tract level**, a spatial resolution fine enough that communities could see the impacts not only in their city, but in their specific neighborhood.

Jurisdictions like Monterey, with their **Disparate Impact Report**, and Los Angeles, with their **COVID-19 Racial, Ethnic & Socioeconomic Data & Strategies Report**, took this a step further. By analyzing their data to better understand the COVID-19 among their vulnerable populations, Monterey and Los Angeles were able to identify local strategies and resources to address disparities in COVID-19 outcomes. Making these reports publicly available – instead of siloed within the health department – brings community partners to the table with actionable strategies.

At the state level, California took an important step towards institutionalizing the importance of making key data publicly accessible in a **memo on COVID-19 Data Transparency** dated June 25, 2020. The State wrote that "all agencies are required to make data open and machine-readable within 60 days," so that "researchers, scientists and others can use these data and trends in their ongoing work to combat COVID-19." While setting an excellent precedent, prioritizing data access for practitioners involved in the COVID-19 response sooner would have been a welcome and important addition.

And, while the CHHS DDG is imperfect, it is part of an impactful suite of open data tools – **the Open Data Handbook and Data Playbook** - that facilitate data sharing, including guidelines for publishing data in machine readable formats, in online dashboards, and compiled into easy-to-read reports for the general public, community-based organizations, and elected officials.

RECOMMENDATIONS

The COVID-19 pandemic revealed significant data barriers within local and state public health departments. It also made clear what is required to modernize public health data systems. State and local public health departments now have an unprecedented opportunity to meaningfully address these challenges and build better public health systems that center health equity.

To accomplish this, we must focus on data. Data play a vital role in an effective and equitable system. The recommendations outlined here re-envision existing data systems; prioritize the participation of local public health departments and community stakeholders in data policies and reporting practices; support development of health equity metrics across California; and expand and improve the collection of key demographic data that are the basis for equity work. In all, these would support State and local efforts to identify, track, and address health inequities. And, they would facilitate closer collaborative relationships between government, healthcare, and the public, making equity a cornerstone of future work.

Support development of modern public health data infrastructure

As the backbone of public health work, data systems are a critical component. During the pandemic, shortfalls in existing systems revealed significant opportunities for improvement. Post-pandemic, the State could play a transformative role in upgrading and modernizing the public health data systems that local public health departments rely on for their vital work.

A new public health data infrastructure, brought fully into the 21st century, would include:

1. standards for data interoperability,
2. clearly defined data sharing protocols,
3. regularly updated, core datasets,
4. uniform data collection and input practices,
5. and a commitment to transparency in public reporting, with features and functions designed to support this.

In addition, a fundamental component of modern disease surveillance systems – "CalREDIE 2.0" – is streamlined integration with provider reporting, case investigation, and contact tracing tools. This "interoperable-by-design" approach ensures that best-fit tools for State and LHDs can work seamlessly with each other.

All components of a modern public health data infrastructure would prioritize flexibility and interoperability. These are the characteristics that facilitate data sharing between and within local public health departments and the State. As not all health departments will use the same suite of software or data tools, it is critical to ensure that all components of a new data infrastructure can communicate is key.

As a first, interim step, existing data management systems could be upgraded or redesigned to support these new infrastructure standards, prioritizing fixes and tools that allow for interoperability. This allows the State and LHDs to select, develop, and use the tools that best suit their needs. As new systems come online, data could be seamlessly transferred between the old and new tools, easing the transition. To prevent data siloing, new systems, either off the shelf or custom developed, must be interoperable by design. With all parties using interoperable systems, data can be shared more quickly, effectively, and completely, enabling a more rapid public health response.

Integrate local public health department stakeholders in state governance of data for policies, practices, and metrics

Public health is fundamentally a collaborative, collective endeavor. In a state as large as California, the most effective public health policies and practices are created with insights provided by those working in local communities across the State, who have on-the-ground expertise.

Formally integrating these local insights into CDPH data practices and decision-making could begin with the formation of a taskforce, comprising representatives of local public health departments alongside select CDPH staff. The taskforce could be charged with envisioning what this close integration might look like once implemented: identifying key stakeholders, gathering input, and drafting guidelines for a collaborative partnership. With support from both the State and locals, these guidelines can be instituted across CDPH and incorporated into workflows. The existing forum of CCLHDME has some of these characteristics, but in over one year of meetings, LHD participants have noted that CDPH representatives frequently brought near-finished products for comment. The goal of the taskforce outlined here is to equalize the dynamic between LHDs and CDPH in the development cycle, co-creating and seeking LHD feedback earlier in the process.

Through this recommendation, local expertise is prioritized as a core component of CDPH governance, and is aligned with goals outlined in the State's Portrait of Promise strategic plan. It represents a shift from a top-down approach, inviting local public health department data managers and epidemiologists to meaningfully co-create the data policies, practices, and metrics that guide their work.

Institute "health equity metrics" across State and local government operations and investments

The Blueprint Health Equity Metric and Vaccine Equity Metric represent a vital step forward in explicitly considering health equity in decision-making and resource allocation. In the case of the Health Equity Metric, by tying re-opening to improving local public health disparities, it proved an attractive "carrot" to act on issues of health equity. By redirecting resources to the most affected communities, it provides for real impact.

The State has set a transformational precedent. We see the success of the Health Equity Metric as an important milestone in our collective health equity work, and as a foundational model for replication. We envision Health Equity-like metrics as a critical component in a multi-pronged strategy, at the State and local level, for truly addressing equity.

Building off of this initial success could support the development of Health Equity like-metrics across CDPH, other State agencies, LHDs, and local government. Tools like the Healthy Places Index,

at the heart of the Blueprint Health Equity Metric, are applicable to any agency, State and local, that influences community and social conditions, from transportation and infrastructure to education, housing, and planning.

Health Equity Metrics across the State would institutionalize the importance of considering health, and addressing health disparities, in all facets of state and local work.

Expand and improve collection of demographic data

Accurate data are indispensable to addressing health disparities. By ensuring we collect accurate data, and expanding the categories of data we do collect (such as the social determinants of health), we can better quantify disparate health impacts, and identify new avenues to address them.

However, a significant limitation to action is that public health data systems are populated with data that originates outside the public health system (from clinicians, labs, hospitals, SNF, prison healthcare, and others). LHDs have noted this as a key challenge. One LHD Data Survey respondent said that their pandemic response was hampered by a "lack of will to ensure accurate data are recorded initially [i.e., at the point of care]," and in a CCLHDME meeting a participant called out that "as long as healthcare can report 'unknown race/ unknown ethnicity' we won't get good data."

The most impactful step the State can take to enact this recommendation is to take regulatory action requiring health care providers (clinicians, labs, hospitals, and others) to report demographic data. The regulatory burden on providers has to be weighed against the lives that would have been saved if this information was readily available at the start of the pandemic.

The State's Portrait of Promise strategic plan notes that "failing to account for a community in data means missing the opportunity to understand and address that community's unique challenges, needs, and assets." Disaggregating data is one of the best approaches to identifying health disparities, and ensures that community members see themselves reflected in publicly reported data. To support this, it is critical that CDPH and local public health departments disaggregate data to the fullest extent possible for both internal analysis and public dissemination The health care industry has already moved down this path; the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) will require health plans to stratify selected outcomes by race/ ethnicity by initially using area-based measures and ultimately, individual-level data.

An example of effective data disaggregation is to always separate Asian and Native Hawaiian/ Pacific Islander when reporting, because important differences in health outcomes may be missed if they are combined. The Portrait of Promise speaks to this specifically: "while data showing the difference between aggregated populations can be useful, important disparities in health risks may be missed when looking only at this aggregated data for populations designated by large geographic areas of origin, such as Latinos and Asian/Pacific Islanders." Similarly, report meaningful subgroups of these categories when numbers are large enough. Also consider other data de-identification options, such as limiting stratification by other measures, to protect privacy for small populations.

Building relationships with the community is a core communication goal in the State's Portrait of Promise strategic plan, and can be invaluable towards discovering population-specific data gaps and identifying solutions. This is especially pertinent for small groups, particularly those in the American Indian/Alaska Native, Asian, and Native Hawaiian/ Pacific Islander communities. This can be achieved by partnering with representatives from these communities to collaboratively identify better modes of data collection and reporting.

Standardize data practices statewide, in collaboration with local public health departments, to more effectively track disparities

In concert with expanding data collection as outlined in the previous recommendation, improvements to data practices across the State are key to effectively addressing disparities. This begins by not only collecting demographic characteristics, but doing so in a standardized way. To minimize issues of misclassification, it is important that there are clear definitions for each characteristic. Misclassification can hide the true impact of a health outcome on a population, so this is especially important for race/ethnicity groups such as Native Hawaiian/ Pacific Islander, and Other, which are commonly misclassified.

Circumstances that lead to poor quality data collection may never be completely prevented, however. Across many CCLHDME and CCLHO meetings LHDs have requested increased sharing of data processes from CDPH, specifically codebases, that streamline data collection, cleaning, and analysis, making it much faster to identify disparities as they arise and freeing up staff to focus on core public health activities.

Finally, California is a diverse state. As described in the State's Portrait of Promise strategic plan, "we want everyone to be included in these [equity work] efforts, so special attention will be paid to reaching the corners of the state and the individuals and communities that have historically been challenged to participate in statewide dialogue and action."

To meet this goal, approaches for tracking health disparities (such as health equity metrics) can be developed in careful collaboration with local public health departments (when developed by the State) and with community-based organizations (when developed by LHDs). This helps avoid missteps in a "one-size-fits-all" approach To that end, and in response to LHD requests made on CCLHDME and CCLHO calls, source data and methodology must be made readily available for review by stakeholders, and published publicly once approved. A commitment to transparency, and community co-creation, can help bolster public trust of State and local agencies.

Support comprehensive and transparent public reporting of impact data

To better meet the communication goals included in the State's Portrait of Promise, and representing an opportunity to prioritize public engagement in State-produced data, is the revision of the CHHS Data De-Identification Guidelines; specifically, to support the public release of disease surveillance data at actionable, community-level geographies, preferably at the census tract level, as recommended by supporters of Assembly Bill 1358 (2021), which include the California Pan Ethnic Health Network, PolicyLink, Latino Coalition for a Healthy California, and the California Black Health Network, among many others.

To further bolster engagement, it would be beneficial to focus on community capacity building to participate in data interpretation and dissemination at the local level. Across several CACDC and CCLHDME discussions, LHDs described challenges resulting from the community misunderstanding of publicly-reported data: COVID-19 testing reticence, refusal to share demographic characteristics with case investigators, and confusion on measures included in the Blueprint. In addition, a commitment to regularly incorporating public feedback in the display and communication of published data could avert some of the difficulties LHDs faced. This would ensure that cultural and community sensitivities are honored, and prioritize a collaborative, bottom-up approach to public health.

Data reported at tract and ZIP code levels can come in many forms, with the goal of providing accessibility to the widest audience. This includes publishing data in machine readable formats, online dashboards, and compiled into easy-to-read

reports for the general public. Reflecting challenges shared by LHDs with mismatched or lagged data compared to the State, data should be updated as frequently and transparently as possible, particularly in public health emergencies. As requested by LHDs, automated processes for data updates and publication can be shared to streamline their own local data updates.

To minimize discordance between State and local reports, and limit public confusion (per one LHD on an October CACDC call, "we know we'll get a lot of questions when our counts don't match the State"), the State and local public health departments should endeavor to align their data reporting, incorporating feedback from community stakeholders where possible. This can involve sharing reports, publications, and dashboards with stakeholders before releasing to the public, and providing clear methodology, including data sources, for the calculation of metrics.

Develop a unified, bidirectional statewide health information exchange (HIE) with interoperability between state and local public health departments, and healthcare and hospital systems

Public health practice – at the State and local levels – requires reporting from healthcare and hospital systems. Based on conversations with several California health plans and providers, and from discussions with LHDs held on CCLHDME calls, this has largely been a unidirectional relationship, often with ad-hoc data sharing protocols in place. From these conversations:

- LA Care shared that they participate in three different HIEs
- Community Clinic Association of Los Angeles County (CCALAC) noted that there weren't enough hospitals participating in the HIEs for them to be efficient or effective
- California Primary Care Association (CPCA) argued that we need a central HIE, and that we don't need multiple systems like those currently in place for immunization registries

It is a challenge for both parties: hospitals and healthcare systems face an administrative burden in reporting outside of their existing electronic health records systems, and public health departments may get delayed and/or incomplete data. These data are crucial to support direction and refinement of public health programs and resources.

Blue Shield of California summed it up succinctly: the pandemic has supplied "our ACA moment" to rethink our data systems and develop a unified HIE with a mandate for its use. The State can support this new system that is bi-directional, interoperable, and sustainable, to build better data relationships and continuum of care between local public health departments, hospitals, and healthcare systems. The National Academy of Medicine, in its Health Data Sharing to Support Better Outcomes report, details what this might look like, and recommends setting policies that "establish ground rules and standards across networks, as well as support the development of technologies and systems that promote, rather than impede, data sharing."

In short, development of data standards, core datasets, support for Meaningful Use, and data sharing protocols that allow for streamlined reporting between systems are core components of a unified HIE. These protocols need to build in clear guidance and development of electronic messaging standards, specifically for laboratories and other reporting entities in healthcare and hospital systems to ensure timely, accurate data collection and interoperability with existing State and LHD data systems.

5

Advance Health Equity and Strengthen Resilience through Ongoing Community-Informed Policy and Practice Changes

RECOMMENDATIONS

- Address Racism as a Public Health Crisis
- Support Community-informed Policy Priorities both Locally and in State and Federal Policy Priorities
- Institutionalize the Use of a Health Equity Framework, including the Development of Health Equity Metrics, in Ongoing Investment and Resource Allocation Decisions
- Center Communities Most Impacted by Inequities in Policy, Program, and Resource Allocation Decisions
- Conduct a Comprehensive Review of Emergency Assistance Funding Sources at the Federal Level and Work to Remove Eligibility Restrictions that Prohibit Individuals from Obtaining Resources Needed During an Emergency
- Expand Access to Resources and Protections Needed to Meet Immediate Social Needs and Protect Health and Safety during COVID-19 and Beyond
- Identify and Fund Comprehensive Strategies to Strengthen Community Resilience during COVID-19 and in Preparation for Future Public Health and Climate Change-Related Emergencies

"When will public health and the critical role it plays in improving the quality of life collectively in the present and overall safety of communities in the future truly be realized?"
LHD respondent

OVERVIEW

COVID-19 exposed and exacerbated deeply rooted inequities across the public health, healthcare, workforce, and economic systems. These inequities were often starkest by race and place. In the United States, racism is at the root of the inequities in nearly every major measure of health status that exists. Structural racism, including a history of historic and contemporary disinvestment, has laid the foundation for the inequities in COVID-19 outcomes that can be seen in infections and death rates for Black, Latinx, Indigenous, Pacific Islander, and other communities of color across California. It is also the reason behind why low-income communities and communities of color that have been disproportionately impacted throughout the COVID-19 pandemic, are largely the same communities who have been and will continue to be most adversely impacted by climate change impacts. Without structural changes to policy, processes, and resource allocation, these same communities will continue to suffer the worst impacts and health outcomes throughout the COVID-19 pandemic and future public health and climate change-related emergencies.

Both the inequities laid bare by COVID-19 and the unjust murders of George Floyd, Breonna Taylor, and Ahmaud Arbery, and other Black Americans, have led to a nationwide reckoning on the importance of addressing racism as a public health crisis. In response to this recognition, jurisdictions across California have taken bold steps to declare racism a public health crisis and are working to develop strategies for addressing the impacts of centuries of structural racism on government policies and practices. Local public health departments (LHDs) have played a key leadership role in the development of local resolutions to address the role of structural racism in inequitable health outcomes, both during COVID-19 and beyond. Many jurisdictions, with leadership support from LHDs, are also working to identify, implement, and support community-informed policy and practice priorities at the local, state, and federal levels that work to advance health and racial equity. Local pulic health departments are also working to support community-informed policy priorities needed to improve health outcomes and strengthen community resilience during COVID-19 and beyond, especially for communities of color most impacted by inequities.

The development of the State of California's Health Equity Metric has also allowed many jurisdictions, some for the first time, to explicitly prioritize disproportionately impacted communities in short and long-term decision-making and resource allocation. Many LHDs are institutionalizing the use of neighborhood-level, disaggregated data, through the use of data tools like the Healthy Places Index (HPI), to identify those communities that have been most impacted by structural racism and disinvestment. Local public health departments are working with community partners to identify and implement community priorities in those disproportionately impacted communities in ongoing response and recovery processes.

Local public health departments, in partnership with communities most impacted by inequities, can continue to play a key leadership role in the identification of priority neighborhoods and communities for investment and resource allocation with a specific focus on those investments needed to address structural inequities and support community resilience both during COVID-19 and future public health and climate change-related emergencies. There is no "going back to normal" when "normal" was not working for so many communities throughout California. Through a specific focus on, and commitment to, equity and community-informed policy, practice, and resource allocation decisions, there is a possibility that California can emerge from this crisis a more just, equitable, and resilient California for all.

CHALLENGES

1. The impacts of structural racism and systemic disinvestment on health outcomes have been exposed by, and exacerbated throughout, the pandemic; jurisdictions were not well equipped to address the impact of structural racism on health outcomes throughout the pandemic
2. Prior to COVID-19, there was not a consistent statewide mechanism in place for prioritizing disproportionately impacted communities in public health emergencies, resource allocation, and investment decisions
3. Policies in place at the federal, state, and local levels prior to the crisis have been insufficient for addressing the needs of disproportionally impacted community members during the crisis; policy changes that occurred to address those needs during the pandemic must be institutionalized long-term in order to better support individuals and families most impacted by inequities
4. Social service supports available to disproportionately impacted individuals and families before the crisis, proved insufficient during the crisis; eligibility restrictions and access challenges created additional barriers for those most in need of assistance
5. The compounding impacts of climate change further exacerbate inequitable outcomes during public health and climate change-related disasters

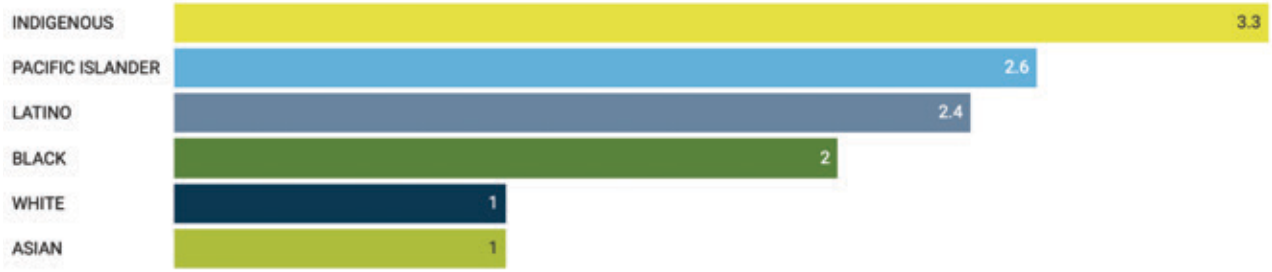
1. The impacts of structural racism and systemic disinvestment on health outcomes have been exposed by, and exacerbated throughout, the pandemic; jurisdictions were not well equipped to communicate and address the role of structural racism on health inequities throughout the pandemic

The COVID-19 crisis has laid bare the stark racial inequities in the United States since its inception, driven by centuries of racist policies and practices that have created and normalized a fundamentally unequal America; an America where people of color, especially Black Americans, are more likely to live in under-resourced, high poverty, highly segregated neighborhoods than White Americans, and are more likely to suffer from chronic illness, preventable disease, and multiple underlying health conditions (or "co-morbidities"). The deep racial and ethnic inequities that exist today are a direct result of structural racism: historical and contemporary policies, practices, and norms create and maintain an unequal American society.

According to nationally updated data from the American Public Media (APM) Research Lab, Indigenous and Black Americans experienced the highest overall mortality rates due to COVID-19. Black, Indigenous, Latinx, and Pacific Islander Americans all have a COVID-19 death rate double or more than that of White Americans. American Indian or Alaska Native people are 3.5 times more likely, Latinx Americans are 3 times more likely, and Black Americans are 2.8 times more likely to be hospitalized as a result of COVID-19, when compared to White Americans.

ADJUSTED FOR AGE, OTHER RACIAL GROUPS ARE THIS MANY TIMES MORE LIKELY TO HAVE DIED OF COVID-19 THAN WHITE AMERICANS

(REFLECTS CUMULATIVE MORTALITY RATES CALCULATED THROUGH MARCH 2, 2021)



Source: APM Research Lab

Here in California, similar inequities emerge by both race and place. As of July 8, 2021:

Death rate for Latino people is **21% higher** than statewide

Deaths per 100K people:

186 Latino
153 all ethnicities

Case rate for Pacific Islanders is **35% higher** than statewide

Deaths per 100K people:

12,360 NHPI
9,123 all ethnicities

Death rate for Black people is **9% higher** than statewide

Deaths per 100K people:

167 Black
153 all ethnicities

Case rate for communities with median income <$40K is **37% higher** than statewide

Cases per 100K people:

12,497 income <$40K
9.123 all income brackets

Furthermore, Californians living in crowded housing, and with less access to paid leave and other worker protections, have a higher risk of infection of COVID-19. Social determinants of health that impact COVID-19 outcomes, such as food insecurity, lack of health insurance, and housing instability, can increase the risk of COVID-19 infections and deaths. Inequities in the social determinants of health based on race and place are largely the result of structural racism.

From the start of the pandemic, local jurisdictions were ill prepared to address the scale and impact of these deeply rooted inequities on members of their communities, especially during the height of a pandemic. Without structural and multi-systemic efforts already in place, LHDs were unable to address the root causes of inequities, and were instead forced to create temporary solutions for deeply rooted, long-term problems. As a result, inequities based on race, place, and income, continued to be revealed throughout the pandemic, and, in most cases, became worse.

The Community Survey conducted between November 2020 and January 2021 found that:

- Respondents identified the need for LHDs to [incorporate] a racial equity lens both internally and externally and make clear connections on the intersectionality of COVID-19 with other sectors, such as the justice system and the transportation system.
- CBOs ranked the following priorities for LHDs in response to the need to address the impact of inequities on health outcomes:
    - » Address differences in health based on race and place (high priority = 80%)
    - » Address differences in health based on economic inequities (high priority = 80%)

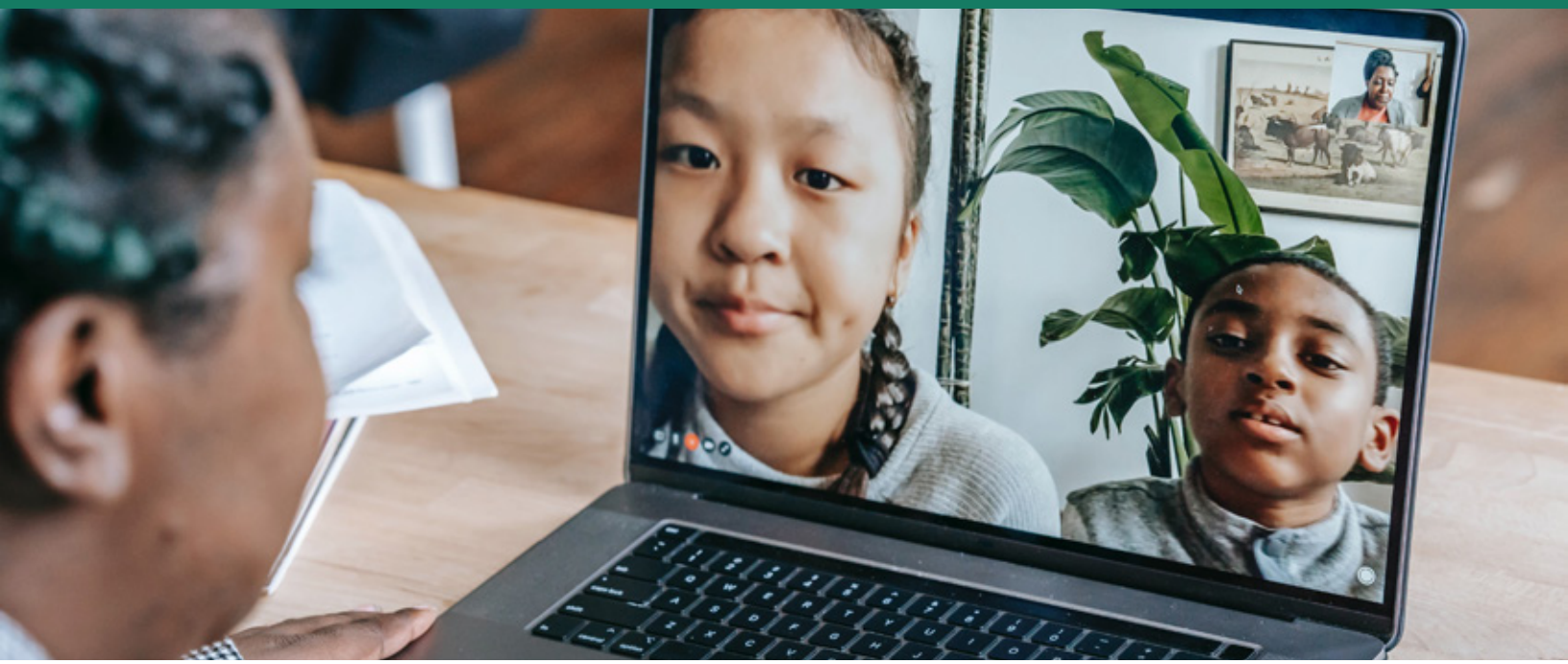
Best Practices

DECLARING RACISM A PUBLIC HEALTH CRISIS: DEVELOPING STRATEGIES FOR ADDRESSING AND DISMANTLING THE IMPACT OF RACISM ON HEALTH OUTCOMES

Many counties and cities across California have taken a stand in declaring racism a public health crisis and committing to a series of actions to begin to address the role of racism on inequitable health outcomes. In California, the County of San Bernardino **became the first County in California to declare racism a public health crisis**. This has paved the way for others across California to issue similar statements, often with leadership support from LHDs. According to the **American Public Health Association (APHA) Map of Declarations**, as of July 1, 2021 over 30 entities (County Boards of Supervisors, City Councils, Boards of Educations, etc.) throughout California have passed resolutions declaring their intent to address racism and its impacts on health outcomes. In April, following the lead taken by local entities across the United States, the Director of the Center for Disease Control and Prevention (CDC) **also released a statement declaring racism a public health crisis**. Her announcement accompanied a national commitment by the CDC to **accelerate its work to address racism** as a fundamental driver of racial and ethnic health inequities in the United States, paving the way for other local jurisdictions to take similar action.

LOCAL PUBLIC HEALTH DEPARTMENTS LEAD THE WAY ON ADDRESSING RACISM AS A PUBLIC HEALTH CRISIS

Local public health departments throughout California are leading multi-sector, community-wide efforts to address the impact of racism on health, economic, and other social outcomes. In the City of Long Beach, the Office of Equity, while located in the Department of Health, led the development of the City's **Framework for Reconciliation**, which included the launch of the City's first Black Equity Fund. In Santa Cruz, the County's commitment to addressing racism and resulting inequities, also aligns with the County's **Collective of Results and Evidence-based (CORE) investments program**, a collective impact approach to achieving equitable health outcomes. In Contra Costa County, Contra Costa Health Services served as the host organization for the establishment of the County's first **Office of Racial Equity and Social Justice**. Across California, LHDs are embracing their role as governmental leaders and key community partners in developing and implementing strategies for addressing the impact of racism on health outcomes both during COVID-19 and beyond.



2. Prior to COVID-19, there was not a consistent statewide mechanism in place for prioritizing disproportionately impacted communities in public health emergencies, resource allocation, and investment decisions

At the start of the pandemic, jurisdictions were often forced to develop their own approaches for addressing emerging and urgent equity priorities. One LHD described feeling like they were playing a game of "whack-a-mole," trying to address a seemingly unlimited number of crises as they emerged without a standard or consistent regional or statewide approach. While the health and economic impact of COVID-19 on low-income Californians and Californians of color continued to grow, LHDs had to try their best to protect residents most vulnerable to the impacts of the virus through public health orders and guidance; orders and guidance that could be ignored or overturned, even by their own local governing bodies (for more on this issue, see the "Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts When Issuing Health Orders and Guidance" report chapter). In interviews, some LHDs described the exhausting task of trying to "convince" elected officials of how bad the health inequities were, while simultaneously trying to secure limited resources that could be directed towards those communities most impacted by the virus. This uneven approach to addressing health inequities often led to confusion and disparate outcomes across counties, regions, and the state as a whole.

Best Practices

PRIORITIZING COMMUNITIES MOST IMPACTED BY INEQUITIES DURING COVID-19 & BEYOND

Many LHDs identified the **State of California's Health Equity Metric**, part of the State's **Blueprint for a Safer Economy**, as a helpful and pivotal tool for supporting their work to advance equity during the COVID-19 response. The metric, the first of its kind in the country, provided departments with the data needed to justify prioritizing the most disproportionately impacted communities throughout their jurisdictions. Many departments felt the metric supported their ongoing work to prioritize communities most impacted by inequities in resource and investment allocations. The development of the State's health equity metric, and the use of the **Healthy Places Index (HPI)** for prioritizing communities with the least opportunities for healthy conditions, supported a more consistent local, regional, and statewide approach to prioritizing disproportionately impacted communities in resource allocation and decision-making. During one interview, a LHD stated that the "HPI raised the visibility of inequities to elected officials and [helped direct resources] to community-based organizations in the most impacted communities." The State's **Vaccine Equity Metric**, developed in February, utilized a similar prioritization metric in an effort to ensure communities most impacted by inequities would also be prioritized in COVID-19 vaccine distribution and administration. In addition to support from many LHDs, many **health and racial justice community partners** and **advocates** also echoed their support for the use of community-informed equity metrics and prioritization throughout the COVID-19 response and recovery process.

The Health Equity Metric was not only a consistent approach for protecting the health and wellness of communities most vulnerable to the impacts of the COVID-19 crisis, it was also a statewide effort to prioritize the investment of resources more broadly in those same communities facing inequities. As part of the **Blueprint Health Equity Metric** requirement, LHDs were also required to develop **Targeted Investment Plans** that allocated resources to the lowest HPI quartile in each jurisdiction. Altogether, $272 million in Coronavirus Aid, Relief and Economic Security (CARES) Act and Epidemiology and Laboratory Capacity (ELC) funding is being directed to the most impacted

communities (defined as those in the lowest HPI quartile). CDPH is also directing $5 million in funding for CBOs to implement **Health Equity Pilots** within these same disproportionately impacted communities. This approach worked to set a standard for prioritizing communities most impacted by inequities in resource allocation and investment decisions.

Many LHDs and other intra-governmental partners are now institutionalizing the use of data tools and health equity metrics for identifying priority communities for community-based resource and investment decisions beyond direct health services related to COVID-19. San Diego County's **2021 Emergency Rental and Utilities Assistance Program (ERAP),** provides payment assistance for renters who need help with rent and utilities, using the HPI to support prioritization for eligible applicants. Jurisdictions are recognizing that the institutionalization of a consistent, data-informed approach (both quantitative and qualitative) to the COVID-19 response and recovery, is also an approach that can be implemented to address the root causes of inequities that drove disparate outcomes throughout the pandemic.

3. Policies in place at the federal, state, and local levels prior to the crisis proved insufficient for addressing the needs of disproportionately-impacted community members during the crisis; policy changes that occurred to address those needs during the pandemic, must be institutionalized long-term in order to better support individuals and families most impacted by inequities

From the start of the pandemic, it was clear that federal, state, and local policies in place were insufficient for addressing the health, safety, and social needs of disproportionately-impacted community members. For many jurisdictions, the impact of COVID-19 on low-income residents and residents of color became apparent almost immediately; from housing instability, to food insecurity, millions of Californians were facing a crisis within a crisis. Calls for policy changes at the local, state, and federal level were widespread; from eviction moratoriums, to expanded food assistance, to enhanced worker protections, to childcare assistance, COVID-19 exposed critical gaps in the policy protections needed to protect the health and safety of Californians most vulnerable to the impacts of the crisis.

For California's frontline and essential workers, the absence of policy and enforcement protections was particularly acute, as these workers were often more likely to get be exposed to, get sick, and die from COVID-19. Workers without adequate paid sick and family leave, were less likely to be able to quarantine safely and effectively in their homes. Workplace outbreaks have exposed some of the most dangerous instances of non-compliance with public health orders and guidance. In one tragic example in Los Angeles County, more than 300 employees tested positive at Los Angeles Apparel, a garment manufacturing facility in South Los Angeles, where the company was in violation of infection control protocols.

"Wouldn't it be lovely if there was ever a time when there was a recognition that public health emergencies aren't episodic"
LHD respondent

"[LHDs] had to pivot from focusing on social determinants to focusing on COVID containment…[it was] difficult for health departments to focus on the social determinants driving further COVID spread due to LHDs being under-resourced and overwhelmed" LHD respondent

Local public health departments have struggled to address all the priority and urgent needs of their residents from the start of the pandemic; from working to coordinate Personal Protective Equipment (PPE) distribution for frontline and essential workers, to food distribution for children and families, to identifying technology resources for students needing to learn from home. Local public health departments have often been frontline responders throughout the pandemic and among the first to recognize the massive policy and resource gaps in their communities. However, many LHDs have also had limited ability to directly impact the policy changes needed at the local, state, and federal levels to protect and support their most disproportionately impacted residents.

In the LHD Survey:

- Only 10% of LHDs indicated they were very effective at advocating for policy changes needed (at the local, state, and/or federal level) to support their most vulnerable communities

In the Community Survey:

- Close to 2/3 of respondents felt that policy changes in response to the COVID-19 pandemic at the federal level have been insufficient
- Less than half of respondents reported that their frontline or essential community members often or always had access to PPE. One respondent elaborated further adding that it was, "[not because] it's provided by the employers but [because] organizations and other providers are supplying PPE."
- Less than 1/3 of respondents indicated that the frontline or essential community members they serve were always or often made aware of their rights as employees
- Over 1/3 of respondents indicated that frontline or essential community workers were "rarely or never" able to safely isolate or quarantine without fear of losing employment; close to 1/3 invdicated that frontline community workers were only sometimes able to safely isolate or quarantine
- Nearly all respondents (90%) reported the inability to pay rent as a top housing issue
- 3/4 of respondents identified the threat of eviction as a top housing issue throughout the pandemic
- Nearly all respondents (95%) reported healthy food access as a top issue throughout the pandemic

"We have been successful in recent years working with advocates for policy change that impacts vulnerable populations. However, the Central Valley is significantly behind other areas of the state in policies that reduce health inequities. This has significantly impacted COVID outcomes for vulnerable populations in the Valley" LHD respondent

Best Practices

PUBLIC HEALTH COUNCILS

As the COVID-19 pandemic has consistently demonstrated, workers who feel empowered to identify and address health order violations are essential to slowing the transmission of COVID-19. In workplaces across the country, workers have warned of COVID-19 risk and have raised concerns to their LHDs and elected officials regarding employers who were not adhering to public health orders and guidance. Workplace and public health standards are virtually impossible to enforce when workers lack information on their rights or fear retaliation when speaking out.

On November 10, 2020, the Los Angeles County Board of Supervisors, with leadership from the Los Angeles County Department of Public Health, passed a motion to establish the nation's first Public Health Councils Program. The Public Health Councils aim to support workers who are interested in forming workplace councils to help monitor compliance with public health orders and safety protocols at their worksites. The County Public Health Department partnered with certified worker organizations to train workers on County health order protocols. The goals of the Councils were to expand the capacity of the Department of Public Health and ensure the health and safety of the County's large frontline and essential worker population. In conjunction with the Public Health Councils Program, the Los Angeles County Board of Supervisors unanimously passed an emergency anti-retaliation ordinance, aimed at protecting workers from employer retaliation when reporting workplace violations.

"HERO PAY" FOR FRONTLINE WORKERS

Throughout the pandemic, frontline and essential workers put themselves and their families at risk to ensure the continued provision of essential services, often without the assurance of basic protections for their personal and economic security. In response, dozens of cities and counties across California passed "hazard pay" or "hero pay" ordinances. The City of Long Beach was the first city in California to pass such a local ordinance. Coachella became the first city in the nation to extend their "hazard pay" ordinance to the City's large farmworker population. Counties also passed similar county-wide ordinances: San Francisco, Santa Clara, and Los Angeles Counties all passed "hero pay" ordinances of an additional $5 per hour on top of their regular hourly pay for their frontline and essential workers.

STRENGTHENING EVICTION PROTECTIONS AND RENTAL ASSISTANCE SUPPORT

Early in the pandemic, when it first became clear that large-scale industry and education closures would lead to even greater housing instability for low-income renters and homeowners, several Bay Area counties mobilized to pass local eviction moratoriums and protections. Contra Costa, Alameda, and Solano counties were among the first to adopt local, county-wide eviction moratoriums. Organizers and LHDs throughout the Bay Area partnered to support the passage of local ordinances at the city and county levels. Local eviction moratoriums proved vital at the start of the pandemic, when State policies were still being developed. The local moratoriums and protections eventually laid the groundwork for the passage of statewide protections for tenants and property owners.

"[LHDs] need additional resource support to address economic needs of communities" LHD respondent

Best Practices

INCREASING AND EXPANDING FOOD ASSISTANCE

Food assistance programs in non-pandemic times are lifelines for low-income individuals and families. During the pandemic, the need for robust food assistance programs and expanded eligibility for individuals and families, became even more critical. Local public health departments throughout California have been critical partners in reaching out to individuals and families to ensure they are receiving essential food assistance and support. Policy changes at the State and local level, have been imperative for ensuring food security throughout the pandemic. The Families First Coronavirus Response Act gave the Agriculture Department (USDA) **authority to let states temporarily modify procedures** to make it easier for families to continue participating in or apply for SNAP. The law allowed CalFresh[4] recipients to purchase food online, expanded CalFresh eligibility to college students, and increased CalFresh allocations for individuals and families. Similarly, the U.S. Department of Agriculture allowed for increased flexibility to ensure as many children and families as possible could benefit from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The expanded food assistance and access have been critical during a pandemic where millions of Californians faced food insecurity, **some for the first time.**

4. Social service supports available to disproportionately-impacted individuals and families before the crisis, proved insufficient during the crisis; eligibility restrictions and access challenges created additional barriers for those most in need of assistance

The COVID-19 crisis exposed and exacerbated the inequities in basic needs resources and social support services available for communities most vulnerable to the health and economic impacts of the crisis. Basic needs, such as safety, housing (including isolation and quarantine support), food, and economic assistance, became as vital for many families as access to testing and healthcare. Those resources in place to support struggling Californians before the crisis, proved insufficient for supporting communities most vulnerable to COVID-19 during the crisis. Insufficient resources included, but were not limited to, PPE for frontline and essential workers, economic assistance for individuals and families, rental assistance and housing support for those at risk of homelessness or housing instability or who were in need of isolation or quarantine support, and food assistance for individuals and families facing economic insecurity.

While many government programs expanded access and capacity to provide critical support in response to the pandemic, LHDs and community partners noted that eligibility and access barriers continued to limit the number of individuals who could receive these critical supports. In one example elevated by multiple LHDs, access to a food assistance program for older adults, Great Plates Delivered, limited eligibility for individuals receiving assistance from other state or federal nutrition assistance programs. The Great Plates Delivered Program provided seniors with three home-delivered, restaurant-quality meals per day. However, the program excluded seniors already receiving other nutrition assistance like CalFresh or Meals on Wheels. This essentially denied enhanced nutrition benefits to those who needed them most. Seniors with higher incomes who were not accessing nutrition assistance programs were able to access $66 per day, while their lower income counterparts were excluded from this program, receiving the maximum benefit of only $6.26 per day under the expansion of the CalFresh

4 CalFresh, known federally as the Supplemental Nutrition Assistance Program or SNAP, provides monthly food benefits to individuals and families with low-income and provides economic benefits to communities.

program, and were left to navigate a rapidly-evolving emergency food system.

In other cases, long wait times, complicated enrollment criteria, and barriers to technology access, limited access to critical supports, often for those most in need of assistance. For undocumented Californians, the situation was often even more dire. Undocumented individuals and families were unable to receive many of the expanded economic benefits available through federal legislation. For those benefits and resources that were available to undocumented residents (e.g., access to free testing, isolation support, etc.), fears around public charge and immigration enforcement often had a dampening effect on residents' willingness to seek out resources and basic needs support.

In the Community Survey:

- Unemployment (85%) was ranked as the number one economic issue, followed closely (80%) by accessing financial support (e.g. employment benefits).
- Impacts to safe and reliable spaces for children such school closures (75%) and issues with childcare (70%) emerged as top issues.
- 65% of respondents identified access to stable internet as a top issue for individuals and families
- Close to half of partners surveyed cited the need for undocumented resident support (42%), including:
  - » Individual financial supports like cash assistance (39%), and technology support (36%)
- Community partners elevated the negative cooling effect of public charge on many residents who needed access to testing and quarantine support

Best Practices

EXPANDING HOUSING FOR THOSE WHO NEED IT MOST

In response to the urgent need for short- and longer-term housing support throughout the crisis, local jurisdictions, in partnership with LHDs, implemented a variety of housing support programs. **Project Roomkey** provided people experiencing homelessness and were recovering from COVID-19, or were exposed to COVID-19, a place to recuperate and properly quarantine outside of a hospital. It also provided a safe place for isolation for people experiencing homelessness and at high risk for medical complications should they become infected. The City and County of San Francisco's **Right to Recover Program** provided $1,285 to reimburse or pay reasonable and necessary personal, family, or living expenses to any worker living in San Francisco who tested positive for COVID-19, and anticipated experiencing financial hardship during their two-week quarantine or isolation period. In Stanislaus County, **the LHD created a local program** to provide an $800 paycheck to support workers who had to isolate or quarantine due to infection or exposure.

On July 24, 2020, Governor Gavin Newsom announced the launch of the **Housing for the Harvest program**. The program was designed to provide temporary hotel housing options for essential farm and food processing employees who were either COVID-19 positive or exposed, did not require hospitalization, and were unable to isolate at home, to have safe and suitable places to isolate elsewhere. **Many LHDs throughout the State** from Santa Barbara, to Imperial, to Monterey Counties, partnered with trusted community partners to connect farmworkers in need of housing and isolation support with temporary housing.

Best Practices

CONNECTING RESIDENTS TO BASIC RESOURCES

Local public health departments throughout California leveraged partnerships with **local "211" providers** to connect residents to much needed health, economic, and basic needs supports. This included connections to expanded food assistance through local food banks and other meal delivery programs, connections to rental or mortgage assistance programs, and in some select cities, **pet food assistance for struggling pet owners**. In San Louis Obispo, **the LHD partnered to implement a program to deliver food and prescription medication** for self-isolating seniors (65+) and individuals with chronic medical conditions. Approximately 900 households were served weekly by this program. Local public health departments also partnered with California's **Great Plates Delivered** program to support reaching older adults and helping them stay safe at home during the pandemic. Older adults who were eligible for assistance, were able to receive three free, restaurant-quality meals per day, although there were barriers to accessing the program for some older adults (a more detailed discussion is provided in the challenges section on page 84 above and recommendations around addressing eligibility restrictions can be found in the "Recommendations" section beginning on page 95).

PROVIDING VITAL FINANCIAL SUPPORT FOR UNDOCUMENTED RESIDENTS

COVID-19 exacerbated and amplified the need for assistance for undocumented California residents during public health emergencies. In recognizing this need, the State of California launched the **Immigrant Resilience Fund**. The fund provided financial assistance of up to $1,000 to over 230,000 undocumented California families. The fund was the first State program of its kind in the nation, and was replicated in other states and cities across the US.

Local jurisdictions also worked to establish local UndocuFunds in counties and cities across California. The **Sonoma County UndocuFund** was launched in 2017 to support undocumented residents impacted by wildfires but ineligible for FEMA assistance. The fund was reactivated in response to growing community need throughout the COVID-19 pandemic. **San Francisco launched an UndocuFund** modeled after the Sonoma County mutual aid model, disbursing critical financial assistance to the City and County's undocumented residents. Since its inception in July, **San Mateo County's Immigrant Relief Fund** has awarded over $11 million in grants to immigrant families needing relief during the COVID-19 pandemic who did not qualify for CARES Act assistance. In Ventura and Santa Barbara Counties, **the 805 Undocufund**, created in the aftermath of the 2017 Thomas Fire, reopened in 2020 to assist undocumented families impacted by the outbreak of COVID-19.

Throughout the crisis, the **California Protecting Immigrant Families Network** also worked to address the vital need to support undocumented individuals and families with education and outreach support around public charge. This work included a robust coalition of community partners who worked throughout the crisis to create a comprehensive, multilingual suite of **"know your rights"** materials that was shared with LHDs and community partners throughout the state. These materials supported undocumented immigrants with accessing vital health and economic resources throughout the crisis.

5. The compounding impacts of climate change further exacerbates inequitable outcomes during public health and climate change-related emergencies

The communities disproportionately impacted by the COVID-19 emergency are largely the same communities who have been and will continue to be most adversely impacted by climate change impacts, and often have the fewest resources to prepare, respond, and recover from these impacts. Throughout the COVID-19 emergency, communities with the fewest resources, communities of color, and agricultural and service workers, generally suffered the most devastating impacts. These same communities are often also most vulnerable to extreme heat events, wildfires, smoke events, and flooding emergencies. During a record-setting extreme heat event in the summer of 2020, families and communities who would normally gather together in shared spaces to stay cool, whether family apartments or shopping malls, were forced to choose between risking COVID-19 exposure or heat illness. Similarly, during the unprecedented wildfires and smoke events of the summer and fall of 2020, agricultural and outdoor workers were put at increased risk of serious illness caused by prolonged toxic smoke exposure as well as COVID-19, and in many cases were inadequately supplied with PPE effective in reducing COVID-19 transmission and filtering out harmful particulate matter from wildfire smoke. Despite the laudable efforts of community-based organizations and LHDs to provide PPE and support to these populations, lack of resources and staff capacity continue to be a limiting factor.

Given the chronic disinvestments in the nation's public health departments, other sectors and communities, LHDs are unprepared to address multiple or compounding emergencies, such as COVID-19 and extreme heat events or extreme precipitation and mudslides. Throughout the

COVID-19 emergency, LHDs were faced with the challenge of setting up cooling, clean-air, and warm, dry shelters, while maintaining necessary physical distancing and COVID-19 mitigation protocols. While many LHDs and their partners coordinated to adjust shelter capacities, connect clients with COVID-19 related and other resources, and distribute supplies, there is much more to be done to protect and support communities most disproportionately impacted by inequities, especially during emergencies. The impacts of climate change will continue to worsen over the coming decades, therefore it is critically important that public health departments, other sectors and communities are adequately resourced and supported to prepare for, respond to, and recover from climate change-related events and others compounding emergencies.

The California Department of Public Health (CDPH) also released guidance and resources for LHDs and communities related to a broad range of COVID-19 and climate change-related impacts. This guidance includes, but is not limited to, public health strategies for reducing exposure to wildfire smoke during the COVID-19 pandemic and guidance to reduce the risk of COVID-19 transmission in cooling centers.

Best Practices

GUIDANCE FOR COVID-19 AND CLIMATE IMPACTS

During the unprecedented 2020 wildfire season and weeks long unhealthy air quality event, Alameda County issued guidance on **COVID-19 Considerations for Extreme Heat & Unhealthy Air Quality**. The document includes guidance on cooling and cleaner air centers, tools to assess air quality, and information about how to reduce smoke exposure at food distribution and COVID-19 testing sites. Alameda County also shared the Environmental Protection Agency's guidance on how to reduce smoke exposure during Shelter-in-Place by **creating a clean air room** within the home. The California Department of Public Health (CDPH) also **released guidance and resources for LHDs and communities related to a broad range of COVID-19 and climate change**-related impacts. This guidance includes, but is not limited to, public health strategies for reducing exposure to wildfire smoke during the COVID-19 pandemic and guidance to reduce the risk of COVID-19 transmission in cooling centers. As climate change impacts become more frequent and severe, the likelihood of co-occurring public health emergencies increases, therefore LHDs must plan and prepare for these scenarios, with particular emphasis on communities disproportionately impacted by inequities.

Recommendations

Address racism as a public health crisis

In response to the national recognition of the impact of structural racism on health and other social outcomes, counties and cities across California have made commitments to address the impact of racism on health outcomes. Local public health departments have often played a key governmental leadership role in the development of these resolutions, as well as the development of community-led recommendations for addressing the impact of structural racism on health and other outcomes. Local public health departments can continue to play a key leadership role in supporting the development of resolutions to address and dismantle the impact of racism on health outcomes. In addition, LHDs can contribute to defining the impact of racism in perpetuating and exacerbating health inequities, including the provision of key quantitative and qualitative data points from individuals and communities most impacted by inequities.

The work to address structural racism requires a sustained and ongoing commitment. Local public health departments can support jurisdictions in embracing a "Health and Equity in All Policies" approach to policymaking and resource and investment decisions. Local public health departments can also play a key role in advocating for long-term funding to support community-informed racial equity priorities (e.g. Long Beach's Black Health Equity Fund).

Addressing the impact of racism on health and other outcomes, will require sustained, ongoing commitment. As bodies whose mission it is to protect the health and wellbeing of their communities, LHDs are well positioned as partners and key government leaders to support the work of community to transform the policies, practices and processes needed to begin to address the impact of structural racism on health and other social outcomes.

Support community-informed policy priorities both locally and in state and federal policy priorities

Throughout the COVID-19 pandemic, community-driven policy change at the local, state, and federal level has played a critical role in addressing the disproportionate impact of the pandemic on low-income Californians and Californians of color. It is important that policies put in place in response to the pandemic, from eviction protections, to expanded food access, to economic assistance for individuals and families in need, should be extended

throughout the pandemic and beyond. The Los Angeles County Public Health Council Program and anti-retaliation ordinance are models for other LHDs and jurisdictions throughout the COVID-19 response and recovery process. While safety in the workplace is essential during COVID-19, it is also important that jurisdictions consider similar models for monitoring workplace health and safety standards during COVID-19 and beyond. Similarly, eviction protections, rental assistance programs, and efforts to produce more housing opportunities throughout the pandemic, can also be considered essential ongoing policy considerations for a just response and recovery.

The State and local jurisdictions can consider enacting stronger policies outlined in the CDPH COVID-19 Health Equity Playbook for Communities, as well as policies that strengthen public health infrastructure, advance health equity, and strengthen community resilience. Local public health departments can continue to support community-informed policy demands at the local, state, and federal levels. Local public health departments can also consider regional approaches and alignment when advocating for local policy priorities. Policies that work to address health inequities and improve community health and resilience locally, will better support community members who live, work and play across city and county borders.

Throughout the COVID-19 pandemic, policy differences throughout localities in the same region, led to greater confusion and uncertainty, especially for low-wage workers and families. Public health regional bodies, like the Bay Area Health Inequities Initiative and the Public Health Alliance of Southern California, have developed regional policy platforms aimed at identifying those local, state, and federal policies and investments needed to address inequities and support impacted Californians in the short and long term. These regional policy platforms align with and draw from community-informed policy priorities that have been established by public health and racial justice organizations, like Human Impact Partners, PolicyLink, and the California Pan-Ethnic Health Network. The policy priorities identified in these platforms, support the health and racial equity policy changes needed to truly address structural health inequities that have led to disproportionate impacts throughout the pandemic. The implementation of robust policy change in alignment with these community informed policy priorities, will support the creation of a more just, equitable California during COVID-19 and beyond.

"[With] CDPH and the State making health equity a priority in terms of addressing COVID, [it] has actually given us, as a local health department that tends to the more conservative side, the courage to use stronger language when discussing health equity issues. Instead of talking about health disparities... [now we can say] 'we want to eliminate racial injustice in our county.'"
LHD respondent

Institutionalize the use of a health equity framework, including the development of health equity metrics, in ongoing investment and resource allocation decisions

The State of California has established several equity-focused metrics throughout the pandemic that many LHDs have identified as critical tools for supporting their work to advance equity during the COVID-19 response . The State of California's Blueprint Health Equity Metric (announced in October 2020), and subsequent Vaccine Equity Metric (announced in March 2021), helped facilitate a consistent, aligned approach for identifying communities most in need of COVID-19 resources and investment support. As part of the Health Equity Metric requirement, LHDs were also required to develop Targeted Investment Plans that direct resources to the lowest HPI quartile in each jurisdiction. Altogether, $272 million in LHD CARES and ELC funding was being directed to many of the most disproportionately impacted communities (defined as communities in the lowest HPI quartile) through the development of these plans. The metrics and accompanying Investment Plans have supported jurisdictions in explicitly directing resources to communities most impacted by health inequities during the COVID-19 response.

Many LHDs, as well as community-based partners and advocates, feel the development of equity metrics at the state and local levels can support their ongoing work to prioritize communities most impacted by inequities in resource allocation and investment decisions during COVID-19 and beyond. It is important that local, state, and federal policymakers build off the models developed during COVID-19 and work to develop community and data-informed equity metrics for use in all ongoing resource prioritization and investment decisions. The incorporation of an equity data tool such as the HPI in the development of equity metrics, can support LHDs in identifying communities in their own jurisdictions most impacted by health inequities. The HPI can support LHDs in identifying priority community needs and directing investments aimed at strengthening the social determinants of health (economic security, housing stability, etc.) at the neighborhood level. To date, the HPI has helped direct over $1 billion in grant funding to communities most impacted by health inequities statewide. In addition to place-based metrics, the State and LHDs must work with community partners to identify those community members who may be vulnerable during COVID-19 as well as other public health and climate change-related emergencies that may not be fully reflected in the identified equity metric or data tool (e.g. racial/ethnic populations who may not be fully and/or accurately captured by the data, including: linguistically isolated communities, those who are incarcerated, those with serious mental health needs, persons experiencing homelessness, etc.).

Center communities most impacted by inequities in policy, program, and resource allocation decisions

Many LHDs have begun to incorporate a health equity lens into decision-making at the local level, working in partnership with the communities they serve to develop community-driven health and resource priorities. In addition to the incorporation of quantitative data (e.g., an equity metric and/or data tool) and qualitative data (e.g., lived experience data), LHDs can consider institutionalizing the use of a health or racial equity tool to assess potential impacts of all policy, program, and resource allocation decisions during emergency response and recovery planning. Human Impact Partners, in partnership with Big Cities Health Coalition, released an "Equity Lens Tool for Health Departments." The tool aims to ensure equity in COVID-19 planning, response, and recovery by centering communities most impacted by inequities in the decision-making process. In addition, the Praxis Project offers LHDs and other governmental decision-makers strategic tools to support the development of organizational policies and processes that will lead to authentic co-creation of solutions

in partnership with the communities they serve. Local public health departments can also work to establish and institutionalize a funded community advisory committee to advise local and state health departments on equity across their operations and identify any gaps in the data-informed metrics (see also "Embed Equity Throughout Local Health Department Emergency Planning, Response & Recovery Processes"). Institutionalization of equity tools and community-informed approaches across departments and jurisdictions, can ensure greater community accountability and consistency as work advances towards a more just, equitable future for all Californians.

Conduct a comprehensive review of emergency assistance funding sources at the federal level (e.g., FEMA Funding) and work to remove eligibility restrictions when said restrictions prohibit individuals from obtaining resources needed during an emergency

A comprehensive review of funding sources available to provide and/or enhance critical social service supports and resources during emergencies must be conducted at the federal level and work must be done to remove eligibility restrictions that prohibit individuals from obtaining critical resources needed during an emergency (The Center for Law and Social Policy developed a brief and recommendations for addressing many of these barriers at the federal level). Federal Emergency Management Assistance (FEMA) funding includes a duplication of benefits restriction that limits access to certain resources and support for individuals in need (e.g. FEMA restrictions around duplication of benefits that led to the exclusion of seniors from the Great Plates Delivered program (read more in the challenges section around eligibility barriers above)). Eligibility restrictions like this one, can deny benefits to those who need them most during emergencies.

It is important that access to social service supports that address basic needs should be expanded and eligibility restrictions should be eliminated to the fullest extent possible. This also includes particular consideration for undocumented residents. Limiting accessibility to vital basic needs and social service supports will only serve to further exacerbate structural inequities and fail to meet the fundamental needs of countless low-income Californians and Californians of color.

Expand access to resources and protections needed to meet immediate social needs and protect health and safety during COVID-19 and beyond

During public health, climate change-related, and other local, state, and national emergencies, it is important that the state of emergency triggers the rapid deployment of local support that aims to bring much needed resources to impacted communities (e.g. expanded food and housing assistance support). Basic needs also include expanded paid sick and family leave, so that individuals can feel supported in caring for themselves and their loved ones during COVID-19 and in future emergencies.

It is important that emergency-specific resources that have provided critical housing and food assistance support for vulnerable Californians, like Project Roomkey, Housing for the Harvest, and expanded CalFresh and WIC eligibility, also be considered for continuation beyond the pandemic. It is also important that expanded access to State and local rental assistance and mortgage assistance resources also be prioritized beyond the COVID-19 pandemic.

Due to the disproportionate impact of the pandemic on frontline and essential workers, those workers should be prioritized in policy and resource allocation during COVID-19 and beyond. The identification of PPE for this and future emergencies can be a State and local priority. In addition, strengthening worker protections and ensuring the health and safety of California's workers in response to the pandemic, will serve California's workers and their families in the future. With support from the California Department of Public Health Office

of Health Equity, Human Impact Partners has developed and released a full report to support LHDs in taking action to support worker health and safety during COVID-19 and beyond.

it is important that the State and LHDs should identify and address access barriers that are not based on eligibility requirements but continue to limit the ability of individuals to receive critical resources and support. These barriers may include access barriers for individuals living with disabilities (see a list of recommendations co-developed by the Los Angeles County Department of Public Health's Center for Health Equity, in partnership with partners who represent and or serve individuals living with disabilities, for improving accessibility for individuals living with disabilities during COVID-19 vaccine distribution and beyond), long wait times, complicated forms or paperwork, or inequitable access to technology needed to enroll in program supports.

Identify and fund comprehensive strategies to strengthen community resilience during COVID-19 and in preparation for future public health and climate change-related emergencies

In the face of devastating climate change impacts and an ongoing pandemic, the need to proactively advance climate adaptation and resilience is clearer than ever. Strengthening community resilience during COVID-19 and in future public health and climate change-related emergencies, will require the building of equitable, community-driven solutions. Asian Pacific Environmental Network's Resilience Before Disaster: The Need to Build Equitable, Community-Driven Social Infrastructure, outlines a set of comprehensive recommendations for strengthening community resilience during COVID-19 and beyond.

A key recommendation for strengthening community resilience is the identification and funding of robust, community resilience hubs, specifically in disproportionately impacted low-income communities and communities of color. Community resilience hubs are existing community-serving facilities that provide support or resources to the community, and may be schools, community centers, or libraries. As defined by the Asian Pacific Environmental Network, resilience hubs "are physical institutions that offer space for community members to gather, organize, and access resilience-building social services on a daily basis, and provide response and recovery services in disaster situations." Many resilience hubs have been central points of support in their community for decades, while others may have emerged more recently during the COVID-19 pandemic, providing food distribution or other services. Investing in community resilience hubs is an important strategy to strengthen our systems more broadly. It is critical that state and local government, as well as philanthropy, prioritize funding existing sites to increase their capacity to serve communities during emergencies and non-emergency times. Funding support can include retrofits to incorporate green building practices, renewable energy and microgrids, energy-efficient HVAC systems, broadband and other technology infrastructure. It is important that any investment in community resilience hubs be driven by community needs and priorities, specifically in communities most disproportionately impacted by inequities.

There were several pieces of legislation in the 2021 session that aimed to advance community resilience hubs. Most notably Assembly Bill 1087 introduced by Assembly Member Chiu, which would have created an Environmental Justice Community Resilience Hubs Program. Local public health departments can push to support legislation and policy priorities that support the identification and funding of community resilience hubs and other community-driven social networks in their departmental and jurisdictional policy platforms.

6

Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts when Issuing Health Orders and Guidance

RECOMMENDATIONS

- Ensure That State of Emergency Declarations at All Levels are Broadly Framed and Communicated
- Develop Community-Informed Mitigation Plans that Analyze Equity Impacts and Incorporate Equity Metrics into Health Orders and Guidance
- Foster Greater Public Courage in Support of Local Public Health Officials
- Implement Basic Preventative Measures at the State or Federal Level
- Provide Local Public Health Departments with More Advanced Notice and a Greater Opportunity for Meaningful Feedback Before Enacting or Changing State Orders and Guidance
- Fund Regional Public Health Department Coalitions to Facilitate Collaboration and Provide Technical Assistance
- Ensure Culturally Competent Communications and Messaging About Orders/Guidance
- Engage Public Relations for Public Health Messaging

OVERVIEW

As the threat of COVID-19 grew and eventually turned into a global pandemic, public health departments at all levels issued orders and guidance meant to protect community health and safety. Despite good intentions by all actors, these orders and guidance were not always consistent or coordinated with each other, and politics often came into play. As a result, there was often public confusion, which led to anger, backlash, and even violence in some cases. At a time when coming together was so important to protect each other's health and safety, and ultimately beat the virus, the nation became divided. This put communities most impacted by inequities at greater risk. In addition, orders at all levels were often instituted, as well as loosened or lifted, without adequate financial supports and protections for the hardest hit communities, including essential workers and small business owners. This is partly because there may not have been resources immediately ready at the time for other sectors to coordinate with public health and provide the necessary supports to implement the health orders and guidance without adverse impacts. Given the urgency of many orders at the start of the pandemic, equity analyses and mitigation plans generally could not have immediately provided relief, but could have helped address some of these issues as the pandemic continued. The implementation of the Blueprint Health Equity Metric and Vaccine Equity Metric are good examples of how the State incorporated equity into its strategies later on in the pandemic, and are best practices that are recommended to become standard practice and institutionalized across all orders and guidance moving forward.

Because of the rapidly changing nature of the pandemic, orders and guidance at all levels often had to be enacted or changed on short notice, and without opportunity for meaningful feedback from the agencies responsible for implementation. For local public health departments (LHDs), this has been a challenge, as they have had to answer questions from elected officials and constituents while still learning about newly-issued orders and guidance from the state and federal levels. There was also variation between jurisdictions on certain orders and guidance where state or federal orders were not issued, leading to public confusion over the variation in local responses. In many cases, the blame has unfairly fallen on local public health officials because of these sudden shifts and variation, and the impacts they had on communities. These challenges were raised repeatedly in the surveys and interviews conducted as part of this report, and also highlighted in other COVID-19 reports by the National Academy of Medicine and National Homeland Security Consortium. Almost all public health officials have reported harassment and death threats from people angry at how these orders and guidance

have impacted their lives, and a significant number have resigned during the pandemic. Nearly 1 in 6 Americans lost a public health leader during this pandemic, the largest exodus in American history. At times, orders and guidance were rescinded or watered down to satisfy elected officials and businesses eager to reopen, even when the threat of COVID-19 transmission remained high. This endangered those already with the highest risk of getting COVID-19, many of whom are essential workers and living in multigenerational households in neighborhoods with high community spread. These same communities also faced a lack of tailored outreach, education, and communication about the pandemic, which resulted in many community members hearing information too late or not at all, not in their spoken language, or from unofficial sources that might not have been providing accurate information (e.g., misinformation through social media, word-of-mouth).

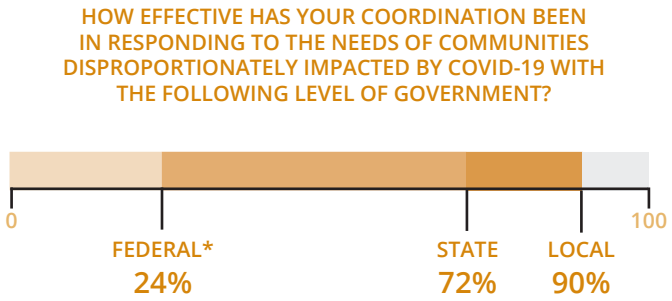
At all levels, the COVID-19 pandemic was often framed as a "public health emergency," even when a broader state of emergency was also declared or proclaimed. Framing the emergency in a broader way as a serious event that impacted not only public health, but communities as a whole, similar to the way natural disasters are framed, could have helped build greater support and encourage all sectors to come together. Moreover, a greater focus on public relations could also have helped generate greater public support and compliance with health orders and guidance that was issued based on the evidence and risk. In future emergencies, all sectors need to come together and do everything possible to protect the health and safety of everyone, especially those most impacted by COVID-19, and support the orders and guidance that scientifically-trained health professionals are issuing with equity in mind.

CHALLENGES

1. Coordination issues between different levels of government led to conflicting communications and messaging
2. Resistance from jurisdictional leadership, elected officials, other sectors, and the general public to ensure compliance with local public health officer orders undermined ability to protect impacted communities
3. Almost all health directors and health officers received harassment and even death threats
4. Health orders and guidance were difficult to communicate and disseminate to the most impacted communities

1. Coordination issues between different levels of government led to conflicting communications and messaging

There were varying levels of effectiveness with coordination reported by LHDs in both this report's survey and interviews.



*Most LHDs interviewed noted that they had very minimal direct coordination with federal entities since it was mediated through the State

In addition to the statistics above, LHDs also provided open-ended responses on experience coordinating with the state and federal levels, and there was a consensus on the following challenges. The experience of California LHDs was not unique, and these challenges were also felt by LHDs in other states and with the federal government, as highlighted in other COVID-19 reports by the National Academy of Medicine and National Homeland Security Consortium.

- Basic prevention strategies such as masking and social distancing were not always issued as statewide orders from the outset, so LHDs had to make the decision whether to issue them first. This resulted in many LHDs having to justify and battle these orders with the general public, taking time and effort away from the actual response. It also put local public health officials unnecessarily in the hot seat.

"This could be more of a partnership rather than paternalistic" LHD respondent

- Because things changed so rapidly with the pandemic, LHDs were not always given advance notice of new state orders and guidance, nor were they often given an opportunity for meaningful feedback before they were enacted. Many heard about new or changed state orders and guidance through media at the same time the public learned of them, including changes to vaccine eligibility and revisions to the reopening

framework. This resulted in LHD officials having to explain and answer questions about these new or changed state orders and guidance from a confused and angry public before they had all the information needed to implement the orders. For example, LHDs found out about both the lifting of the statewide Stay-at-Home orders in January 2021 and the Vaccine Equity Metric announcement in March 2021 from the media, with no advance notice from the State. In this report's LHD interviews, many expressed disappointment about not being given greater notice or the opportunity to provide feedback on these state orders and guidance. They spoke about being on State calls where orders and guidance were being explained as final decisions, without any chance to weigh in before enactment.

- In addition to a lack of adequate notice, there was also a lack of adequate preparation time to implement these State-issued orders and guidance. Sometimes orders were issued or lifted with no warning and went into effect immediately. Again, LHDs were not always given an adequate opportunity to provide any input on these decisions before they were made.
- State-issued orders and guidance sometimes lacked an equity focus, especially early on in the pandemic. They were also not always accompanied with policy and financial supports to ensure the most impacted communities could comply without any adverse consequences.
- City LHDs had their own challenges navigating the State's requirements, and whether they were required to submit their own plans and comply with certain orders and guidance as the local authority, or if the County was responsible for taking the lead role.

"State changes guidance and protocols without informing locals beforehand. Makes announcements on Fridays to be implemented on Mondays without warning and not heeding our feedback." LHD respondent

Best Practices

Existing regional public health department coalitions provided a valuable space for open dialogue, constructive brainstorming, and coordinated decision-making:

84% of LHD survey respondents stated that regional coordination has been effective

- In March 2020, Six Bay Area health departments acted together in issuing a regional stay-at-home order and continued to work together and coordinate in issuing orders and determining reopening strategies
- In Southern California, LHDs within the Public Health Alliance of Southern California membership provided vaccines in open tiers to people that either lived or worked in their jurisdictions. This provided regional support and recognizes that jurisdictional boundaries are fluid and that working together is an asset.

Best Practices

Regional public health department coalitions provided technical assistance and acted as a staff extender for over-stretched LHDs. They hosted regular meetings, developed equity-focused guidance documents and resources, connected LHDs with CBOs and other partners, and weighed in on policies that impacted LHDs. Specific examples from the Public Health Alliance of Southern California (Public Health Alliance), Bay Area Regional Health Inequities Initiative (BARHII) and San Joaquin Valley Public Health Consortium (SJVPHC) are provided here:

Public Health Alliance™ OF SOUTHERN CALIFORNIA

The Public Health Alliance is a coalition of executive leadership from 10 LHDs in Southern California, representing 60% of the State's population.

Early on in the pandemic, the Public Health Alliance began convening its Leadership Council, which is comprised of the 10 LHD directors in the region, on a biweekly basis to discuss emerging issues and share best practices and lessons learned. The Leadership Council approved a Rapid Response Policy Platform to allow the Public Health Alliance to act on time-sensitive COVID-19 policy actions and elevate the need for an equitable response and recovery. The Public Health Alliance's Health Equity Working Group also met monthly to share resources and discuss pressing equity issues.

The Public Health Alliance also set up a Public Health Alliance COVID-19 Resources website to post helpful information for its member LHDs to ensure an equitable response and recovery. These materials include:

- A guide for public health departments on addressing racism and discrimination during COVID-19, with specific messaging examples. This guide assisted LHDs with addressing the racism and discrimination faced by many populations disproportionately impacted by COVID-19, including the Asian American and Pacific Islander populations.
- A Vaccine Equity Video Series to elevate promising and replicable practices for equitable vaccine distribution. The series works to showcase community-informed and equity-centered practices that specifically aim to reach disproportionately impacted low-income Californians and Californians of color.
- COVID-19 Equity Snapshots, a curated, consistent resource designed to assist partners in continuing to prioritize equity and elevate the power of public health in response to the COVID-19 crisis. The snapshot topics include:
  - » Racism as a Public Health Crisis
  - » Climate & Health Equity
  - » Using Data to Advance Equity
  - » Advancing Equity for Individuals and Families Experiencing Homelessness
  - » Food Security as Equity
  - » Advancing Racial Equity
  - » Health Justice Strategies
  - » Advancing a Welcoming & Inclusive Framework
- A public health department funding brief and collateral materials to assist LHDs with making the case for increasing funding for their department in the face of budget cuts due to the COVID-19 pandemic.
- A co-developed brief and webinar with BARHII on Embedding Equity into Emergency Operations to assist LHDs throughout the State with identifying ways they can integrate equity into their emergency operations structure.

"Counties are quick to share examples of policies, procedures, practices, forms, etc. Coordination by CHEAC and CCLHO very helpful. Some coordination with neighboring counties for outreach to shared most vulnerable communities, but scheduling conflicts make it difficult" LHD respondent

Best Practices

BARHII is a coalition of 11 LHDs in the Bay Area, representing 20% of the State's population, plus the Rise Together Coalition, which includes over 200 non-profits focused on economic opportunity and racial justice.

BARHII convened its members on a monthly basis, and also provided technical assistance via webinars, learning circles, and general membership meetings on COVID-19 response, elevating best practices. Topics included:

- Black Led Recovery Roundtable
- Embedding Equity Officers in Emergency Command Centers (a co-led webinar with the Public Health Alliance)
- Safeguarding the Health of Essential Workers (done on both regional and then national level with NACCHO)
- The New Eviction Policy Landscape
- A Housing Racial Equity Lab
- Webinar on Re-Entry & COVID-19
- Understanding the Post-Election Landscape on the state & national levels and how it will inform BARHII's COVID-19 response in 2021
- Essential Worker Protections learning circles for Local Public Health Jurisdictions (a smaller roundtable for local public health jurisdictions)
- California State health equity measure meeting with regional public health directors
- Like the Public Health Alliance, BARHII also established a COVID-19 Resources website. Specific resources include:
- A Rapid Response and Rolling Recovery Framework, focused on 4 R's for an equitable response and recovery:
    1. Require Protection for Essential Workers
    2. Rebuild Stability for Families, Small Businesses and Social Enterprises
    3. Reconnect Communities and Protect Mental Wellness
    4. Revolutionize the Status Quo to Protect the Health of People of Color
- A COVID-19 Equity Investment Guide
- Op-ed pieces, briefs, and white papers related to best practices; some of these were developed in partnership with others, such as the Public Health Alliance, NACCHO, Policy Link, the UC Berkeley Labor and Occupational Health Center, and the Berkeley Media Studies Group.
- A series of focused presentations to key stakeholders

Best Practices

SAN JOAQUIN VALLEY PUBLIC HEALTH CONSORTIUM
Calaveras • Fresno • Kings • Madera • Mariposa • Merced
San Benito • San Joaquin • Stanislaus • Tulare • Tuolumne

SJVPHC is a coalition of 11 LHDs in the San Joaquin Valley, oSJVPHC is a coalition of 11 LHDs in the San Joaquin Valley, one of the largest rural and agricultural regions in the nation. SJVPHC members met twice a week or more since the early months of the pandemic, to serve as a sharing platform to exchange ideas on a host of COVID-19 related activities as well as provide mutual support around response success and challenges involving outreach and education, testing, and contact tracing activities. For example, during the meetings, those member counties with laboratory testing capacity were identified and arrangements were made for testing services to be provided for those without public health laboratories. Similarly, not all members had access to an in-house Epidemiologist, or in some cases a Health Officer, and cross jurisdictional support and services were identified and arranged. These regular Zoom meetings served a variety of purposes and were essential to the local and regional response efforts. The weekly sessions also presented the opportunity for members to meet with CDPH staff for coordination purposes (i.e., California COVID-19 Testing Task Force). SJVPHC staff also developed a regional website at Valley COVID Help and a companion site in Spanish at Ayuda del Valle COVID to simplify access to local COVID-19 information and resources for both English and Spanish-language audiences. Finally, staff arranged for a contract with a media firm — JP Marketing— for the development of localized COVID-19 media messaging and to support members' communications requirements.

In addition to regional public health department coalitions, statewide public health associations, including the California Health Executives Association of California (CHEAC) and California Conference of LHLocal Public Health Officers (CCLHO)/Health Officers Association of California (HOAC), also provided resources and a clearinghouse of COVID-19 information and updates through regular meetings, daily email updates, listservs, and other critical information sharing. For example, CHEAC sent a daily digest to local healthlocal public health department directors that packaged the Governor's press conference notes, newly-released state orders, guidance, and other resources in one email sent each evening, while HOAC sent a daily round-up of health officer orders.

As with public health department coalitions and statewide associations, the healthcare sector also found great value in a coordinated response. Early on, the Community Clinic Association of Los Angeles County (CCALAC) began regularly convening their peer network, including Chief Medical Officers and Behavioral Health Leads, to facilitate bi-directional communication and coordinated response efforts. CCALAC acted as a conduit between state partners, including the California Primary Care Association and CDPH and their clinic members. CCALAC provided templates, best practices, and compliance policies and procedures from the top down, and feedback and local needs from the bottom up. Similarly, the L.A. Care Health Plan established a standing weekly meeting (eventually shifted to monthly) with the Los Angeles County Department of Public Health and HealthNet to facilitate regular communication and coordination between public health and two health plans representing of 30% of the LA County population. This early and ongoing coordination enabled effective collaboration to manage COVID-19 outbreaks in LA County skilled-nursing facilities, and with early vaccination strategy planning.

"State has been difficult to work with regarding vulnerable populations. Feels like they are trying too hard to accommodate disparate counties which results in odd watered-down policy decisions. I'd like to see more opportunities for Counties to make their own decisions."
LHD respondent

2. Resistance from jurisdictional leadership, elected officials, other sectors and the general public to ensure compliance with local healthlocal public health officer orders undermined ability to protect impacted communities

As local public health officials issued orders and guidance, coordination with key sectors like businesses and schools often proved difficult. There were many instances of resistance to orders for closures, instituting preventative measures, and restrictions on reopening. There was a false narrative that developed, pitting public health against the economy, rather than the real message that public health officials were trying to convey: these orders were the way communities could more safely and quickly open up the economy if they were followed. There was also a lack of enforcement of health orders and guidance by law enforcement, including mask mandates. The sheriffs in Orange and Riverside counties both went on record saying they would not enforce mask requirements. Sonoma County's sheriff also did, but later backed down. Some county elected officials even rescinded health orders by legislative action. Later on in the pandemic, the push to reopen certain sectors also conflicted with health orders and guidance. Courts were involved to clarify the authority of local public health officials to issue these orders, and did not always rule in their favor. This all undermined the ability of LHDs to protect the communities most impacted by COVID-19.

Best Practices

To provide guidance on the legal authority of local publichealth officials to issue health orders and guidance in the face of threats, ChangeLab Solutions published **Legal Authority for Local Public Health Officers' & Local Governments' Responses to COVID-19 in California**.

"Sherriff and DA have publicly made their opinions known that they do not see COVID as a big deal and will not enforce"
LHD respondent

"Push to open in response to community pressures. Significant lack of support to enforce beyond educational responses from law enforcement" *LHD respondent*

A review by the Kaiser Health News service and The Associated Press found that at least 248 state and local health leaders had resigned, retired or been fired between March 31, 2020 and April 1, 2021. Nearly 1 in 6 Americans lost a public health official during the pandemic, representing the largest exodus of public health officials in American history.

3. Almost all health directors/officers received harassment and even death threats

In this report's LHD survey, **71% of local public health officials reported they received threats or harassment. In the report interviews, almost all indicated receiving death threats. In some communities, elected officials themselves were making these threats and even encouraging them.** As of April 5, 2021, 16 local public health officials and three State health officials in California had resigned. A review by the Kaiser Health News service and The Associated Press found that at least 248 state and local public health leaders had resigned, retired, or been fired between March 31, 2020 and April 1, 2021. Nearly 1 in 6 Americans lost a public health official during the pandemic, representing the largest exodus of public health officials in American history. The media has written numerous articles about this alarming trend throughout the pandemic, documenting the threats and harassment of local public health officials across the United States in communities large and small. This is an unacceptable work environment, and almost nothing was done to correct it.

These threats and harassment impacted the ability of LHDs to address the response, especially for those most impacted by COVID-19. In this report's survey, **56% of LHDs reported that political pressures/the political environment were a barrier to their response.** LHDs reported having to walk a fine line with their orders and guidance to satisfy elected officials but also ensure the health and safety of the most impacted community members, and sometimes could not take as strong an action as was necessary because of these pressures.

HEADLINES FROM VARIOUS NEWS SITES, 2020

Best Practices

- To counter these threats and harassment, many groups issued supportive statements:
  - California Endowment (June 24, 2020)
  - Trust for America's Health (June 23, 2020)
  - Public Health Alliance Statement (June 22, 2020)
  - Public Health Institute Statement (June 22, 2020)
  - Prevention Institute Statement (June 22, 2020)
  - NACCHO/Big Cities Health Coalition (June 15, 2020)
  - California Medical Association (June 4, 2020)
  - California Medical Association (Sept. 14, 2020)
- California State Senator Richard Pan also issued a statement condemning threats of violence against the Yuba-Sutter County Health Officer (May 3, 2021)
- Polls and surveys also indicated that most people were in support of public health officials and COVID-19 related measures, despite many of the threats, violence and other opposition that arose:
  - The California Health Care Foundation's COVID-19 Tracking Poll found that nearly 7 in 10 people had trust in the State and LHDs.
  - The California Endowment similarly found that nearly two-third (68%) of people supported efforts by LHDs
  - The U.S. Centers for Disease Control and Prevention found 80% of people supported stay-at-home orders and non-essential business closures
  - In a Washington Post-University of Maryland poll, people gave federal public health officials a 71% approval rating

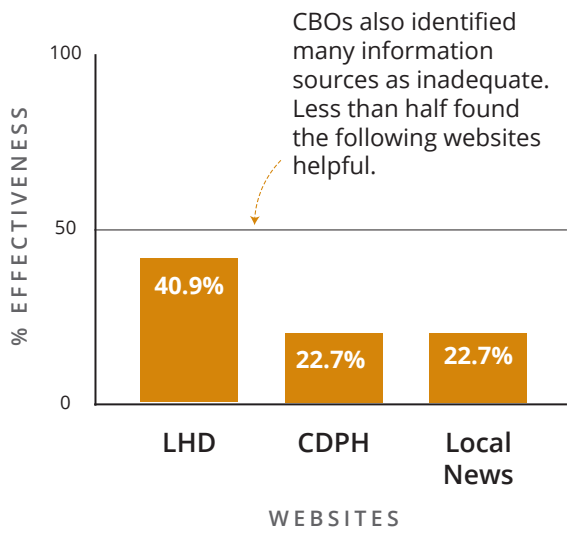
Philanthropy, including the California Endowment, also provided rapid response communications for several LHDs who were dealing with these threats. They also utilized their own social media and communications platforms to express support for local public health officials and offer a positive voice in these discussions.

"The political pressure to "reopen" and "get back to business as usual" as well as straight up opposition to "government overreach" present huge challenges to an evidence informed, effective and consistent response—caused a lot of confusion, political backlash and fueled mistrust."
LHD respondent

4. Health orders and guidance were difficult to communicate and disseminate to the most impacted communities

Because many health orders and guidance were issued on short notice and made effective immediately, not all community members were able to be reached right away via traditional communications channels. **In this report's CBO survey, the top communications challenge identified by over 50% of respondents was that the outlets for communication were not reaching the communities that they represent and/or serve. Additionally, fear of stigmatization/discrimination (42.1%) and insufficient multilingual and culturally informed information/outreach (36.8%)** rounded out the top three communication challenges.

HELPFULNESS OF INFORMATION SOURCES



Best Practices

Nearly two thirds of surveyed CBOs identified culturally informed communications/outreach (63.6%) as a key resource, and nearly 60% indicated that resources to expand testing access (59.1%) and relationships/partnerships with trusted messengers (59.1%) as important resources to increase awareness and accessibility of testing.

- Several LHDs reported conducting regular telebriefings with specific sectors throughout the response (e.g., healthcare, business, schools, etc.). For example, Fresno hosted biweekly calls with CBOs in English and Spanish to provide updates on COVID and receive feedback (https://www.centralvalleycf.org/COVIDcall/)
- Blue Shield created an ethnic media guide, and funded ethnic media outlets to provide information to the most impacted and hardest to reach communities.They also shared the guide and contact information with LHDs and community-based organizations to assist with getting the word out to media and serve as trusted messengers.
- Community partners created culturally and linguistically appropriate, community-friendly materials for COVID-19. For example, the California Pan-Ethnic Health Network (CPEHN) collected best practices from their network, which include:
  - Mental Health: Black Women for Wellness in Los Angeles produced a guide on Wellness & COVID-19
  - Immigrants:
    - CHIRLA in LA produced COVID-19 Know Your Rights Materials in English and Spanish
    - California Rural Legal Aid Foundation has a comprehensive guide for immigrants in the Central Valley in English and Spanish
- Indigenous Peoples: CIELO compiled resources in indigenous languages
- Stimulus check: Neighborhood Legal Services of Los Angeles County produced fact sheets on the stimulus check in English (COVID-19 Stimulus Check Eng.pdf) and Spanish (COVID-19 Stimulus Check SPN.pdf)

Recommendations

Ensure that State of Emergency Declarations at all levels are broadly framed and communicated

Governments at all levels in California declared states of emergency early on the pandemic, but in many cases these declarations were messaged narrowly as public health emergencies. This led many people to underappreciate the magnitude and threat of the pandemic, compared to a wildfire or other natural disaster that has widespread community impacts. As detailed in the National Homeland Security Consortium's report on the COVID-19 pandemic, this emergency more closely resembled a natural disaster than most recent public health emergencies, as for the first time in U.S. history, all 50 states and territories were under a simultaneous emergency declaration. In the future, it is important that when states of emergency are declared for pandemics and other major public health threats, they are framed more broadly so that all sectors are supportive and encouraged to come together to address the public's health and safety. There is also a need in the future for greater clarity and guidance on how non-health sectors can support public health orders to ensure protections for the communities likely to be most impacted when a state of emergency is declared.

Develop community-informed mitigation plans that analyze equity impacts and incorporate equity metrics into health orders and guidance

Because the pandemic response was a fast-moving situation, many health orders and guidance at both the local and state level had to be issued on short notice, and immediate inequities unfolded. Later on, the State was able to be more proactive about addressing equity in the response, including the incorporation of equity metrics into the reopening and vaccine distribution processes. In the future, it will be helpful to build off of these models and develop community-informed mitigation plans at the local and state levels before enacting all orders, guidance, and policies. These plans would be guided by a funded and nimble community advisory committee, and include an equity analysis that identifies the equity impacts and assesses how to address them. Equity metrics would be incorporated to ensure that policies, investments and resources prioritize the most impacted communities. The plan would ideally include specific policy and financial supports that could lessen or eliminate adverse equity impacts, and a timeline for implementation, if they are not feasible in advance. The plan could also assess the policy implications of enacting an order, as well as identify the potential opposition and approaches for addressing it. This is an important

"[Local health department staff] need our support. The experts who comprise our public health departments are true heroes. We should be thanking them for their tireless work and heeding their advice, not threatening their safety and careers." National Association of City and County Health Officials, ***Compromising the Role of Public Health Officials Makes Our Nation Less Safe***

paradigm shift in governmental operations that will help elevate equity and ensure that orders, guidance and policies do not adversely impact the hardest hit communities. It is also an opportunity to establish and institutionalize a funded community advisory committee to advise local and state health departments on equity across their operations. Tying health orders more directly to equity metrics, including financial aid and policy supports, will help truly implement the order, provide the resources for social needs that will be impacted by the health orders, and make it easier to comply and avoid adverse financial impacts.

Foster greater public courage in support of Local Public Health Officials

Public health officials shared that they work to prioritize the most impacted communities when issuing orders and guidance. When challenged by elected officials or individuals within their own community, it threatens the safety of everyone. It is important for people in positions of power to support the ability of local public health officials to issue local public health orders that are stricter than State guidance when local conditions warrant, and to encourage and incentivize compliance with orders and guidance. Moreover, it is important to support their encouragement of other sectors to do their part in supporting the most impacted communities. For example, the De Beaumont Foundation's 7 Ways to Align Business & Health provides concrete examples of how to promote greater coordination between the business and health communities. Finally, when local public health officials receive threats, harassment, or violence, State and local leaders need to denounce those activities, and take action. State and local officials could consider administrative/legislative actions that reaffirm public authority in times of emergency and bolster the protection and authority of local public health officials. Our society needs to create a culture with greater courage to stand up for and support public health officials in the face of threats, where there is an immediate and united response in support of these officials rather than staying silent and letting the loudest and most critical voices dominate.

"The efforts to bully and sideline public health officials must stop. We are in the midst of a deadly pandemic, and in order to respond to and recover from it, we must have a robust public health system that rewards—rather than sanctions—strong, honest public health leadership and expertise....More than ever, our lives depend on being able to trust guidance from public health leaders and departments. When we silence or threaten those charged with safeguarding the public's health, we undermine our ability to keep communities as healthy as possible." Prevention Institute, ***Stand up for public health leadership today***

Implement basic preventative measures at the Federal or State level

Because the COVID-19 pandemic unfolded quickly and rapidly evolved, coordination between different levels of government was not always as effective as it could be or even possible. An example of this was the issuance of some basic preventative measures that are universally known to provide protection (e.g. masks, social distancing, closure of certain businesses/facilities). In many cases, LHDs acted quickly and issued orders on things like mask requirements before the State was able to act, but this led to confusion when there was variation between communities. In the future, it will be helpful if the state or federal government takes the lead on issuing these basic prevention measures so that local public health officials can focus more efficiently on orders and guidance that are specific to their communities. Prevention is the same regardless of where you live, and things like mask mandates proved to be more of a battleground than they imagined. In addition, LHDs were often stymied by elected officials or other public officials within their jurisdictions who were leading on messaging instead of them. It is important that these local public health officials have encouragement and authority to lead on messaging and communications and that their credibility is not undermined by other decisionmakers within their communities.

Provide local public health departments with more advanced notice and a greater opportunity for meaningful feedback before enacting or changing state orders and guidance

Recognizing that the COVID-19 pandemic unfolded quickly and evolved rapidly, and that notice and feedback were not always possible, it is important that LHDs have the opportunity to coordinate with other levels of government, as well as other agencies within their jurisdiction, on the issuance of orders and guidance that impact their communities. To that end, the following are important for local, state, federal and other levels of government to consider to promote greater coordination and effectiveness with LHDs moving forward. These recommendations were lifted up by LHDs in the surveys and interviews we conducted, and also recommended by the National Homeland Security Commission in their COVID-19 report:

- Provide Provide more advanced notice about upcoming orders, guidance and policies to LHDs before they are implemented.
- Provide a greater opportunity for meaningful feedback from LHDs before orders, guidance and policies are enacted, so that local health officials can help identify the impacts, challenges and any unintended consequences.
- Share materials in advance of calls discussing these orders, guidance and policies
- Notify LHD executives before notifying the media, elected officials and public so that they learn of shifts in orders and guidance beforehand and have the needed context and can answer questions.
- Provide a minimum amount of time before orders, guidance, policies, etc. go into effect so that LHDs have time to prepare coordination.
- Ensure that other impacted sectors and communities receive adequate notice and a realistic timeline to ensure they avoid adverse impacts.
- Provide LHDs with a transparent, full list of State-level contacts so they can identify the right person to support them with a variety of different queries and assistance needs. This list needs to be updated frequently and have full contact information so that officials who to contact with specific requests or questions.

Fund regional public health department coalitions to facilitate collaboration and provide technical assistance

In this report's LHD survey, 84% of respondents stated that regional coordination has been effective. The forum provided by regional public health department coalitions has been one of the most important places where neighboring LHDs have been able to work together to ensure an equitable response and recovery. Health orders and guidance that cross jurisdictional boundaries are more effective than those that are siloed, and discourage people from going to the next city or county to engage in activities not allowed in their own jurisdiction. Supporting these regional public health department coalitions in building regional capacity to elevate equity is critical for their ongoing equity work, as well as preparing for future emergencies. The regional public health department coalitions including: the Public Health Alliance of Southern California (Public Health Alliance); the Bay Area Regional Health Inequities Initiative (BARHII); and the San Joaquin Valley Public Health Consortium (SJVPHC), have an important role in convening LHDs, sharing updates, providing technical assistance, and generating regionally-specific guidance and resources. They have deep relationships and are trusted partners with many LHDs and community-based organizations, and demonstrated experience bridging these relationships and providing technical assistance at a regionally focused level. These groups need more support and resources to assist their members with elevating health equity and acting in a more collaborative and coordinated way on LHD operations, public guidance, and policymaking.

Ensure culturally competent communications and messaging about orders/guidance

Because orders and guidance shift rapidly in an emergency, there needs to be a greater emphasis on ensuring all communications and messaging can reach everyone, especially those who will be most impacted. It is important that all health orders and guidance be translated into multiple languages, and disseminated via ethnic media and other platforms where they can reach their intended audiences. Community-based organizations need to be looked toward as trusted messengers to deliver these communications to the most impacted communities.

Engage public relations for public health messaging

Communications has been a major challenge for LHDs during the pandemic, and a stronger focus on public relations could have helped garner more support. The message that public health orders actually help us reopen the economy more quickly and safely could have been more effectively conveyed early on in the pandemic to combat the resistance that emerged. Instead, it got lost, and counter-messaging stating the exact opposite got stronger as pressure to reopen grew. State and LHDs would benefit from hiring a public relations firm to assist with messaging local and state health orders and developing a comprehensive and equity-focused communications strategy. This strategy could assist with more effectively translating the science into more compelling messages, and reaching target audiences such as elected officials. There are national examples such as the Public Health Communications Collaborative that have developed communications materials from a national perspective, but a more localized public relations efforts would reach more people locally and build greater support among communities across the State and encourage them to do their part to defeat COVID-19.

"Public health really needs a heavy communications budget. Not health education professionals, but communications and public relations firms. The messaging would be better embedded in the psyche of the communities, it would make it be a value" *Philanthropy executive interviewee*

"Public health needs a PR Agent" *Philanthropy executive interviewee*

7

Build Effective, Actionable Partnerships Between Public Health and Healthcare Systems

RECOMMENDATIONS

- Build and Support Stronger Partnerships Between Healthcare, Public Health, and Communities
- Develop a Unified, Bidirectional Statewide Health Information Exchange
- Establish Effective, Efficient, Ethical, and Equitable Data Sharing Agreements
- Embed Equity into Healthcare System Emergency Response Structures
- Assess and Address Healthcare System Vulnerabilities for Future Emergencies
- Improve Oversight and Resilience of Long-Term Care Facilities
- Support and Expand Opportunities for Telehealth and Telemedicine
- Incentivize Pay for Value-Based Care versus Volume
- Leverage Resources Made Available through Medicaid Demonstration Waivers to Advance Health Equity
- Establish Collaboratively Funded Investment Mechanisms to Advance Equity and Prevention
- Ensure Existing Healthcare Funding Streams Include Investments in Prevention and Local Public Health Departments

OVERVIEW

The COVID-19 emergency has necessitated rapid changes across the healthcare sector to meet the needs of patients and communities. The healthcare system, including health plans, hospitals, and clinics, quickly responded to address emerging needs, from mailed prescriptions and telemedicine appointments, to COVID-19 testing and distributing Personal Protective Equipment (PPE), to food distribution and providing internet access. Given the complex and evolving nature of the pandemic, with far-reaching impacts from acute disease incidence to sweeping economic and social impacts, this crisis required coordinated action across California's health system in the broadest sense, including local public health departments (LHDs), health plans, clinics, and more. This crisis made it abundantly clear that the siloed nature of healthcare and public health systems hindered the COVID-19 response and undermined shared goals of reducing health disparities and advancing health equity. In regions where healthcare, public health, and community partners had established relationships, all sectors were able to more effectively and equitably meet the needs of patients, providers, and communities. The COVID-19 emergency sharply elevated the urgency for an integrated, efficient, and coordinated continuum of care between public health and the healthcare system.

While the healthcare system pivoted quickly to support patients, providers, and communities throughout the crisis, it is clear that rapid and meaningful structural changes are needed to ensure the health system is equipped to elevate health equity and protect and support the health of residents, especially those most impacted by inequities. The healthcare system is poised to make lasting changes in data processes and infrastructure, provision of care to the most impacted communities, equity in emergency response operations, and coordinated oversight of ancillary healthcare facilities.

Furthermore, the stark inequities of the COVID-19 emergency, when combined with the clear disparities based on community conditions and structural racism, have contributed to a growing awareness and motivation within the healthcare system to engage in upstream social determinants of health policy, systems, and environmental work. Healthcare leaders described the rapid increase in social needs (e.g. food and housing support) among their patients and were surprised to learn how thin a financial and social margin many of their patients were living on. It is important to note that social needs and social determinants of health are fundamentally different and require drastically different strategies. Social needs are midstream factors such as a family's need for access to healthy food, which may be addressed by a regular food distribution program, while social determinants of

health are structural, systemic, and political factors, like lack of grocery stores in certain neighborhoods, and income inequality. The healthcare system has often been engaged in and supportive of social needs, but has generally not participated in upstream social determinants of health work. The COVID-19 pandemic however can be the catalyst for a shift. The expanded understanding and motivation to engage in the root causes of poor health outcomes and inequities will require meaningful, resourced partnership with the communities served by healthcare systems and public health partners. Hospitals and healthcare facilities have often functioned as anchor institutions in under-resourced communities, and now the healthcare system has an opportunity to further engage with, uplift, and be held accountable by their communities.

SOCIAL DETERMINANTS AND SOCIAL NEEDS

Figure 1. Social Determinants and Social Needs

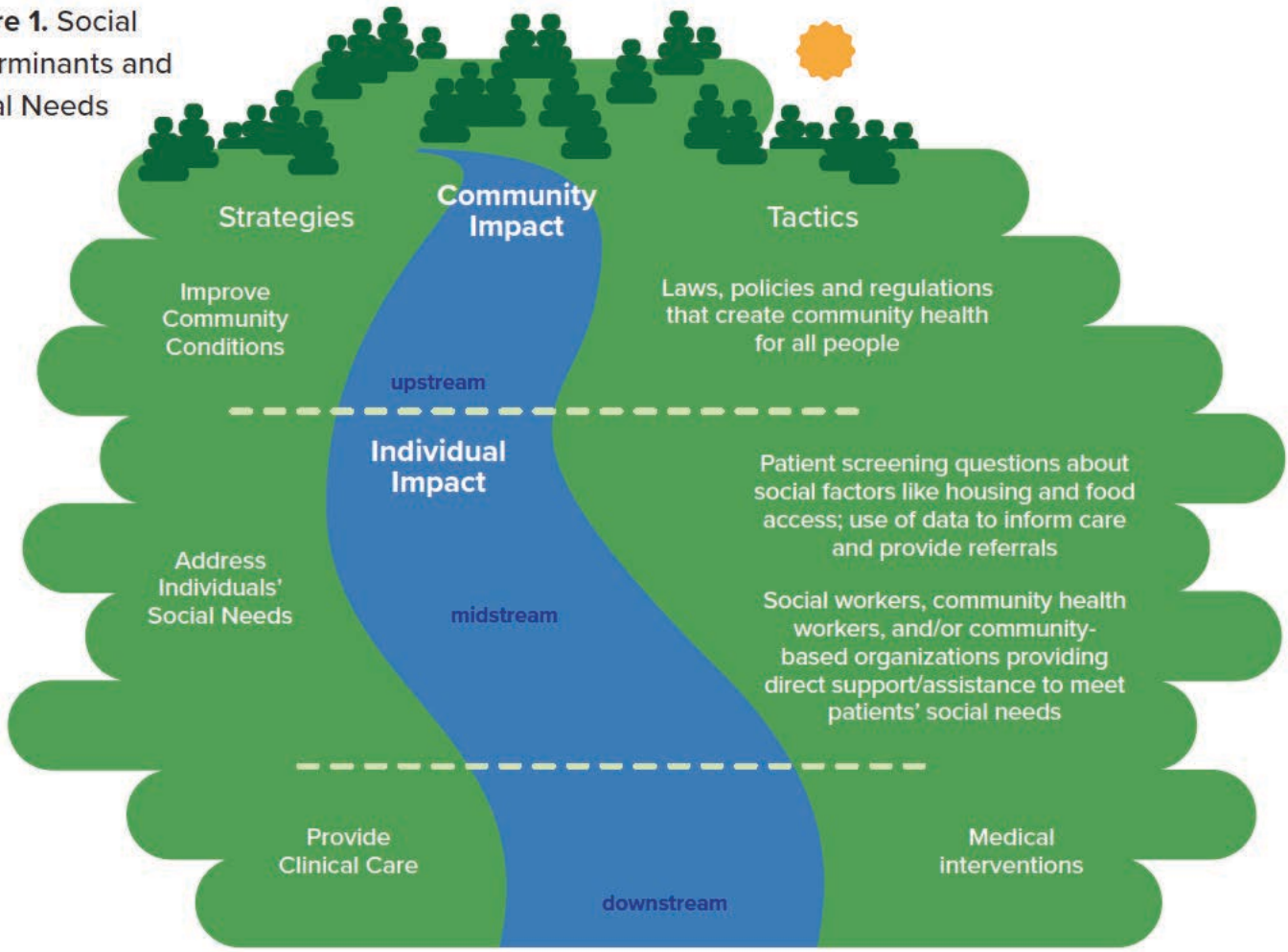


Figure adapted from https://www.healthaffairs.org

CHALLENGES

1. Overall lack of coordination and communication between the public health and healthcare systems
2. Difficulties making organizational and operational changes to reflect different local public health orders
3. Challenges collecting, sharing, and using data between healthcare systems and public health
4. Inability to capture inequities using global, aggregated data analysis
5. Dramatic increase in social needs rapidly followed "stay at home" orders and business closures
6. Limited ability to address root causes of COVID-19 disproportionate impacts
7. COVID-19 revealed the serious vulnerability of long-term care facilities
8. Healthcare system is more prepared for short-term than long-term emergencies
9. Negative financial impact on the healthcare system

1. Overall lack of coordination and communication between public health and healthcare Systems

Despite the dire need for a joint response, healthcare and public health leaders described challenges in coordinating and routinely communicating across sectors. Some healthcare leaders noted that they made efforts to engage with their respective LHDs, but due to the intensity of the response activities and public health's limited staff capacity, they were often unable to coordinate. Healthcare leaders noted that due to high staff turnover both within the state and local public health departments, it was often unclear what the chain of command was and who was leading specific response activities. There was a similar challenge in identifying which local agencies were responsible for which activities and programs within a jurisdiction. It was often difficult for the healthcare sector to determine which local agency they should contact and coordinate with for specific needs, such as contact tracing or food

"Coordinating the response would have been easier with stronger relationships with CDPH, we need to know where the conversations are happening, who is engaging where, and what is the chain of command" Healthcare interviewee

distribution. One healthcare leader noted that "there were unclear channels, no one knew who was doing what, the City, the Sheriff's Department, the County Health Department, Department of Health and Human Services…" Additionally, some healthcare leaders described that their clinic members were left out of important conversations regarding testing and vaccine allocation planning, while many of the local hospitals were continuously engaged. Among healthcare sector interviewees, there was general consensus that while some LHDs effectively communicated and coordinated, overall there was a lack of coordination that would have enabled a more effective and equitable response.

Best Practices

Despite the challenges outlined above, according to healthcare leaders, the COVID-19 response strengthened relationships between LHDs and the healthcare system overall. Furthermore, healthcare systems with established relationships with LHDs and community-serving organizations were better positioned to support a coordinated response.

ESTABLISHED COMMUNICATION AND COORDINATION

Early on in the COVID-19 emergency the **L.A. Care Health Plan** established a standing weekly meeting (eventually shifted to monthly) with the **Los Angeles County Department of Public Health** and **HealthNet** to facilitate regular communication and coordination between public health and the two health plans representing 30% of the LA County population. This early and ongoing coordination enabled effective collaboration to manage COVID-19 outbreaks in LA County skilled-nursing facilities, and with early vaccination strategy planning. Similarly, the **Inland Empire Health Plan** (IEHP) worked closely with San Bernardino and Riverside Health Departments to coordinate messaging and response. For example, IEHP collaborated with both LHDs to develop all of the COVID-19 related scripting for their nurse advice line to minimize contradictions and provide consistent messaging to the community. The **California Primary Care Association** described how a standing relationship with CDPH, through a grant and contract in place pre-COVID, helped facilitate communication, coordination, and an understanding of the protocols put in place to manage the pandemic.

CROSS-JURISDICTION COORDINATION

Health plans and regional trade associations that provided coverage or representation across multiple counties and jurisdictions were able to help facilitate the sharing of best practices between LHDs. IEHP helped facilitate information sharing and collaboration in the Inland Empire region to coordinate COVID-19 response strategies. For example, IEHP was able to share information and facilitate dialogue between San Bernardino and Riverside Counties regarding Riverside County's response to COVID-19 outbreaks in skilled nursing facilities. Ultimately, San Bernardino County enacted the same strategy as Riverside; partnering with the federal government to deploy the CDC strike team.

2. Difficulties making organizational and operational changes to reflect different local public health orders

Among healthcare systems and plans that provide coverage or services across multiple jurisdictions, interviewees described the ongoing challenge of making organizational and operational changes to reflect the different health orders in effect in different jurisdictions. Healthcare leaders described differing guidance related to testing and vaccine allocation as a major challenge, in some cases hindering their ability to respond as efficiently or effectively as they would have under uniform guidance. Others also described challenges understanding and coordinating guidance from different state-level agencies. Lack of uniformity in state and local level COVID-19 related guidance limited the healthcare systems ability to enact streamlined, uniform policies and practices across their networks and facilities.

Best Practices

Throughout the COVID-19 response, regional trade organizations, professional associations, and other coalitions served a critical role in shaping coordinated responses across the healthcare system, including health plans, hospitals and clinics. They include the California Primary Care Association (CPCA), which represents more than 1,380 not-for-profit community health centers, and Regional Clinic Associations, including the Community Clinic Association of Los Angeles County (CCALAC). Representatives from both organizations described strategies to provide support, bi-directional communication, and joint advocacy to support providers and patients. CPCA described rapid advocacy for telemedicine coverage as the most critical policy to supporting the needs of patients and providers during the COVID-19 emergency; within three days of the statewide shelter in place order, there was approval for telehealth. Additionally, CPCA quickly shifted the technical assistance they provided to their members, including holding weekly information sessions on medical and policy related topics. Similarly, CCALAC began regularly convening their peer network, including Chief Medical Officers and Behavioral Health Leads, to facilitate bi-directional communication and coordinated response efforts. CCALAC acted as a conduit between state partners, including the CPCA and CDPH, and their clinic members. CCALAC provided templates, best practices, and compliance policies and procedures from the top down, and feedback and local needs from the bottom up. (For information on public health coordination see **"Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts When Issuing Health Orders and Guidance"**).

3. Challenges collecting, sharing, and using data between healthcare systems and public health

Throughout the COVID-19 emergency the healthcare system has described challenges collecting, sharing, and using data to coordinate with public health agencies at the local, state, and federal levels. The overarching challenges were the lack of consistency in indicators and data, as well as inadequate data and reporting infrastructure. There was not a set list of indicators collected by the healthcare and public health system, or an efficient way to transmit this information between collaborating entities. With limited cooperation, each LHD sets its own preferred format for, and method of receiving, reports. As a result, hospital systems were being required to produce multiple versions of the same report and transmit them in multiple ways, including via fax, secure email, or secure file transfer protocol (SFTP). Many healthcare leaders shared that they had inadequate access to data and that voluntary sharing protocols left a lot of gaps in necessary information. For example, LA Care Health Plan shared that they had inadequate access to death data, while the CPCA noted that primary care providers were unable to obtain COVID-19 testing data from OPTUM, which partnered with the State to expand COVID-19 testing capacity. Others described being able to get better and more consistent data from clinical laboratories like LabCorp and Quest than LHDs. One county echoed this from the perspective of the LHD, noting that "providers are to the point where they can export a lot of info from their EHRs [electronic health records], but LHDs have no way to get it into CalREDIE in a timely way." As a statewide healthcare system, Kaiser Permanente (KP), described how inconsistent reporting requirements across counties, made it very difficult to efficiently share data across counties, both within the KP network and with LHDs.

Best Practices

In Spring and early-Summer 2020, KP worked with the Public Health Alliance of Southern California to better understand gaps and barriers in data sharing between healthcare systems, health plans, and LHDs. The Public Health Alliance facilitated conversations between KP and LHD epidemiologists, and followed up via individual and small group interviews with LHD data staff. These discussions yielded valuable insights into the challenges introduced through inter-system data sharing, and identified opportunities for improvement.

4. Unable to capture inequities using global, aggregated data analysis

Disaggregating data is one of the best approaches to identifying health disparities. Failing to stratify data can hide inequities in COVID-19 health impacts. When data are not disaggregated by race/ethnicity, sexual orientation/gender identity (SOGI), and other demographics, healthcare and public health systems are unable to respond with targeted outreach and education, programs, and resources, further exacerbating inequities among disproportionately impacted communities. Some healthcare systems acknowledged that they do not typically analyze data disaggregated by race/ethnicity and other demographics, which would identify health inequities, but rather look at global outcomes. Another healthcare system reported that their response could have been more impactful if they had received and been able to act upon disaggregated data earlier on in the pandemic. As discussed in greater detail in the "Catalyze Transformative Shifts in Utilizing Data" chapter, LHDs on the receiving end of data reported by hospitals and healthcare

systems, frequently reported that important demographic characteristics, like race/ethnicity, were left blank or filled in with "other" or "unknown". This suggests that, in addition to a change in data analysis practices, a shift in training at the provider level is required, emphasizing the importance of accurately capturing demographic measures.

The COVID-19 emergency made it clear that data collection, analysis and reporting methods need to modernize, and include a focus on disaggregated data.

5. Dramatic increase in social needs rapidly followed "stay at home" orders and business closures

It is well documented that the COVID-19 emergency and associated economic recession have had dire impacts on individuals, families, and communities, especially communities of color, low-wage workers, and those already experiencing inequities due race and/or place. Job and income loss, loss of insurance, and other economic impacts placed people in a position of reliance on emergency support systems that many had never relied on before. This increased demand taxed support systems and networks that were never intended to meet the sustained needs caused by a national emergency, and generally had to operate with fewer donations and volunteers. Feeding America estimates that 45 million people (13.9%), including 15 million children (19.9%) experienced food insecurity in 2020, relative to 35 million people (10.9%), including 11 million children (14.6%) in 2019. Nearly 95% of the community survey respondents reported that healthy food access was a major concern for their communities, while 74% identified the overburdened emergency food system as a serious concern. Over 90% of community survey respondents indicated that inability to pay rent was also a major concern, along with threat of eviction (75% of respondents). While emergency support networks, community-based organizations (CBOs), and LHDs were on the frontlines of trying to meet these needs, healthcare systems and providers also witnessed the dramatic increase in social needs first hand. LA Care described the rapid increase in member use of their platform to search for reduced cost services, citing that the top searches were "food" followed by "housing." CCALAC also described concerns about the digital divide, and acknowledged that while the rapid increase in telehealth is vitally important, there are still serious inequities in access to the internet and technology.

Best Practices

Health plans and healthcare systems responded quickly to meet the growing social needs of their members and patients. Some provided direct supports to individuals and families, while others drastically increased their capacity to connect people to other organizations and resources to meet social needs. Kaiser Permanente established a help line for the specific purpose of connecting patients to social needs resources, while Blue Shield expanded upon their existing relationship with Unite Us to increase providers ability to connect patients to organizations providing social needs resources. Blue Shield also supported patients by waiving co-payments, co-insurance, and deductibles associated with COVID-19 treatment. A number of health plans, including LA Care and IEHP, directed outreach to patients, redirected grant dollars to support food distribution activities, partnered with food distribution organizations, and, in some cases, delivered meals to patients. LA Care operated several food distribution events out of their community resource centers, at which patients were also able to use the Internet to attend telehealth appointments and search for other resources.

6. Inability to address root causes of COVID-19 disproportionate impacts

Our healthcare system is not currently designed to address the social determinants of health. As described above, many health plans and healthcare systems are striving to more effectively address the social needs of their patients and communities, but very few have been able to actively engage in policy, systems, and environmental change related to the social determinants of health. The disproportionate impacts of the COVID-19 pandemic, including deaths, infections, and economic factors are driven by systemic inequities and structural racism, making it abundantly clear that the healthcare sector needs to be involved in upstream strategies. Health plans described that while they are responsible for paying for healthcare and addressing downstream health impacts, they are not involved in social determinants of health work, although they generally feel as if they should be. Healthcare leaders described the need for guidance from their LHDs and CBOs on engaging in upstream strategies to advance health equity.

Best Practices

While many healthcare systems are still largely addressing social needs and have yet to expand their scope to focus on the social determinants of health, there are some early adopters who are paving the way. In November 2019, the **Healthcare Anchor Network**, a group of 14 hospital and health systems, announced a collective $700 million investment in place-based initiatives focused on the social determinants of health. The primary goal is to generate sustainable returns on investment while also deploying capital to address social determinants of health needs in their communities. Examples of place-based investments include affordable housing, grocery stores in food deserts, childcare centers, Federally Qualified Health Centers, and local business investments.

For more information see **Healthcare Anchor Network** and the Public Health Alliance of Southern California's **Innovative Community Investment Strategies** brief.

"The healthcare system reimbursement model is inherently racist, it places all the power with the payer, not with the patient, in the safety-net system the payer decides what you need" *Healthcare interviewee*

"COVID impacts made it clear that equity and SDOH must be at the forefront of healthcare" *Healthcare interviewee*

7. COVID-19 revealed the serious vulnerability of long-term care facilities

As of July 2022, over one third of all US COVID-19 deaths, or 184,000, were linked to long-term care facilities, including residents and employees, with over 10,236 COVID-19 deaths associated with skilled-nursing facilities in California. Numerous LHD, healthcare system, and health plan executives shared the challenges and missed opportunities to more effectively coordinated with and support long-term care facilities. One health plan reported that preventing and responding to outbreaks in SNFs was one of the most challenging efforts to coordinate given the numerous actors involved in oversight and regulation, sharing one specific point of confusion regarding who was responsible for paying for containment testing, the facility itself, the health plan, or the California Department of Public Health (CDPH).

Long-term care facilities (LTCFs), including skilled-nursing facilities (SNFs) and assisted-living facilities (ALFs), and their residents and staff are uniquely vulnerable to a respiratory illness like COVID-19: the residents are generally older, often with underlying health conditions; they live in congregate settings; and often receiving hands-on care from staff who are also caring for multiple patients. Due to low wages and part-time positions, many employees work at multiple facilities, complicating attempts to contain outbreaks in single facilities. Furthermore, there were many intersecting factors that caused LTCFs to be very vulnerable to the pandemic, including:

- The national PPE shortage; and the focus on prioritizing PPE in hospitals over SNFs/ALFs when supplies were limited;
- Transfer of COVID infected patients from acute care settings into overcrowded unprepared SNFs;
- Inadequate infection prevention (IP) protocols from the federal government and lack of IP training for SNF and ALF staff;
    - » Inexperienced and inadequately trained and supported staff.
    - » Inconsistent containment testing for residents and employees.
- Inconsistent messaging and lack of clear communication to families and SNF/ALF visitors about infection prevention protocols;
- Direct care workforce shortage, resulting in even higher turnover in historically understaffed SNF facilities.
    - » Many SNF workers did not feel adequately protected (lack of PPE and IP protocols) and quit their jobs or sought higher paying, safer jobs in other industries.
    - » Many SNF workers quit because they lacked childcare during the pandemic.
- Lack of paid sick leave for workers forced many to come to work when ill and spread infection;
- Overcrowded SNFs with 2-3 residents per room sharing bathroom facilities;
- Aging SNF infrastructure with buildings lacking proper ventilation and other amenities for infection prevention;
- Long-Term Care Ombudsmen, who play a key role in protecting long term care facilities residents in California were prevented from entering facilities during the shut-down, leaving residents and families with little or no oversight or advocacy.

There are many agencies that share regulatory and oversight responsibilities for long term care facilities in California. The California Department of Public Health licenses and regulates Skilled Nursing Facilities. The California Department of Social Services licenses Residential Care and Assisted Living Facilities. Additionally, the Long-Term Care Ombudsman Office also provides an important role in oversight and protection of long-term care

residents, helping to mediate and initiate complaints and conflicts in both SNFs and ALFs. During the pandemic, there was a lack of coordination between the multiple oversight state agencies and local public health and social services departments, all issuing their own, sometimes conflicting guidance—leading to a great deal of confusion across facilities and family members.

Generally, LTCFs receive one routine inspection per year, in addition to complaint-based inspections. When the COVID pandemic hit, they paused the regular yearly inspections so regulators could focus on facilities with outbreaks. Additionally, LTC Ombudsman were prevented from entering facilities at all and families were not allowed in to advocate for residents and issue complaints. Furthermore, in August 2020, CDPH provided changes in guidance to skilled-nursing facility inspectors, instructing inspectors to take a more cooperative and "consultative" approach with the facilities when they encountered violations. Some stakeholders vocalized concerns about this approach, indicating that this change in guidance could reduce accountability and requirements to address documented violations in a given time period. While this issue is still evolving at the time of publication, it presents an opportunity to increase transparent and independent oversight of long-term care facilities.

Best Practices

The California Department of Public Health, in alignment with the Centers for Disease Control and Prevention (CDC) model, developed a skilled nursing facility strike team to help mitigate and contain COVID-19 in California facilities. CDPH provided resources for SNFs to help prevent, detect, and prepare for COVID-19, including **Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19**, and **Detection and Management of COVID-19 Cases in Skilled Nursing Facilities**. In January 2021 CDPH issued an **All Facilities Letter** to notify all SNFs that they "can seek cost-sharing assistance and a state staffing contract to help increase staffing level," given the major strain on SNF staffing levels. The CDC also developed specific guidance for nursing homes, **Interim Infection Prevention and Control Recommendations to Prevent and SARS-CoV-2 Spread in Nursing Homes**, as well as a **Nursing Home Infection Preventionist Training Course**.

The California Department of Aging worked with the Alzheimer's Association to conduct **low-tech webinars** for caretakes, family, and friends through statewide calls in multiple languages to help educate families on safety, support, and resources related to the COVID-19 emergency. These webinars were conducted in multiple languages with community partners to increase accessibility.

County of Santa Clara Emergency Operations Center organized local resources to meet the projected staffing needs for skilled nursing facilities, distributing **a survey** for residents to document specific skills and match them with the needs of SNFs in the county. San Mateo County Health and the Health Plan of San Mateo designated three SNFs as **Centers of Excellence**, based on "high standards of patient care and expertise with infection control," tasked with providing care to COVID-19 positive patients requiring a higher level of care.

For additional nationwide best practices see The Centers for Medicare and Medicaid Services **Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes**.

8. Healthcare system is more prepared for short-term than long-term emergencies

As the pandemic progressively worsened, it quickly became clear that the healthcare system was not prepared for an emergency the scope, magnitude or duration of the COVID-19 pandemic. Healthcare providers were donning makeshift PPE, hospitals were forced to move ventilators from one patient to another, and cities were establishing temporary morgues outside of hospitals. While the PPE supply chain eventually improved, private companies began producing hand sanitizer, and manufacturers refurbished and built more ventilators, the healthcare system will remain vulnerable to future emergencies without significant changes in emergency preparedness and planning. Personal Protective Equipment supply has emerged as a critical issue throughout this emergency, triggering a nationwide shortage for healthcare providers and the general public. Some hospitals reported using a typical year's supply of masks in less than 10 days. One healthcare system described how emergency planning is often siloed in one branch or office of the healthcare system or facility, lacking a broader coordinated approach and planning process. Another health plan shared concerns related to regional emergencies, such as earthquakes, and the healthcare system's ability to respond in such an event given limited PPE supplies and a lack of coordinated cross-sector emergency planning.

Best Practices

RAPID ACQUISITION AND DISTRIBUTION OF PERSONAL PROTECTIVE EQUIPMENT

Early in the pandemic response, health plans and healthcare systems acted quickly to support providers and facilities in acquiring and distributing PPE and other essential supplies. In many cases, health plans or regional trade associations were able to leverage existing relationships to quickly purchase and distribute supplies to provider networks. For example, IEHP spent over $3 million in reserve funding to purchase PPE for providers in the Inland Empire. Kaiser Permanente established regional and national command centers to effectively acquire and distribute PPE and medical supplies, while also addressing regional variations in need and capacity. Local public health departments also played an important role in distributing PPE to providers and communities, often those who have been disproportionately impacted by COVID-19. The California Primary Care Association described Los Angeles County Department of Public Health's partnership with community clinics to distribute PPE as a successful model.

IMPLEMENTED STRATEGIES TO REDUCE EXPOSURE RISK AND BURDEN ON HEALTH SYSTEMS

Despite the immense challenges posed by the COVID-19 emergency, the healthcare sector was able to employ rapid, innovative strategies to reduce exposure risk of patients and providers, and reduce the burden on hospitals. The Inland Empire Health Plan implemented several strategies to further these efforts. They quickly shifted all prescriptions to 90-day by-mail to support and protect patients, while ensuring continuity of medication management. The Inland Empire Health Plan also implemented a strategy early on to keep less ill patients out of the hospital while reducing the burden on hospitals; IEHP secured 500 oxygen concentrators that could be sent home with and used by patients, who were also seen daily by a provider via a telemedicine appointment. The Inland Empire Health Plan also recognized the immense burden being placed on skilled nursing facilities (SNFs) to care for COVID-19 positive patients with limited staffing, supplies, and support. In response to this, the health plan paid SNFs an additional amount per day per COVID-19 positive patient. These are only a few of many examples of innovation employed by the healthcare system in response to the COVID-19 emergency.

9. Negative financial impact on the healthcare system

The healthcare system, including health plans, hospitals and clinics, and providers have been deeply impacted by the pandemic. While COVID-19 created an increased demand for specialized acute care, including providers and equipment in hospitals across the country, it also left many office-based small, rural, and safety-net providers with up to 60% reductions in visit volumes and on the brink of financial collapse. This is extremely concerning both for providers and the communities they serve, who are often un- or under-insured and lower-income. The Community Clinic Association of Los Angeles County noted a rapid decrease in drop-in visits, preventive services, and elective surgeries. Furthermore, IEHP described how postponement of preventive visits and elective procedures put many non-capitated specialist providers (those who are reimbursed based on a fee-for-service structure) at serious financial risk, which impacts both the provider, the facility, and the surrounding community. Another factor that seriously impacted the healthcare system, safety-net providers, and clinics in particular, is the reality that many have had to absorb the costs of vaccines, while spending large sums on PPE for staff and patients. These factors placed major financial burdens on clinics that already operate on very thin margins, while serving many of the most disproportionately impacted communities.

Best Practices

RAPID ADVOCACY FOR TELEHEALTH TO SUPPORT PATIENT ACCESS AND HEALTHCARE SYSTEM RESILIENCE

Quickly following the statewide stay-at-home in March 2020, health plans, regional trade associations, and other healthcare actors advocated for expanded access to and reimbursement for telehealth, telemedicine, and telephonic care. This shift enabled ongoing access for patients and reduced the financial impact on providers by curbing delay of services. The California Primary Care Association was able to get approval for telehealth within three days of the stay-at-home order, while the CCALAC deployed medical staff to shelters to help facilitate telephonic visits with providers among those experiencing housing insecurity or homelessness. LA Care rapidly expanded their "teledoc" service to meet the increased need for virtual appointments, and this model was adopted by other sister health plans.

MAINTAIN AND SUPPORT CLINIC AND PROVIDER FINANCIAL HEALTH

As described above, many providers faced negative financial impacts throughout the COVID-19 emergency due to postponement of care and fewer visits overall. This is particularly challenging for non-capitated providers. In order to support providers and the overall health or the community, especially in provider-poor areas, IEHP implemented a policy to bolster the financial health and resiliency of non-capitated providers. Inland Empire Health Plan paid these providers the average amount they would have received over the designated period. Similarly, Blue Shield described their ability to redistribute funds to providers, given the decrease in healthcare utilization, while receiving stable income from premium payments.

RECOMMENDATIONS

Build and support stronger partnerships between healthcare, public health, and communities

The COVID-19 emergency revealed the major challenges working across the silos of the healthcare, public health, and community-based systems, in some cases thwarting efforts to respond to community needs in an efficient and equitable way. Healthcare and public health must strive to break down these silos and work collaboratively on a routine basis to meet the needs of the communities they serve, especially those disproportionately impacted by inequities. As the public health system is striving to develop a more community-based, equity-centered workforce, as well as establishing funded partnerships with CBOs, the healthcare system has an opportunity to join these partnerships and begin developing trusted relationships with public health and community partners (see "Build a Resilient Equity-Focused Public Health Workforce for the 21st Century" for more information). In the wake of the COVID-19 emergency, the healthcare and public health systems are at a critical inflection point, in which they can make lasting systemic change to integrate community partners and priorities as the third pillar in a more expanded vison of a 21st century health system.

As the urgency to address both social needs and the social determinants of health grows, it is imperative to establish the structures and mechanisms to collaborate, hold one another accountable, and envision an equitable future together. To shape equitable, collaborative partnerships, it is critical that healthcare, public health, and communitiesy co-create a common set of priorities across systems, guided by the following principles outlined in the Aligning Systems with Communities to Advance Equity through Shared Measurement brief.

1. Requires up-front investment in communities to develop and sustain community partners' capacity
2. Is co-created by communities to center their values, needs, priorities, and actions
3. Creates accountability to communities for addressing root causes of inequities and repairing harm
4. Focuses on a holistic and comprehensive view of people and communities that highlights asset and historical context
5. Reflects shared values and intentional, long-term efforts to build and sustain trust

Following the guiding principles above, healthcare, public health, and communities can implement the following strategies to build robust partnerships.

- Exploration and acknowledgement of the historical and contemporary context of healthcare and public health in the community, including racism, power dynamics, past and ongoing collaborations, etc.
- Establish trust throughout ongoing collaboration, capacity building, and funding support through transparent, long-term contracts
- Prioritize the development of shared language across the three pillars to reduce sector-specific jargon
- Establish standing mechanisms and opportunities for information sharing and collaboration
  - » Establish ongoing executive level meetings, including public health and community partners to share power in setting priorities and making high-level decisions
  - » Include public health and communities in Health and Human Services and Medical commissions to break down silos
- Create ongoing opportunities for co-creation of priorities and future visioning to explore innovative initiatives and evolving goals
  - » See Foresight – Designing and Future for Health for guidance
  - » See ReThink Health's Portfolio Design for Healthier Regions for more information
- Develop collaborative funding mechanisms for social determinants of health and equity, including Accountable Communities for Health and Wellness Trusts (see more in the following recommendations)

Develop a unified, bidirectional statewide health information exchange

Public health practice – at the State and local levels – requires reporting from healthcare and hospital systems. Consistently sharing data between the healthcare and public health systems was a major challenge throughout the COVID-19 pandemic. Based on conversations with several California health plans and providers, and from discussions with LHDs held on California Conference of Local Public Health Data Managers and Epidemiologists calls, this has largely been a unidirectional relationship, often with ad-hoc data sharing protocols in place. From these conversations:

- LA Care shared that they participate in three different HIEs
- Community Clinic Association of Los Angeles County (CCALAC) noted that there weren't enough hospitals participating in the HIEs for them to be efficient or effective
- California Primary Care Association (CPCA) argued that the public health and healthcare system needs a central HIE, not multiple systems like those currently in place for immunization registries

It is a challenge for both parties: hospitals and healthcare systems face an administrative burden in reporting outside of their existing electronic health records systems, and LHDs may get delayed and/or incomplete data. These data are crucial to support direction and refinement of public health programs and resources.

Blue Shield of California summed it up succinctly: the pandemic has supplied "our ACA moment" to rethink our data systems and develop a unified HIE with a mandate for its use. The State can support this new system that is bi-directional, interoperable, and sustainable, to build better data relationships and continuum of care between local public health departments, hospitals, and healthcare systems. The National Academy of Medicine, in its Health Data

Sharing to Support Better Outcomes report, details what this might look like, and recommends setting policies that "establish ground rules and standards across networks, as well as support the development of technologies and systems that promote, rather than impede, data sharing." In short, development of data standards, core datasets, support for Meaningful Use, and data sharing protocols that allow for streamlined reporting between systems are core components of a unified HIE. These protocols need to build in clear guidance and development of electronic messaging standards, specifically for laboratories and other reporting entities in healthcare and hospital systems to ensure timely, accurate data collection and interoperability with existing State and LHD data systems. See more information in the 2009 California Health and Human Services Health Information Exchange Strategic Plan.

Establish effective, efficient, ethical and equitable data sharing agreements

In order to improve individual, community, and population health, the healthcare and public health sectors must establish effective, efficient, ethical, and equitable data sharing agreements. The COVID-19 pandemic has demonstrated the urgent need for data sharing in order to measure and act upon health outcomes, particularly in cases of glaring inequities. COVID-19 has made it clear that health data sharing is no longer just a moral imperative, but a vital component and strategy in overcoming the crisis. Furthermore, incorporating measures of community conditions into clinical data will offer an opportunity to address health inequities where they begin.

While the healthcare and public health sectors are often uplifted as the primary actors in data sharing agreements, it is also critical to include community partners, especially those that represent and serve communities disproportionately impacted by inequities. All participants in the healthcare, public health, and community systems would benefit from cross-institutional and cross-sector data sharing. Strategies to modernize data sharing agreements and protocols are outlined below.

- Engage with patients, individuals, and communities in the development of a trusted, privacy and civil rights protected data sharing system.
- Integrate social determinants of health measures in clinical data, such as access to housing, healthy food, employment, and transportation. While these can provide important context on patient populations, they are critical towards addressing the upstream, root causes that contribute to health disparities.
- Ensure government policies support data exchange across networks and support development of technologies and systems that support data sharing, such as Center for Medicare and Medicaid Services Interoperability and Patients Access.
    - » Develop a compensation strategy for asynchronous care, which refers to telehealth services where there is no continuous real-time interaction between the patient and provider, and electronic communication. During the pandemic, insurers and federal agencies relaxed regulations around virtual care reimbursement codes for bidirectional communication among providers, staff overseeing clinical data systems, and patients.
- Create reimbursement codes for bidirectional communication among providers, staff overseeing data systems, and patients.
- Shift the risk/benefit calculus from risk aversion for sharing data to emphasizing risks associated with not sharing data (i.e., misdiagnosis, late diagnosis, repeat test, poor care coordination, medical errors, etc.).
    - » Assess and share the enumerated financial, human and organizational integrity cost of not sharing data across systems and sectors.

- For more information see the National Academy of Medicine's Health Data Sharing to Support Better Outcomes: Building a Foundation of Stakeholder Trust report.

Embed equity into healthcare system emergency response structures

In order to respond effectively and equitably to local, regional, and nationwide emergencies, the healthcare system, including health plans, hospitals, clinics, and other entities must authentically embed equity into all emergency preparedness planning and response structures. Throughout the COVID-19 emergency, inequities were greatly exacerbated unless there were ongoing robust strategies to prevent these outcomes. There are a number of strategies that the healthcare system can implement to embed equity into emergency planning and response structures. Firstly, it is essential that CBO partners and community representatives be included in all planning and response activities to ensure the needs and priorities of the community are being elevated and addressed. Similarly, the healthcare system should provide funding and support to local CBOs who play a critical role in emergency response activities for patients and community, from PPE distribution to operating testing and vaccination sites. Secondly, all health plans, hospitals, and clinics can establish and appoint a health equity lead, or rotating health equity position, to advance health equity strategies throughout planning and response activities. Health equity leads can provide guidance on equity in data collection, analysis and sharing, communications and outreach, and changes in programs or care provision.

During the COVID-19 pandemic Mass General Brigham healthcare system, including Brigham and Women's Hospital (BWH), integrated equity strategies and priorities into their incident command system. The Mass General Brigham COVID-19 response included system-level and hospital-level incident command (IC) teams. The BWH IC team included six equity working groups convened to focus on: "1) data and monitoring COVID equity issues, connected to existing quality and safety infrastructure; 2) access, social determinants of health, and disability; 3) employee equity issues; 4) public policy and advocacy; 5) internal communication; and 6) community health and the local community the hospital serves." (See Figure XX) BWH systematically integrated equity leaders into their IC structure to ensure that COVID-19 response actions did not inadvertently exacerbate inequities that were already playing out in communities. Additionally, BWH implemented strategies to mitigate disproportionately burdening employees of color "with additional, but uncompensated requests related to diversity, equity, and inclusion efforts." This exemplifies a strong model for integrating equity into emergency response structures.

See "Embed Equity Throughout Local Health Department Emergency Planning, Response & Recovery Processes."

Assess and address healthcare system vulnerabilities for future emergencies

The COVID-19 emergency revealed the vulnerabilities in the healthcare system, specifically related to workforce, PPE and supplies, medical equipment, and hospital capacity. While the healthcare system has quickly adapted and rolled out stop gaps and short-term solutions to address these vulnerabilities, it is critical that that system as a whole, in partnership with regulatory state and federal agencies, as well as public health partners, take action to increase the resiliency of the system to future emergencies. As the intensity and frequency of climate change-related emergencies increase, and the potential for regional emergencies such as earthquakes persist, there are a number of strategies the healthcare system can undertake.

In alignment with state and federal partners, healthcare systems need to conduct a robust assessment of the supply chain challenges during

the COVID-19 emergency, including PPE, supplies, and medical equipment, as well as proposed changes to accommodate future regional or nation-wide emergencies that may tax the supply chain. This assessment and future planning must include community clinics and CBOs that were critical partners in the COVID-19 response, including distributing PPE, testing, and vaccination. Community health partners should be included in planning for future emergency allocation and distribution to facilitate a smooth and efficient response to future emergencies. Assessment and planning activities need to include a specific focus on hospitals and clinics in communities disproportionately impacted by inequities, that have been plagued by a lack of investment in healthcare facilities and other health promoting supports and resources. Additionally, it is critical that healthcare system and hospital emergency planning coordinate closely with public health emergency preparedness to support a coordinated and integrated emergency response and recovery strategy. Healthcare systems can coordinate with LHDs to proactively identify inequities and prioritize needs, as well as identify care access vulnerabilities, such as trauma deserts.

Improve oversight and resilience of long-term care facilities

The pandemic elucidated the vulnerabilities of long-term care facilities, in which healthcare is provided outside of the typical healthcare sphere, such as skilled nursing facilities. As has been widely documented, facilities providing care outside of the hospital and clinic setting were hit particularly hard by the COVID-19 pandemic; over 10,000 lives were lost in California alone, as of July 2022. As described in the Challenges above, skilled-nursing facilities and other long-term care facilities faced severe staffing shortages, and inadequate access to PPE and infection prevention protocols. While CDPH conducts annual inspections of each facility, the efficiency and efficacy of emergency oversight and rapid intervention during public health emergencies could be improved. Critical insights and improvements could be achieved by establishing a Long-Term Care Facility Task Force. Essential participants would include: regulatory agencies, health plans, local public health departments, LTC Ombudsman, worker representatives, and patient advocates. The Task Force can engage in the following activities:

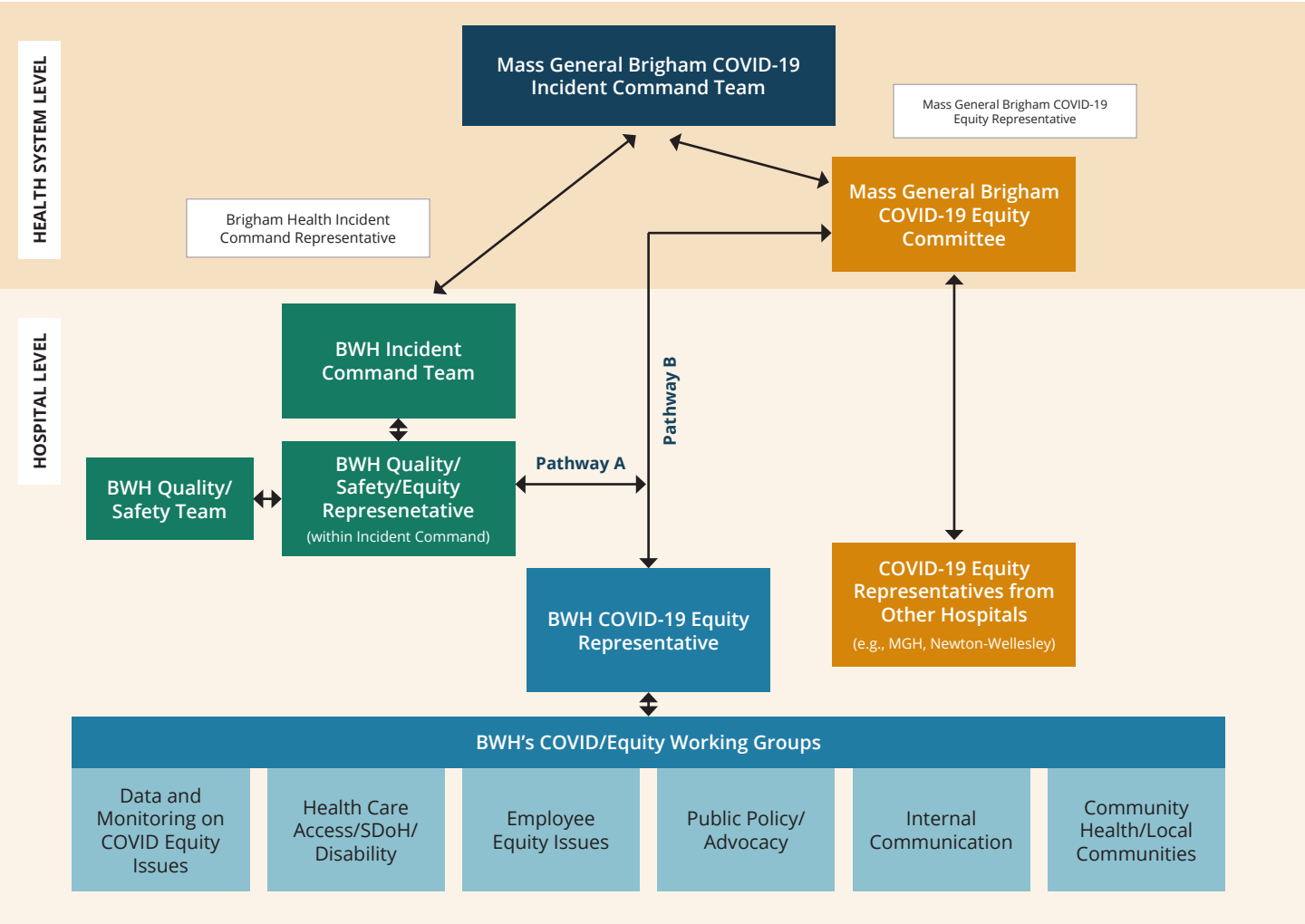


Figure X: Mass General Brigham Incident Command Structure

- Evaluate the shortcomings and underlying policies that contributed to the devastating impacts of COVID-19 in these facilities, including internal practices related to testing and hygiene, communications, coordination, and data collection and reporting.
- Improve emergency oversight and regulatory powers and protocols for the relevant agencies in preparation for future emergencies, to ensure rapid, coordinated, and effective support and response activities
- Increase coordination and collaboration across agencies that hold regulatory and oversight responsibilities to ensure that messaging and protocols are consistent across types of LTCFs.
- Issue recommendations for facility owners and operators, and other stakeholders to address the short, medium and long-term recovery needs and opportunities to build resilience in long-term care facilities, such as:
  - » Develop coordinated emergency response plans in partnership with relevant public and private partners. Plans need to include elements such as: infection control protocols, contingency plans for extreme heat and power shutoffs, communications plans for residents and resident families, etc.
  - » Increase standing PPE supply, and identify supply chain in event of different emergencies (e.g., masks for respiratory

disease versus mask for wildfire smoke).

- ◊ Develop and provide training to managers and staff on proper PPE use, including use of different protective masks and other equipment.

» Require facilities to collect, track, and analyze health outcomes data and establish data sharing agreements with local public health departments.

- ◊ Data analyses should be stratified by race/ethnicity to help identify disparities within facilities.
- ◊ Use predictive analytics to predict outbreaks and identify vulnerable facilities.

» Increase Cost Transparency in Long-Term Care. Assess sufficiency of Medicare and Medicaid nursing home rates to cover direct care and administrative costs, including: expenditure allocations between direct care, administrative costs and other expenses, related party transactions, nursing home resident acuity levels, potential to apply acuity adjustment to rates, and rate implications for adjusted patient ratios and staffing needs.

- ◊ Evaluate data on associations between health and safety outcomes and financial structure of facilities. See California Health Care Foundation's 2020 Edition – Long-Term and End-of-Life Care in California for more information.

» Advocate for increased wages for staff, including hazard pay and paid sick leave, wage enhancements, and minimum staff ratios to support a more robust and consistent workforce.

» Strengthen paid training and certification requirements and opportunities, including annual in-service education requirements to build skills and scopes of practice.

- ◊ Assess quality and adequacy of current workforce training and scopes of work (e.g. Certified Nursing Assistant (CNA) training).
- ◊ Ensure all staff are trained in health equity principles and culturally sensitive care.

- Assess opportunities to improve facility design and distribution of patients to minimize risk of infectious disease spread. For more information see the California Health Care Foundation's COVID-19 in California's Nursing Homes: Factors Association with Cases and Deaths Report.
- LTCF Architectural Reform: Provide incentives and reduce regulatory barriers to renovation of older structures; require single occupancy rooms, better ventilation, and other improvements in facilities that will help with infection prevention, emergency evacuation, digital divide, and climate change.

Support and expand opportunities for telehealth and telemedicine

Early on in the COVID-19 emergency, health plans and healthcare systems rapidly advocated for the covered expansion of telehealth and telemedicine to support continuity of care, preventive services, and COVID-related needs. Healthcare, public health, and community advocates agree that this coverage should be supported and expanded beyond the pandemic as a critical health and equity strategy in the healthcare system. Healthcare and public health described a significant decrease in "no-show" appointments for telehealth visits. Expansion of telehealth and telemedicine is an important healthcare equity strategy in that it creates expanded options for care for populations that do not have

access to a vehicle or transit, or are unable to take time off of work for appointments. The Urban Indian Health Consortium described the expansion of telehealth as not only an effective means for reaching the American Indian and Alaska Native communities throughout the COVID-19 emergency, but also as a much needed ongoing care option. There are a number of important components to effectively advance this recommendation.

- Advocate for payment systems at the federal and state level that allow for the continuation and expansion of these services.
- Collaborate with health equity and community advocates, organizations, and leaders to assess the needs and priorities of communities. This should include an assessment of internet and technology access, preferences for telehealth models, etc.
- Partner with community organizations and trusted leaders to identify community spaces, or health plan association resources centers (e.g. LA Care) to support easier community access to the internet and technology for telehealth visits.
- Fund universal broadband access, especially in rural and low-income areas.

Incentivize pay for value-based care versus volume

The predominant volume-based payment system does not align with healthcare system goals to reduce health disparities and advance health equity, in fact, it can exacerbate existing inequities. Throughout the interviews with healthcare system and health plan leaders, interviewees emphasized the imperative to align healthcare payment systems with burgeoning healthcare goals to address structural racism and systemic inequities. Shifting the healthcare payment model to a value-based or pay-for-performance model will place the emphasis on long-term health outcomes, especially for communities disproportionately impacted by health inequities. While most Medi-Cal payments to providers are not based on fee-for-service they are also not explicitly tied to quality improvement or reducing health disparities. Therefore, it is critical that efforts to reform healthcare at the State and Federal levels consider making payment explicilty tied to health outcomes and reducing disparities. Furthermore, these changes should also include incentives to reach and successfully treat patients and communities most impacted by inequitable health outcomes. Furthermore, the necessary shift to prioritizing quality or health outcomes versus volume underscores the importance of robust data sharing agreements and a statewide health information exchange.

See California Pan-Ethnic Health Network's guide on Centering Equity in Health Care Delivery and Payment Reform for more information.

Leverage resources made available through Medicaid demonstration waivers to advance health equity

Medi-Cal managed care plans can leverage Medicaid Demonstration and Emergency Waiver flexibilities to more effectively and routinely partner with LHDs and CBO partners to advance health equity. The federal Department of Health and Human Services (HHS) allows states to apply for waivers to test new approaches that are not permissible under current Medicaid law. Section 1115 of the Social Security Act (SSA) gives HHS the authority to approve state-specific policy approaches to better serve Medicaid populations. These waivers typically last for five years. Section 1915(b) of the SSA allows states to implement voluntary managed care programs and use cost savings to provide additional services to beneficiaries. California's 2015-2020 waivers included several programs focused on the social determinants of health including a Whole Person Care Pilot, Global Payment Program, and Public Hospital Redesign and Incentives in Medi-Cal (PRIME). In October 2019, the California Department of Health Care Services (DHCS) released its proposal to re-apply

for these waivers. Entitled California Advancing and Innovating Medi-Cal (CalAIM), the proposal builds upon the successes of several programs covered by the expiring Medicaid demonstration waivers (both Section 1115 and 1915(b)). These include the Whole Person Care and Coordinated Care Initiatives. The proposal also integrates key components of the new administration's priorities including homelessness, behavioral healthcare access, children with complex medical conditions, justice-involved populations, and a growing aging population. Due to the COVID-19 pandemic, California was granted a one-year extension of its 2015-2020 waivers so they are now set to expire on December 31, 2021. Most components of CalAIM, if approved, are now set to take effect on Jan. 1, 2022, with a phased-in approach for various other components.

There are a number of strategies that should be implemented in order to leverage these opportunities to include public health. For example, stronger incentives need to be included in these waivers for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management, and in lieu of services. Additionally, clearer guidance should be included in State and federal healthcare policies on how LHDs can access healthcare funding to support LHD priorities, as well as opportunities in which health plans can fund LHD programs or activities.

Another important strategy is to leverage emergency waiver (Centers for Medicare and Medicaid Services Section 1135) flexibilities granted during a public health emergency to more effectively address the needs of disproportionately impacted communities and advance equity in emergency response. For example:

- **Utilize Non-Traditional Facilities to Provide Services –** the 1135 waiver grants approval to allow services to be rendered at unlicensed facilities to increase response capacity (e.g. tents, mobile clinics, isolation centers, shelters, etc.). This is an important strategy to increase capacity in areas that are resource poor, especially during events when communities may have decreased access to transportation to access services.

- **Mobilize and Redeploy Community Providers to Provide Care –** the 1135 waiver allows providers who are not currently licensed as Medicaid providers to be temporarily enrolled to provide care with little to no screening. This is a critical strategy to expand the workforce during an emergency, with particular emphasis on redeploying community providers to areas most disproportionately impacted by the emergency.
- **Facilitate Redirection of Providers to Emergency Needs –** under the 1135 waiver providers that are furloughed or not working can be redirected to address emergency needs, such as COVID-19 case surges.

Establish collaboratively funded investment mechanisms to advance equity and prevention

The healthcare and public health systems can work collaboratively with private and public entities to fund investment mechanisms that center community priorities and advance equity. In order to establish and advance collaboratively funded investment mechanisms, all partners, including healthcare, public health, community development, and CBOs must actively work across silos and include one another in planning activities, and the identification of shared priorities and opportunities. There are several hospital systems around the U.S. that have embraced innovative financing and are working closely with a multi-sector group of partners to invest in their communities. CommonSpirit Health, Trinity Health, and Kaiser Permanente are making community investments in social determinants of health such as affordable housing and food access across California and several other States on the West Coast, while hospitals in the Industrial Midwest and East Coast are leveraging their role as anchor institutions to make community investments in a variety of areas. There are a number of guiding recommendations and robust models that healthcare systems can look to in beginning or advancing these efforts.

The National Alliance to Impact the Social Determinants of Health's Opportunities to Advance SDOH Efforts Through Pooled Funding has identified six recommendations to advance collaboratively funded approaches to advance health equity.

1. Accelerate efforts to enable exiting federal health funding to be used in shared interventions addressing social needs and social determinants of health (SDOH).
2. Allow the use of existing federal program funding to support the development of "backbone" organizations that can be trusted partners in pooling funding and administering initiatives.
3. Coordinate efforts across federal departments to collectively address SDOH, including through pooled funding arrangements, waivers, and additional program flexibilities.
4. Encourage participation by Foundations, states, the private sector, and others in collective initiatives, pooling funding with federal programs to accelerate health, social, and economic gains.
5. Safeguards and "guardrails" should be clearly established to ensure that public funds used in pooled arrangements meet the needs of those they are intended to serve and provide effective stewardship of public funds.
6. Evaluate progress and expand evidence available to guide additional pooled funding initiatives.

There are many established and emerging innovative investment strategies outlined in the Public Health Alliance of Southern California's Innovative Community Investment Strategies report, several of which are outlined below.

ACCOUNTABLE COMMUNITIES FOR HEALTH MODELS

The California Accountable Communities for Health Initiative (CACHI) sites in California have been actively engaged in exploring innovative financing strategies for several years and have a head start on other efforts. CACHI financing strategies include a variety of innovative investment strategies, which are guided by the overarching CACHI structure of multisector collaboration, community engagement, and governance. The National Academy of Medicine published a comprehensive literature review of the effectiveness of strategies in addressing population health challenges, and a chapter in the latest Practical Playbook describes the lessons learned from the CACHI sites after 2 years of implementation. The Funders Forum for Accountable Health has also published an inventory of Accountable Communities for Health (ACH) sites around the country, and 10 case studies of ACH models of varying types.

COMMUNITY HEALTH AND WELLNESS TRUSTS

Three states (Minnesota, Massachusetts, Oklahoma), two counties (Imperial County, California and Pierce County, Washington.) and one city (East San Jose, California) have implemented structured funds to address the social determinants of health in their communities. Often called "Wellness Trusts" or "Public Health Trust Funds," these models raise revenue from specified sources. Those dollars are then directed into a dedicated trust fund that supports community health needs. In the CACHI Initiative, establishing a "wellness trust" is a core component of each cohort's workplan. Each of the 15 sites are actively exploring ways to establish one. One site, Imperial County, had a wellness trust predating the CACHI initiative by several years. The Imperial County wellness trust has been successful in gaining support from the local health plan, businesses, and community-based organizations. A Satewide California Wellness Trust/Health Equity Fund Program concept proposal was proposed by the California Alliance for Prevention Funding through a formal budget request and AB 1038 (2021), which included a Health Equity and Racial Justice Fund as one component. In Pierce County, Washington, a wellness fund called the OnePierce Community Resiliency Fund evolved out of another community investment strategy— an Accountable Community for Health established through a Medicaid Section 1115 Demonstration Waiver. A common concern raised about wellness trusts is whether steering limited resources to a dedicated trust fund is a good use of funding for all partners involved. Many communities have other structured funds or invest their resources to address the social determinants of health in other ways. Restructuring current systems can be difficult. Finding the right revenue source can also be challenging, as creating a fund often involves raising taxes or mandating fees from participating organizations. To address these issues, the Hospital Association of Southern California (HASC) has created a set of Guiding Principles for the Establishment of Public Health Trust Funds to guide implementing of any dedicated trust fund in Southern California where hospitals and health systems are encouraged to participate.

Ensure existing healthcare funding streams include investments in prevention and local public health departments

LEVERAGE HEALTHCARE EXPENDITURES TO IMPROVE PUBLIC HEALTH

We spend an estimated $3.6 trillion annually on healthcare, but less than 3% of that is spent on public health and prevention. As a result, there is a significant opportunity to leverage healthcare resources to improve public health infrastructure. It is important that the healthcare sector expand their investments in prevention and public health including resources for LHDs through their existing funding streams. This is especially important because LHDs provide many basic healthcare services covered by Medi-Cal and Medicare, often with little to no reimbursement. Many LHDs do not have the billing infrastructure set up to properly account and be reimbursed for all the services they provide under Medi-Cal. They also lack the capacity to track all the state and federal policy changes that impact their work, including the complex Medicaid waiver processes. There needs to be greater collaboration between the healthcare and public health sector, and incentive mechanisms need to be put in place to ensure this happens in a meaningful way. For example, California has the opportunity to utilize its Medicaid demonstration waivers to include stronger incentives for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management and in lieu of services. State and federal healthcare policies could provide clearer guidance on how LHDs can access healthcare funding for their needs, including Intergovernmental Transfers (IGT), and how they can get health plans in particular to pay for their specific needs.

FUND PUBLIC HEALTH THOUGH STATE-LEVEL COST CONTAINMENT MEASURES

A small fraction of healthcare cost containment savings redirected to public health could drastically improve public health infrastructure and bolster the healthcare and public health system continuum. The proposed Office of Health Care Affordability (OHCA) within the Office of Statewide Health Planning and Development (OSHPD), would advise and advance a number of activities to contain the cost of healthcare and support affordability for consumers and purchasers. It is important that public health, and LHD leaders in particular, are included in the OHCA Advisory Council and actively engaged to support ongoing systems change. The OHCA activities include the following:

1. Increase public transparency on total healthcare spending in the State
2. Set an overall statewide cost target and specific targets for different sectors of the healthcare industry
3. Enforce compliance with the cost target
4. Promote and measure quality and equity through performance reporting
5. Set a statewide goal for adoption of alternative payment models and develop standards for use by payers and providers during contracting
6. Measure and promote sustained systemwide investment in primary care and behavioral health
7. Monitor and address healthcare workforce stability
8. Increase public transparency on healthcare consolidation, market power, and other market failures

Especially in light of the COVID-19 emergency and the broad understanding of the chronic underfunding and understaffing of LHDs, these activities must include investments in LHDs in the same manner they propose investing in primary care and behavioral health. Furthermore, LHDs must be meaningfully engaged throughout these processes to strengthen partnerships and build capacity across sectors to more effectively support prevention and social determinants of health work. Public health programs are the equivalent of population-level preventive care, and with adequate investment, can have even farther reaching impacts, especially for communities facing health inequities. According to Trust for America's Health, investing $10 per person per year in community prevention programs could yield more than $16 billion in healthcare savings within five years. State-level cost containment savings could be used to fund wellness trusts, as discussed above. The Massachusetts Prevention & Wellness Trust Fund supported "clinical-community partnerships focused on childhood asthma, falls among older adults, hypertension, and tobacco use" from 2014-2018 with demonstrated cost savings and health outcome improvements.

There are a number of existing and emerging strategies to ensure the existing healthcare funding streams include investments in prevention and LHDs. Bridging the gap between healthcare and public health will facilitate the expansion of the continuum of care and enable both sectors to more effectively advance shared health equity priorities.

Conclusion

The COVID-19 pandemic exposed and elevated stark health inequities and racial injustices that have long persisted in California and the nation. The findings of this report make clear that communities, local public health departments, and other systems need significant supports and investments if they are to advance an equitable, just, and resilient recovery. As the nation moves from the adaptation phase to a longer-term innovation phase, it is important to identify opportunities for transformative change.

This report provides a roadmap forward. It is informed by many firsthand accounts from community-based organizations, local public health departments, health systems, philanthropy, and other sectors who were on the frontlines or served as intermediaries for groups experiencing the most inequitable impacts of this pandemic. Each of the seven content areas outline ways systems both supported, and failed, the communities most impacted by COVID-19 and other longstanding health inequities and racial injustices. The report also provides concrete recommendations and emergent best practices for moving forward. Out of necessity, the pandemic provided systems with opportunities to rethink approaches and test new models. There were many best practices of rapid adaptation to protect and support the most impacted communities, as well as sweeping and novel equity-driven approaches implemented across the State. Some of these approaches should be continued and expanded, while others that were not implemented should be advanced and explored. Promoting greater innovation in the approaches to addressing health inequities and racial injustices can catalyze the actions needed to reimagine and rebuild the nation's systems, strengthen communities, and redefine social contracts with community resilience and equity at the core.

It is essential to recognize that the choices made today will have lasting implications on the public's health and the ability to advance healthier, equitable communities tomorrow. The pandemic may be a once-in-a-lifetime event, yet there are many other health inequities and racial injustices occurring on a daily basis that systems need to be prepared to prevent and protect those most likely to be impacted. It is important to invest in communities and systems in ways that enable everyone to live to their full potential, where people have stability and security in their work, homes, schools, and environment to enjoy life, and where all sectors come together to help each other and ensure no one is left behind. This transformation will require co-visioning, and co-creating with community leaders and members to ensure that as the nation rebuilds its systems, the needs and priorities of communities, especially those disproportionately impacted by inequities, are the driving force and pillars of reimagined systems. It is important not to simply return to the status quo, as it was clearly not meeting the needs for everyone. Now is the time for courage and bold action to reimagine and rebuild an inclusive, equitable, and just future for all.

APPENDICES

APPENDIX A

Methodology

From October 2020 to March 2021, the Public Health Public Health Alliance conducted key informant interviews and collected survey responses from local public health departments (LHDs), community-based organizations (CBOs), healthcare systems, equity advocates and others to understand the challenges, emergent best practices, and transformative recommendations. We partnered with our sister organizations the Bay Area Regional Health Inequities Initiative (BARHII) and the San Joaquin Valley Public Health Consortium (SJVPHC) to conduct interviews with their respective local public health department members and community partners. Additionally, we gathered and compiled input from public health practitioner meetings at the local, regional, and state level to further inform the content of the report.

BY THE NUMBERS

68 – Total Interviews

- Local Public Health Departments – 36
- Other Government – 1
- Equity/ Public Health Advocacy Groups – 6
- Community-Based Organizations – 8
- Labor Organizations – 1
- Healthcare – 6
- Funders – 9
- Other – 1 (CACHI)

110 – Total Survey Responses

- LHD Executive Survey – 58 (42 unique, 8 duplicates, 8 unknown)
- LHD Data Survey – 22
- Community Organization Survey – 30

Data Collection

October 29, 2020 - March 4, 2021

INTERVIEWS

The Public Health Alliance, BARHII, and SJVPHC conducted interviews with thirty-four local public health department leaders, two local public health department data experts, six public health advocacy groups, eight community-based organizations, six healthcare systems and health plans, nine funders, and several other sector organizations. The key informant interviews were designed to gather information from multiple sectors on challenges encountered throughout the COVID-19 emergency, specifically related to supporting disproportionately impacted communities, as well as emergent best practices, and ideas for short and long-term recommendations to advance health equity and community resilience. (See Appendix B-E for Key Informant Interview Guides.)

Please see the Acknowledgement section for the full list of interviewees, survey respondents, and contributors.

LOCAL PUBLIC HEALTH DEPARTMENT INTERVIEWEES

Alameda County Public Health Department

City of Berkeley Department of Health Services

Calaveras County Public Health Department

Contra Costa Health Services

Fresno County Department of Public Health

Humboldt County Department of Health and Human Services

Imperial County Health Department

Kern County Health Department

City of Long Beach Department of Health & Human Services

Los Angeles County Department of Public Health

Madera County Public Health

Marin Health and Human Services

Mariposa County Health Department

Merced County Department of Public Health

Monterey County Health Department

County of Napa Health and Human Services

Orange County Health Care Agency

City of Pasadena Public Health Department

Riverside University Health System-Public Health

Sacramento County Department of Health Services

County of San Bernardino Department of Public Health

County of San Diego Health and Human Services Agency

San Francisco Department of Public Health

San Luis Obispo County Public Health Department

County of San Mateo Public Health Department

Santa Barbara County Public Health Department

Santa Clara County Public Health

Santa Cruz County Health Services Agency

Shasta County Public Health

Solano County Public Health

Sonoma County Public Health Division

Stanislaus County Public Health Department

Tulare County Health & Human Services

Ventura County Public Health

OTHER SECTOR KEY INFORMANT INTERVIEWEES

ORGANIZATION	SECTOR	INTERVIEWER
Governor's Office of Innovation	Government	Public Health Alliance
Greenlining Institute	Equity/ PH Advocacy	Public Health Alliance
PolicyLink	Equity/ PH Advocacy	Public Health Alliance
California Pan-Ethnic Health Network	Equity/ PH Advocacy	Public Health Alliance
ChangeLab Solutions	Equity/ PH Advocacy	Public Health Alliance
Public Health Advocates	Equity/ PH Advocacy	Public Health Alliance
Prevention Institute	Equity/ PH Advocacy	Public Health Alliance
Leadership Council	CBO	Public Health Alliance
Center for Race, Poverty and the Environment	CBO	Public Health Alliance
Urban Habitat	CBO	BARHII
Street Level Health Project	CBO	BARHII
Canal Alliance	CBO	BARHII
Richmond Neighborhood Housing Services	CBO	BARHII
Regional Pacific Islander Task Force	CBO	BARHII
Roots Community Health Center	CBO	BARHII
California Consortium for Urban Indian Health	CBO	Public Health Alliance
Service Employees International Union (SEIU) California	Labor	Public Health Alliance
California Primary Care Association	Healthcare	Public Health Alliance
Community Clinic Association of Los Angeles County	Healthcare	Public Health Alliance
LA Care	Healthcare	Public Health Alliance
Inland Empire Health Plan	Healthcare	Public Health Alliance
Kaiser Permanente	Healthcare	Public Health Alliance
Blue Shield of California	Healthcare	Public Health Alliance
Kaiser Permanente	Philanthropy	Public Health Alliance
The California Endowment	Philanthropy	Public Health Alliance
Hilton Foundation	Philanthropy	Public Health Alliance
Blue Shield of CA Foundation	Philanthropy	Public Health Alliance
NorCal Grantmakers	Philanthropy	Public Health Alliance

ORGANIZATION	SECTOR	INTERVIEWER
California Community Foundation	Philanthropy	Public Health Alliance
California Wellness	Philanthropy	Public Health Alliance
The San Francisco Foundation	Philanthropy	BARHII
Roberts Enterprise Development Fund (REDF)	Philanthropy	BARHII
California Accountable Communities for Health Initiative (CACHI)	Other	Public Health Alliance

SURVEYS

The Public Health Alliance also developed and distributed three different surveys, which were distributed through our network and the networks of our regional partners, community-based partners, and others. The first survey was designed for local public health department leadership to provide additional information on COVID-19 response challenges, promising practices, and needs. The local public health department executive survey was completed by fifty-eight individuals, representing forty-two jurisdictions. Respondents represented jurisdictions across the State, with small, medium, and large populations. The second was designed for local public health department data experts, including epidemiologists, communicable diseases leads, etc. and was completed by twenty-two respondents. The third survey was designed for community based partners to understand the barriers, needs, and strategies of community-based organizations and those serving disproportionately impacted communities. Thirty respondents completed the third survey; seventeen of respondents were direct service organizations and 10 respondents were organizing and/or advocacy groups. Over half of all respondents identified public health/community health as a primary focus of their organization. Education and racial justice was the second most commonly identified primary focus by twelve respondents, closely followed by immigration (10), and youth development (10). (See Appendix F-K for the Survey Questions and Results Summaries)

POLICY AND BEST PRACTICE SCANS

The Public Health Alliance also conducted ongoing policy and best practice scans across the public health, healthcare, and community systems in order to capture information to supplement interview and survey results. This included regular monitoring of news coverage and collection of relevant articles; tracking email listservs and local/state/federal announcements; and reviewing academic and institutional research on COVID-19 trends and issues.

APPENDIX B - KEY INFORMANT INTERVIEW GUIDE

Local Public Health Departments

PROJECT OVERVIEW

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Public Health Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure and community conditions.

To help inform our report and collect initial feedback and guidance, the Public Health Alliance is conducting key informant interviews with local public health departments throughout the course of this process. We are pleased to have the Bay Area Regional Health Inequities Initiative (BARHII) and the San Joaquin Valley Public Health Consortium (SJVPHC) help us collect feedback from their members as part of this interview process. Should you have any questions about this project, please contact Bill Sadler, Alliance Director of Operations, at bsadler@phi.org

INTERVIEW QUESTIONS

The following interview questions were developed to help us meet the requirements of the report. There are six questions, with additional prompts as needed, based on the initial response.

Q1. When it became clear that COVID-19 was disproportionately impacting certain communities across the State:
- What were your most effective strategies to respond in your own jurisdiction?
- What supports helped you accomplish this?
- What were the barriers?
- Do you have any example of innovative or best practices you employed? Any stories of something that went surprisingly well?

Q2. How, if at all, have you infused equity into your response and recovery planning process?
- Have you integrated an equity officer and/or staff into your ICS structure?
- What other approaches have you employed for equitably responding to community needs throughout this crisis?
- How, if at all, has the State's new equity measure shifted your response to the pandemic? Are you employing any new strategies?

Q3. When it comes to resources:

- How did the historic disinvestment in public health infrastructure impact your ability to support communities most vulnerable to COVID-19 in your jurisdiction?
- Given the history of disinvestment in low-income communities and communities of color, what resources and/or support would most support you in responding to and preventing the disproportionate impact of the pandemic and other future health and climate emergencies on communities most impacted by inequities in your jurisdiction (financial, staff, political, etc.)?

Q4. Working with and relying on residents and community-based partners became an essential part of the COVID-19 response:

- What are your top strategies for strengthening these partnerships now and into the future?
- What types of community-based outreach/communication strategies seem to be most effective for reaching communities most vulnerable to COVID-19?

Q5. In regards to policy implementation:

- What policies did you put in place or assist with putting in place within your jurisdiction in response to health or economic barriers impacting communities most vulnerable to this crisis?
- In your opinion, what policies that have not been implemented are most critical for supporting communities most vulnerable to this crisis?

Q6. Moving forward, what are the most critical transformations that need to take place to position Public Health for the increasing needs of the 21st century (financial, workforce, infrastructure, etc.)?

- Are there other kind of local, State or federal recommendations?

Q7. (If Time): Is there anything else you would like to suggest in support of local public health departments providing support to impacted communities?

APPENDIX C - KEY INFORMANT INTERVIEW GUIDE

Philanthropy

PROJECT OVERVIEW

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Public Health Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure and community conditions.

To help inform our report and collect initial feedback and guidance, the Alliance is conducting key informant interviews with philanthropic foundations who have supported the COVID-19 response and recovery with their investments. These interviews will supplement the interviews we are conducting with local public health departments, community-based organizations and other sectors across the State. Should you have any questions about this project, please contact Tracy Delaney, Ph.D., Alliance Executive Director, at tdelaney@phi.org.

INTERVIEW QUESTIONS

The following interview questions were developed to help us meet the requirements of the report. There are seven questions, with additional prompts as needed, based on the initial response.

Q1. As you know, COVID-19 has laid bare the stark underlying health inequities and inequitable community conditions that exacerbate health and economic impacts during most public health and climate emergencies. When it became clear that COVID-19 was disproportionately impacting certain communities across the State:

- What strategies did your foundation implement?
- Did you shift where you made investments?
- How quickly were you able to make this shift and did you utilize any new strategies to support more rapid distribution of resources?
- Was your focus on supporting existing grantees or new groups?

Q2. How, if at all, did your existing partnerships with local public health departments facilitate your response and help you determine your investment priorities?

- If existing partnership helped facilitate the response) Are you continuing to partner with local public health departments to determine COVID-19 priorities? If so, how, if at all, has your strategy shifted from the start of the pandemic?

- Did you fund any local public health departments directly?
- Did you connect with local public health departments to help guide your investments to community-based organizations?
- How would you like to partner with public health departments in the future?
- Do you have suggestions on how to more broadly build strong bridges between the public health and the philanthropic sectors so we have better communication and coordination in the future to address health emergencies and natural disasters?

Q3. In terms of policy:

- Have you supported grantees in advancing issues or policy priorities throughout this pandemic? If so, have any of your grantees been successful in these efforts as a result of your funding support?
- What policies that have not been implemented are most critical for supporting communities most vulnerable to this crisis? Do you foresee providing continued support around those priorities?

Q4. Do you see a role for philanthropy to help catalyze a stronger government response in addressing root causes of health inequities, including systemic racism? If so, what might that be?

Q5. In terms of public health infrastructure:

- What does COVID-19 tell us about policy and funding shortcomings in our public health infrastructure?
- What do you see as potential levers that could address and correct chronic underfunding of public health departments?
- Do you see a role for philanthropy in supporting the public health sector? If so, in what areas?

Q6. Has COVID-19 changed your long-term outlook, focus, or work in regards to your:

- Funding portfolio?
- Legislative platform and/or upcoming policy advocacy?
- Do you see a role for advocating for increased public health department infrastructure?
- Other?

Q7. Are there any other lessons learned that you would like to share as a result of this crisis and/or your partnerships with local public health departments?

APPENDIX D - KEY INFORMANT INTERVIEW GUIDE

Equity Organizations

PROJECT OVERVIEW

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Public Health Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure and community conditions.

To help inform our report and collect initial feedback and guidance, the Alliance is conducting key informant interviews with leaders from multiple sectors who have been critical to the COVID-19 response and recovery. These interviews will supplement the interviews we are conducting with local public health departments, community-based organizations, philanthropic foundations and other sectors across the State. Should you have any questions about this project, please contact Bill Sadler, Alliance Director of Operations, at bsadler@phi.org

INTERVIEW QUESTIONS

The following interview questions were developed to help us meet the requirements of the report. There are four questions, with additional prompts as needed, based on the initial response.

Q1. What have been your most effective strategies to respond to and support the needs of communities most disproportionately impacted by COVID-19, specifically related to policy advancement and/or implementation?

- What supports and/or strategies helped you accomplish this?
- What have been the biggest barriers to advancing the policies needed to protect the health and wellness of disproportionately impacted communities throughout this crisis?

Q2. In regards to policy implementation:

- What policies did you prioritize advancing at the local, state, and/or federal level in response to health, economic or environmental barriers impacting communities most vulnerable to this crisis?
- In your opinion, what policies that have not been implemented are most critical for supporting communities most vulnerable to this crisis?
- Are there certain policies you will be advocating for in your upcoming policy work to address the ongoing response and recovery?

Q3. How would you characterize your relationship with the public health sector as the pandemic unfolded?

- Were there any challenges? Were you able to overcome them?
- Have you been able to successfully partner with the public health sector to identify the policy priorities needed to protect the health of disproportionately impacted communities and advance racial equity throughout this crisis?
- What is the partnership with the public health sector you would like to have moving forward?

Q4. Moving forward, what are the most critical transformations that need to take place to support communities most impacted by inequities as we work toward an equitable and just response and recovery and protect against future public health and climate threats?

Q5. (If Time): Is there anything else you would like to add?

APPENDIX E - KEY INFORMANT INTERVIEW GUIDE

Healthcare

PROJECT OVERVIEW

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure and community conditions.

To help inform our report and collect initial feedback and guidance, the Alliance is conducting key informant interviews with leaders from multiple sectors who have been critical to the COVID-19 response and recovery. These interviews will supplement the interviews we are conducting with local public health departments, community-based organizations, philanthropic foundations and other sectors across the State. Should you have any questions about this project, please contact Bill Sadler, Alliance Director of Operations, at bsadler@phi.org

INTERVIEW QUESTIONS

The following interview questions were developed to help us meet the requirements of the report. There are seven questions, with additional prompts as needed, based on the initial response.

Q1. When it became clear that COVID-19 was disproportionately impacting certain communities:
- What were your most effective strategies to respond and support your members/patients?
- What supports helped you accomplish this?
- What were the barriers?
- Do you have any example of innovative or best practices you employed? Any stories of something that went surprisingly well?

Q2. How, if at all, did you work with the State and/or local public health department?
- How would you characterize your relationship with the public health sector as the pandemic unfolded?
- Were there any challenges? Were you able to overcome them?
- What would you suggest to improve things in the future?
- How can we build stronger bridges between healthcare and public health to ensure better communication, overall coordination and partnerships for future health emergencies and natural disasters?

Q3. In your COVID-19 response, did you experience data challenges? If so, what were the challenges and what would you suggest to address them?

Q4. When it comes to resources:

- Did you have adequate funding to appropriately address the needs of your members/ patients?
- Did you seek any additional resources (e.g. CARES Act funding, government aid, member dues, philanthropy, etc.)
- What are your top resource needs and what would you suggest as potential solutions?

Q5. What policies and practices did you put in place to protect the health of your providers, patients and/or the most impacted community members?

Q6. Will COVID-19 result in additions/changes to your upcoming legislative platform or policy agenda? If so, how?

Q7. Moving forward, what are the most critical transformations that need to take place to support an equitable COVID-19 response and recovery?

Q8. (If Time): Is there anything else you would like to add?

APPENDIX F - SURVEY QUESTIONS

Local Public Health Department Executives

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure and community conditions.

To help inform our report and collect initial feedback and guidance, the Alliance has developed this survey for local public health department executives. We will also be conducting key informant interviews with local public health departments throughout the course of this process. **Individual responses are confidential and we will not identify answers from specific local public health departments.** We ask you to identify your department only so we can ensure we are collecting responses from a representative sample of the entire State. This survey includes a total of 40 questions and is designed to take approximately 15-20 minutes of your time. Most responses are multiple choice or rankings, with an option to provide more details in comment boxes after each response.

WHAT LOCAL PUBLIC HEALTH DEPARTMENT DO YOU REPRESENT?

Q1. All individual survey responses will remain confidential. However, for quality assurance purposes, we want to ensure we receive equitable responses throughout the State. All survey results will be shared in the aggregate.

- ○ Prefer not to state

Q2. If you prefer not to state, does your Department represent a small, medium, or large county?

- ○ Small (<100,000)
- ○ Medium (100,001-500,000)
- ○ Large (>500,000)

Q3. In which region is your Department located?

ARE YOU:

Q4. Public Health Director or Designee (please indicate):

- ○ Prefer not to state

Q5. Public Health Officer or Designee (please indicate):

- ○ Prefer not to state

TODAY'S DATE:

- ○ Fill-in-the-blank

STAFFING:

Q6. Our department has had a sufficient workforce to respond to the needs of communities most vulnerable to the impacts of COVID-19 throughout the pandemic.

- ○ 1-4 (Strongly agree-Strongly disagree, No opinion/ Do not know)
- ○ Open box for additional comments

Q7. Our staff have the cross-cutting skillsets to adequately respond to the needs of communities most vulnerable to the impacts of COVID-19 throughout the pandemic.

- ○ 1-4 (Strongly agree-Strongly disagree, No opinion/Do not know)
- ○ Open box for additional comments

Q8. Approximately how many staff have been diverted from their standard roles in your Department to assist with the COVID-19 response?

- ○ [fill in number]

Q9. Approximately what percentage of your overall workforce has been diverted?

- ○ [fill in percentage]

Q10. How, if at all, has this impacted your department's ability to support communities most vulnerable to the impacts of COVID-19? Check all that apply:

- ○ Gaps in other critical department functions that support impacted communities (e.g. WIC, SNAP, BIH, etc.)
- ○ Administrative delays impacting service delivery
- ○ Delays in contracting/procurement with community-based partners
- ○ Impacts on community outreach/engagement
- ○ Other (please describe):

Q11. Of those staff who were diverted, how many have been redeployed back to their standard roles?

- ○ [fill in number]

Q12. Approximately what percentage of your overall workforce have been returned back to their standard roles?

- ○ [fill in percentage]

Q13. Besides diverting internal department staff, what staffing support did you utilize to fill your critical staffing needs? Check all that apply:

- ○ External support from other departments/agencies within our jurisdiction
- ○ California Health Corps
- ○ Medical Reserve Corps or other external supports
- ○ CDC Foundation
- ○ State of California
- ○ Other [please describe]:

Q14. Which of these skills did your department find most critical in supporting communities most vulnerable to the impacts of COVID-19? Check all that apply:

- ○ Finance/Funding
- ○ Administration
- ○ Epidemiological training
- ○ Advanced equity understanding
- ○ Data analysis
- ○ Coding
- ○ Community engagement/partnerships
- ○ Public health nursing
- ○ Multilingual speakers
- ○ Knowledge and partnership/utilization of non-profit organizations
- ○ Communications/media outreach
- ○ Other [please describe]:

Q15. Internal human resources policies/processes (e.g. hiring, onboarding, recruiting, etc.) have facilitated our ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 1-4 (1- Strongly agree, 2 – Somewhat agree, 3 – Somewhat disagree, 4 – Strongly disagree, No opinion/Do not know)
- ○ Open box for additional comments

Q16. Internal contracting/procurement policies/processes facilitated our ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 1-4 (1- Strongly agree, 2 – Somewhat agree, 3 – Somewhat disagree, 4 – Strongly disagree, No opinion/Do not know)
- ○ Open box for additional comments

FUNDING

Q17. The funding we have received throughout the pandemic has been sufficient for addressing the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 1-4 (Strongly agree-Strongly disagree, No opinion/Do not know)
- ○ Open box for additional comments

Q18. To what extent has a lack of funding flexibility acted as a barrier to responding adequately to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response?

- 1-4 (1- Not a barrier, 2- Minor barrier, 3- Moderate barrier, 4- Major barrier, No opinion/Do not know)
- Open box for additional comments

DATA

Q19. How effective have your existing (in place pre-COVID) data systems/surveillance been in equitably supporting your response?

- 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Open box for additional comments

Q20. How effective have your new/modified/adapted data systems/surveillance been in equitably supporting your response?

- 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Open box for additional comments

Q21. Where did you have the biggest challenges with your data infrastructure? Select your top 3:

- Case reporting, investigation, and management
- Contact tracing
- Production/reporting of State-required metrics
- Production/reporting of local dashboard metrics
- Collection of death data
- Collection of hospital data
- Collection of lab data
- Collection of demographic data (e.g., race/ethnicity, age, gender)
- Other [please describe]:

TESTING/CONTACT TRACING

Q22. What COVID-19 testing strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- Expanding testing access in communities most impacted by COVID-19
- Political partnerships/support in conducting outreach (with local electeds, etc.)
- Pop-up testing sites in non-traditional areas (e.g. bus stops, parks, etc.)
- Partnering with community clinics in areas most impacted by COVID-19
- Partnering with community-based organizations/trusted messengers in communities most impacted by COVID-19
- Coordination with other City/County agencies
- Communications/messaging campaigns
- Other [please describe]:

Q23. What additional testing support is needed for your jurisdiction to best support communities most vulnerable to the impacts of COVID-19? Select the top 3:

- ○ Additional staffing
- ○ Resources to expand testing access
- ○ Enhanced lab capacity
- ○ Enhanced data support to support decision-making
- ○ Support from elected officials (e.g. political, outreach, etc.)
- ○ Resources to partner with community-based organizations to conduct outreach and provide additional resources
- ○ Culturally informed communications/outreach
- ○ Relationship/partnerships with trusted messengers
- ○ Enhanced coordination
- ○ Other [please describe]:

Q24. What case investigation strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- ○ Relationship building before and during crisis
- ○ Multilingual case investigators
- ○ Equity-informed staff training
- ○ Hiring case investigators from communities disproportionately impacted by COVID-19
- ○ Partnering with community-based organizations to support case investigations
- ○ Ability to provide incentives
- ○ Other [please describe]:

Q25. What type of additional case investigation support is needed to best support communities most vulnerable to the impacts of COVID-19? Select top 3:

- ○ Additional staffing support
- ○ Assistance in identifying case investigators with needed qualifications
- ○ Equity-informed staff training
- ○ Support from elected officials (e.g. political, outreach, etc.)
- ○ Support partnering with community-based organizations to conduct case investigation and provide additional resources
- ○ Culturally informed communications/outreach
- ○ Additional resources for incentives
- ○ Enhanced coordination
- ○ Other [please describe]:

Q26. What contact tracing strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- ○ Relationship building before and during crisis
- ○ Multilingual contact tracers
- ○ Equity-informed staff training
- ○ Hiring contact tracers from communities disproportionately impacted by COVID-19
- ○ Partnering with community-based organizations to conduct outreach and provide additional resources

- Ability to provide isolation/quarantine housing support
- Additional wraparound resources to support individuals/families (food assistance, housing support, technology, etc.)

Q27. What type of additional contact tracing support is needed to best support communities most vulnerable to the impacts of COVID-19? Select top 3:

- Additional staffing support
- Assistance in identifying contact tracers with needed qualifications
- Equity-informed staff training
- Support from elected officials (e.g. political, outreach, etc.)
- Support partnering with community-based organizations to conduct outreach and provide additional resources
- Culturally informed communications/outreach
- Isolation/quarantine housing support
- Additional wraparound resources to support individuals/families (food assistance, housing support, technology, etc.
- Enhanced coordination
- Other [please describe]:

COORDINATION

Q28. How effective has your coordination been in responding to the needs of communities disproportionately impacted by COVID-19 with:

- The federal government?
  - 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- The State?
  - 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Regionally?
  - 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Within your own Jurisdiction?
  - 1-1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Internally (within your own department)?
  - 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
  - Open box for additional comments
- With community-based organizations representing the communities most impacted by COVID-19?
  - 1-4 (Very effective, 2-Somewhat effective, 3- Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)

Q29. To what extent was shifting and/or contradictory guidance a barrier to the effectiveness of our response to communities most impacted by COVID-19

- 1-4 (1- Not a barrier, 2- Minor barrier, 3- Moderate barrier, 4- Major barrier, No opinion/Do not know)
- Open box for additional comments

Q30. The COVID-19 pandemic has given our department new opportunities to form cross-sector and external partnerships and be seen as leaders in work outside of traditional public health response, specifically in regards to supporting communities most impacted by inequities

- Scale 1-4 (Strongly agree-Strongly disagree, No opinion/Do not know)
- List any sectors in particular that you formed stronger partnerships with during the pandemic
- Open box for additional comments

OPPOSITION/POLITICAL BARRIERS

Q31. Did you or anyone else publicly leading your pandemic response receive any threats or harassment?

- Yes/No
- Open box for additional comments

Q32. To what extent have political pressures and/or the political environment in your own jurisdiction acted as a barrier to your ability to respond effectively to the needs of communities most impacted by COVID-19 during the crisis?

- 1-4 (1- Not a barrier, 2- Minor barrier, 3- Moderate barrier, 4- Major barrier, No opinion/Do not know)
- Open box for additional comments

EQUITY STAFFING/INFRASTRUCTURE

Q33. Approximately what proportion of your staff were deployed to support the COVID-19 response, were previously trained in foundational equity principles (e.g. racial and/or health equity in government, community-based decision-making, anti-racism and bias, etc.)?

- _____%
- Open box for additional comments

Q34. Our Department has funded equity staff in place whose primary role was to support the advancement of equity in your department and/or jurisdiction:

- Yes/No (box to explain if they have additional comments)
- If no, do you believe additional funding for dedicated equity staff would

Q35. If your department had funded staff in place in your department/jurisdiction whose primary role was to advance equity before the crisis began, were those staff deployed to the emergency operations center to help direct response?

- Yes/No (box to explain if they have additional comments)
- If no, do you have staff in the leadership of your ICS who are trained to meet the immediate/long-term health needs of groups most impacted by inequities during an emergency? (Yes/No)
- Open box for additional comments

Q36. Were COVID-19 response strategies developed using an equity lens, specifically:

Used an equity tool to inform decision-making

- 1-4 (Always, Often, Rarely, Never, I don't know/No response)
- Open box for additional comments

Q37. Developed and/or reviewed by equity staff/team

- 1-4 (Always, Often, Rarely, Never, I don't know/No response)
- Open box for additional comments

Q38. Developed and/or reviewed by community advisors/representatives

- 1-4 (Always, Often, Rarely, Never, I don't know/No response)
- Open box for additional comments

Q39. Other tool or approach not listed above [Please describe]:

Q40. Did you engage community groups/members most impacted by inequities in the decision-making process throughout your response?

- 0-4 (Never, Rarely, Sometimes, Often, Always)
- Open box for additional comments

COMMUNICATIONS

Q41. What are the biggest communications challenges your department has faced in regards to supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- Lack of sufficient language translation funding
- Lack of effective language translation contractors/staff
- Insufficient staffing to provide multilingual and culturally informed information/outreach
- Regional coordination
- Lack of pre-existing relationships with media, etc.
- Lack of sufficient interpretation support
- Difficulty creating culturally appropriate messaging
- Difficulty outreaching to traditionally hard to reach communities
- Limited/no funding for internal communications staff/messaging development
- Other [please describe]:

COMMUNITY ENGAGEMENT

Q42. How critical were the community partnership established before the pandemic in supporting communities most vulnerable to the impacts of COVID-19 during the crisis?

- Scale 1-4 (Very critical, Somewhat critical, Not very critical, Not critical at all, No opinion/Do not know)
- Open box for additional comments

Q43. The COVID-19 pandemic has given our department the opportunity to establish new community partnerships that have been critical in supporting communities most impacted by inequities
- Scale 1-4 (Strongly agree, Agree, Disagree, Strongly disagree, No opinion/Do not know)
- Open box for additional comments

SOCIAL DETERMINANTS OF HEALTH

Q44. What social determinants of health issues have emerged as the most critical issues for communities most impacted by COVID-19 throughout your City/County's response? Rank in order of most to least critical:
- Housing issues (eviction moratorium/tenant protections, homelessness)
- Economic issues (industry/worksite regulations, paid family leave, occupational health, essential workers, shutting down businesses)
- Education issues (school closures/reopening, child care, parental supports)
- Nutrition (healthy food access, SNAP/WIC benefits)
- Transportation (public transportation access, accessing medical services that are drive-through, sidewalk space to handle outdoor dining and other uses)
- Neighborhood (senior centers, park access, closure of recreation centers, beaches, other outdoor facilities)
- Other (please specify)

Q45. How effective has your department been at advocating for the policy changes needed (local, state, federal) to better support communities most vulnerable to the impacts of COVID-19 throughout this crisis?
- 1-4 (1-Very effective, 2-Somewhat effective, 3-Somewhat ineffective, 4- Very ineffective, No opinion/Do not know)
- Open box for additional comments

Q46. Our department wwas able to provide and/or ensure adequate PPE for internal and external essential workers
- 1-4 (Always, Often, Rarely, Never, No opinion/Do not know)
- Open box for additional comments

ADDITIONAL COMMENTS (OPEN ENDED)

Q47. When thinking about your COVID-19 response thus far, what are the top 3-5 things that have best supported your ability to respond to the needs of communities most impacted by COVID-19 throughout the crisis?

Q48. When thinking about your COVID-19 response thus far, what are the top 3-5 things that would have better supported your ability to respond to the needs of communities most impacted by COVID-19 throughout the crisis?

Q49. Is there anything else you would like to share that is not captured above?

APPENDIX G - SURVEY QUESTIONS

Local Public Health Department Data Experts

Q1. What Local Public Health Department do you represent? (If you prefer not to state, please continue to the next question.)

Q2. If you prefer not to state your affiliation, does your Department represent a small, medium, or large county?

- ○ Small (<100,000)
- ○ Medium (100,001 - 500,000)
- ○ Large (>500,000)

Q3. In which region is your Department located?

- ○ Far North
- ○ Bay Area
- ○ Greater Sacramento Region
- ○ Central Valley
- ○ Southern California

Q4. What is your role or title?

Q5. Overall, where have you had the biggest challenges with your data infrastructure? Select all that apply.

- ○ Case reporting, investigation, and management
- ○ Contact tracing
- ○ Production/reporting of State-required metrics
- ○ Production/reporting of local dashboard metrics
- ○ Collection of death data
- ○ Collection of hospital data
- ○ Collection of lab data
- ○ Collection of demographic data (e.g., race/ethnicity, age, gender)
- ○ Communicating data to the general public
- ○ Other (please specify)

Q6. Additional comments or details on data challenges:

Q7. What aspects of your data infrastructure have improved over the course of the pandemic? Select all that apply.

- ○ Case reporting, investigation, and management
- ○ Contact tracing
- ○ Production/reporting of State-required metrics
- ○ Production/reporting of local dashboard metrics
- ○ Collection of death data
- ○ Collection of hospital data
- ○ Collection of lab data
- ○ Collection of demographic data (e.g., race/ethnicity, age, gender)
- ○ Communicating data to the general public
- ○ Other (please specify)

Q8. For those things that improved, what contributed to the improvement? Select all that apply.

- ○ New funding
- ○ Increased staffing/capacity
- ○ New tools
- ○ Guidance from CDPH
- ○ Other (please specify)

Q9. Is there a particular success or best practice you would like to share? If so, please describe.

Q10. Additional comments or details on successes, best practices, or data infrastructure improvements:

Q11. Does your jurisdiction track indirect COVID-19 impacts (such as job losses or housing/food insecurity) in your vulnerable communities?

- ○ Yes
- ○ No

Q12. If yes, please describe. How are these data used in your jurisdiction?

Q13. If not, please select the reasons:

- ○ Limited staff capacity
- ○ Lack of funding
- ○ Political/jurisdictional will
- ○ Data limitations
- ○ Other (please specify)

Q14. Are there other data that would be helpful for your jurisdiction's COVID-19 response, particularly among your vulnerable communities?

- ○ No
- ○ Yes (please specify)

Q15. Additional comments or details on data and equity impacts in your jurisdiction

APPENDIX H - SURVEY QUESTIONS

Community-Based Organizations

The California Department of Public Health's Office of Health Equity (CDPH-OHE) has contracted with the Public Health Alliance of Southern California (Alliance) to produce a report with policy, program, and resource recommendations, and best practice examples, ensuring that local public health departments are adequately prepared to protect communities most vulnerable to the health and socioeconomic impacts of COVID-19 as well as future public health emergencies. This report will elevate best practices, including examples of community-informed efforts supporting communities most vulnerable to the impacts of COVID-19, throughout the response and recovery process. The report seeks to improve long-term recovery through recommended policy changes and investments in public health infrastructure, community conditions, and community-based initiatives that work to protect and improve the health of communities most impacted by inequities.

A key component of this report will be uplifting community-informed feedback and guidance to local public health departments, the State, and key decisionmakers, in order to inform policy and investment decisions about the COVID-19 response and recovery. To assist us with collecting this feedback, the Alliance has developed this survey for community-based organizations and advocacy groups that represent and/or directly serve community members disproportionately impacted by the COVID-19 pandemic. **Individual responses are confidential and we will not identify answers from specific organizations. All questions on this survey are entirely voluntary, but we hope you will feel comfortable providing this critical information so that we can fully understand survey results and elevate key needs and recommendations.** This survey is designed to take approximately 15-20 minutes of your time. Most responses are multiple choice or rankings, with an option to provide more details in comment boxes after each response.

This survey has three sections: (1) Organization Information, (2) COVID-19 impacts on your organization, (3) COVID-19 impacts on the communities you serve, and (4) Health Department Priorities During COVID-19 & Beyond

TODAY'S DATE

- ○ Fill-in-the-blank

ORGANIZATION INFORMATION

WHAT COMMUNITY ORGANIZATION DO YOU REPRESENT?

Q1. All individual survey responses will remain confidential. However, for quality assurance purposes, we want to ensure we receive equitable and representative responses throughout the State. All survey results will be shared in the aggregate.

- ○ Organization Name:
- ○ Organization Website/URL:

Q2. Please provide a brief (1-2 sentence) summary of what your organization does and the community/ies you represent and/or serve:

- ○ [Blank Box]

Q3. Is your organization:

- ○ An independent 501(c)(3)
- ○ A program administered/sponsored by a fiscal intermediary (please name)
- ○ Another structure (please describe)
- ○ I don't know/not sure

Q4. Is your organization located in a small, medium or large county?

- ○ Small (<100,000)
- ○ Medium (100,001-500,000)
- ○ Large (>500,000)
- ○ Our organization works across multiple counties
- ○ Our organization works statewide

Q5. In which region is your organization located (check all that apply)?

- ○ Far North
- ○ Bay Area
- ○ Greater Sacramento Region
- ○ Central California
- ○ Southern California
- ○ Central Coast
- ○ Statewide

ARE YOU PRIMARILY:

- ○ An organizing and/or advocacy group
- ○ Direct service organization
- ○ Faith-based entity
- ○ Other (please describe)
- ○ Prefer not to state

PLEASE IDENTIFY THE PRIMARY FOCUS AREAS FOR YOUR ORGANIZATION (CHECK ALL THAT APPLY)

- ○ Behavioral Health
- ○ Economic security
- ○ Education
- ○ Environmental/Climate Justice
- ○ Housing Stability
- ○ Homelessness
- ○ Immigration
- ○ LGBTQ+ Rights
- ○ Public Health/Community Health
- ○ Racial Justice

- ○ Transportation
- ○ Workforce Development
- ○ Youth Development
- ○ Other (please describe)

COVID-19 IMPACTS (ORGANIZATIONAL)

OVERALL IMPACTS:

Q6. How has COVID-19 most negatively impacted your ability to carry out your mission-driven work (select top 3):

- ○ Loss of funding
- ○ Ability to respond quickly to priority needs
- ○ Inability to hold trainings or events in person
- ○ Inability to see clients in person
- ○ Staff and client health
- ○ Communications with clients most vulnerable to the impacts of COVID-19
- ○ Food and housing access
- ○ Mental health
- ○ School closures
- ○ Domestic violence
- ○ Job loss
- ○ Technology access
- ○ Lack of community cohesion due to isolation
- ○ Other (please describe)

Q7. What are the top 3 things that have most supported your organization throughout this crisis?

- ○ Box one
- ○ Box two
- ○ Box three

RESOURCES/SERVICES TO COMMUNITY

Q8. Are you providing specific services related to COVID-19?

- ○ Yes
- ○ No
- ○ Other (please specify):

Q9. If yes, which resources are you providing for your community members being impacted by COVID-19 (check all that apply)?

- ○ Outreach
- ○ Education
- ○ Legal support
- ○ Housing/rental assistance

- ○ Food
- ○ Childcare
- ○ Worker's rights
- ○ Financial assistance
- ○ Other (please describe):

Q10. Which of the following would be most impactful in terms of how government and philanthropic funding should be directed to organizations like yours to combat COVID-19 and its impact (select top 3):

- ○ General operating support
- ○ Individual financial support (e.g. direct cash assistance)
- ○ Homeless housing support
- ○ Healthcare
- ○ COVID-19 related testing or treatment
- ○ Basic needs
- ○ Childcare
- ○ Education/Teachers
- ○ Mental health support
- ○ Small business support
- ○ Undocumented resident support
- ○ Language translation/interpretation
- ○ Technology support
- ○ Personal Protective Equipment (PPE)
- ○ Other (please describe):

CONTRACTING/PROCUREMENT

Q11. Have you entered any contracts with your local public health department or other local government agencies during the pandemic in order to support the communities you represent and/or serve:

- ○ Yes, the local public health department
- ○ Yes, another government agency (please name)
- ○ No
- ○ Other (please describe):

Q12. Who initiated the contracting conversation?

- ○ Our organization
- ○ Local health department/government agency
- ○ Other (please describe):

Q13. How would you rate the ability of your organization to navigate these contracting processes?

- ○ 1-4 (1-can navigate without difficulty, 2-can navigate with very little difficulty, 3-can navigate but with difficulty, 4-cannot navigate at all, No opinion/Do not know)

Q14. Have your local public health department or other local government agency contracting/procurement policies/processes easily facilitated your ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout your response?

- 1-4 (1- greatly facilitated, 2 – somewhat facilitated, 3 – somewhat impeded, 4 – strongly impeded, No opinion/Do not know)
- Open box for additional comments

Q15. To what extent would technical assistance around local government contracting/procurement policies/processes positively impact your ability to quickly apply for and receive funding needed to support the communities you represent and/or serve?

- 1-4 (1-strongy impact, 2-somewhat impact, 3-would not really impact, 4-would not impact at all, No opinion/Do not know)

PARTNERSHIP & ENGAGEMENT

Q16. **When thinking about the COVID-19 response thus far:**

- What are the top 3-5 things have gone well in terms of working with your local public health department to respond to the needs of the communities you represent and/or serve? [open box]
- What are the top 3-5 things your health department could have done that would have better supported your ability to respond to the needs of the communities you represent and/or serve? [open box]

Q17. How helpful were the health department or other local government partnerships established before the pandemic in supporting the communities your organization represents and/or serves throughout the crisis?

- Scale 1-4 (Very helpful, somewhat helpful, not very helpful, not helpful at all, No opinion/Do not know)
- Open box for additional comments

Q18. To what extent do you agree that the COVID-19 pandemic has given your organization the opportunity to establish new partnerships with your health department or other local government entities that have been essential in supporting the communities you represent and/or serve.

- Scale 1-4 (strongly agree, agree, disagree, strongly disagree, no opinion/do not know)
- Open box for additional comments

Q19. Throughout the pandemic, how often has your organization, or other organizations representing communities disproportionately impacted throughout this crisis, been engaged in decision-making processes by your local public health department?

- 0-4(never, rarely, sometimes, often, always)
- Open box for additional comments

DATA

Q20. What data sources/tools have you found most helpful for understanding the impact of COVID-19 on the communities you represent and/or serve?

- ○ Local health department website
- ○ California Department of Public Health (CDPH) website
- ○ Other State website
- ○ California Healthy Places Index COVID-19 Resource Map
- ○ Local news website (e.g. Los Angeles Times, Sacramento Bee)
- ○ Other State/national database (e.g. Johns Hopkins)
- ○ Other (please describe):

Q21. Are you familiar with the data being provided by your local public health department/ jurisdiction on the impact of COVID-19 on the communities your organization represents and/ or serves.

- ○ Yes
- ○ No
- ○ Other (please describe)

Q22. If yes, to what extent are the data being provided by your local public health department sufficient for understanding the health impact of the pandemic on the communities your organization represents and/or serves:

- ○ 1-4 (More than sufficient, 2-Somewhat sufficient, 3- Somewhat insufficient, 4- Very insufficient, No opinion/Do not know)
- ○ Open box for additional comments

Q23. What additional data and/or data support would be most useful in your work to support the communities you represent and/or serve (select top 3):

- ○ Further disaggregation of data by race/ethnicity
- ○ Further disaggregation of data by age
- ○ Further disaggregation of SOGI (sexual orientation and gender identity)
- ○ Further disaggregation of data by place (e.g. zip code, census tract, etc.)
- ○ Data interpretation/explanation support
- ○ Enhanced technology support
- ○ Other (please describe):

COVID-19 IMPACTS (ON THE COMMUNITIES YOU REPRESENT AND/OR SERVE)

Q24. What are your top 3 concerns related to the impact of COVID-19 on the communities you serve and/or represent:

- ○ Box one:
- ○ Box two:
- ○ Box three:

TESTING/CONTACT TRACING:

Q25. Based on what you have learned so far, what COVID-19 testing strategies appear to be most effective in supporting the communities you represent and/or serve? Select the top 3:

- ○ Expanding testing access in communities most impacted by COVID-19
- ○ Political partnerships/support in conducting outreach (with local electeds, etc.)
- ○ Pop-up testing sites in non-traditional areas (e.g. bus stops, parks, etc.)
- ○ Partnering with community clinics in areas most impacted by COVID-19
- ○ Partnering with community-based organizations/trusted messengers in communities most impacted by COVID-19
- ○ Coordination with other City/County agencies
- ○ Communications/messaging campaigns
- ○ Communications/messaging campaigns to reduce stigma/discrimination
- ○ Other [please describe]:

Q26. What resources would best support the communities you represent and/or serve to increase the awareness and accessibility of testing? Select the top 3:

- ○ Resources to expand testing access
- ○ Support from elected officials (e.g. political, outreach, etc.)
- ○ Partnering with community-based organizations to conduct outreach and provide additional resources
- ○ Culturally informed communications/outreach
- ○ Relationship/partnerships with trusted messengers
- ○ Enhanced coordination
- ○ Other [please describe]:

Q27. Based on what you have learned so far, what COVID-19 contact tracing strategies appear to be most effective in supporting the communities you represent and/or serve? Select the top 3:

- ○ Relationship building before and during crisis
- ○ Multilingual contact tracers
- ○ Equity-informed staff training
- ○ Hiring contact tracers from the neighborhoods/communities disproportionately impacted by COVID-19
- ○ Partnering with community-based organizations to conduct outreach and provide additional resources
- ○ Ability to provide isolation/quarantine housing support
- ○ Additional wraparound resources to support individuals/families (food assistance, housing support, technology, etc.)
- ○ Other [please describe]:

Q28. What type of additional support and/or strategies would best support awareness and openness to contact tracing efforts in the communities you represent and/or serve? Select top 3:

- ○ Additional staff to conduct outreach/education
- ○ Equity-informed training
- ○ Support from elected officials (e.g. political, outreach, etc.)

- ○ Partnering with community-based organizations to conduct outreach and provide additional resources
- ○ Culturally informed communications/outreach
- ○ Isolation/quarantine housing support
- ○ Additional wraparound resources to support individuals/families (food assistance, housing support, technology, etc.
- ○ Enhanced coordination
- ○ Other [please describe]:

COMMUNICATIONS

Q29. What are the biggest communications challenges the communities you represent and/or serve have faced throughout this crisis? Select the top 3:

- ○ Lack of sufficient language translation
- ○ Lack of effective language translation
- ○ Insufficient multilingual and culturally informed information/outreach
- ○ Lack of sufficient interpretation support
- ○ Messaging is not culturally appropriate or relevant
- ○ Outlets for communication are not reaching the communities we represent and/or serve
- ○ Fear of stigmatization/discrimination
- ○ Other [please describe]:

Q30. What strategies would best support outreach and/or communications to the communities you represent and/or serve:

- ○ Relationship building before/during crisis
- ○ Hiring outreach workers from the neighborhoods/communities disproportionately impacted by COVID-19
- ○ Partnering with community-based organizations to conduct outreach and provide additional resources
- ○ More direct outreach from local public health department staff/officials
- ○ Diversifying outlets for outreach/communications
- ○ Stronger partnerships with ethnic media outlets
- ○ Other (please describe):

ESSENTIAL/FRONTLINE WORKERS

Q31. Do you represent and/or serve community members who are considered essential or frontline workers?

- ○ Yes
  If yes → next set of questions
- ○ No
  If no → skip to next section
- ○ Other (please describe):

Q32. If yes, how often have the frontline or essential community members you serve had access to adequate PPE throughout the crisis?

- ○ 0-4 (never, rarely, sometimes, often, always), Do not know
- ○ Open box for additional comments

Q33. How often have the frontline or essential community members you serve been made aware of their rights as employees (as they related to COVID-19) throughout this crisis?

- ○ 0-4 (never, rarely, sometimes, often, always), Do not know
- ○ Open box for additional comments

Q34. How often have the frontline or essential community members you serve and their families been able to safely isolate or quarantine when needed without fear of losing their employment?

- ○ 0-4 (never, rarely, sometimes, often, always), Do not know
- ○ Open box for additional comments

POLICY CHANGE

*Policy changes can include policies that are directly in response to COVID-19 (e.g. COVID-19 related worker protections, local eviction moratoriums, expanded SNAP/WIC access, etc.) or policies that have impacts during COVID-19 & beyond (e.g. stricter rent control, expanded paid sick leave, enhanced worker protections, etc.)

Q35. Recent policy changes in response to COVID-19 have been sufficient for responding to the needs of the communities you represent and/or serve:

	Strongly agree	Agree	Disagree	Strongly disagree	No opinion/ Do not know
At the ***local*** level	1	2	3	4	5
At the ***state*** level	1	2	3	4	5
At the ***federal*** level	1	2	3	4	5

Additional comments:

Q36. Based on the needs of the communities you represent and/or serve, what policies have not been implemented that would be most helpful in supporting communities most vulnerable to this crisis?

	Please and/or describe
At the ***local*** level	
At the ***state*** level	
At the ***federal*** level	

Additional comments:

SOCIAL DETERMINANTS OF HEALTH

Q37. What social determinants of health issues have emerged as the most critical issues for the communities you represent and/or serve (select all that apply)?

- ○ Housing (select top 3):
  - » Inability to pay rent
  - » Inability to pay mortgage
  - » Inability to pay utilities
  - » Threat of eviction
  - » Tenant protections
  - » Homelessness and shelter access
  - » Ability to safely isolate/quarantine
  - » Overcrowded housing
  - » Please list other top concerns:
- ○ Economic (select top 3)
  - » Unemployment
  - » Accessing financial support (e.g. Unemployment benefits)
  - » Industry/worksite COVID-19 regulations
  - » Occupational health protections
  - » Business closures
  - » Paid Family Leave benefits
  - » Access to PPE
  - » Please list other top concerns:
- ○ Education (select top 3)
  - » School closure
  - » School reopening
  - » Homeschooling
  - » Access to stable internet
  - » Access to other needed technology
  - » Child Care
  - » Parental Supports
  - » School meals
  - » Education gap
  - » Please list other top concerns:

- Nutrition (select top 3)
  - Healthy food access
  - Changes to SNAP benefits
  - Changes to WIC benefits
  - Closure of local food retailers
  - Increase demand on emergency food resources (e.g. pantries)
  - Please list other top concerns:
- Transportation (select top 3)
  - Changes to public transportation schedules (e.g. timing/frequency)
  - Accessing drive-through medical services (e.g. drive-through testing)
  - Concern about using shared mobility options (e.g. bike or scooter sharing services)
  - Changes to public space to accommodate outdoor dining/retail (e.g. sidewalk interruptions)
  - Ability to access PPE while using public transportation
  - Please list other top concerns:
- Neighborhood and Community (select top 3)
  - Park access
  - Closure of recreation centers, trails, beaches, other outdoor facilities, etc.
  - Limited access to senior centers
  - Restrictions on community/social gatherings and support
  - Separation from family
  - Limited cooling centers
  - Please list other top concerns:

HEALTH DEPARTMENT PRIORITIES DURING COVID-19 & BEYOND

Q38. How much of a priority, if at all, should it be for your local public health department to focus on the following:

	High priority	Somewhat of a priority	Lower priority	Not a priority	No opinion/ Do not know
Addressing differences in health based on race and place	1	2	3	4	5
Addressing differences in health based on economic inequities	1	2	3	4	5
Hiring diverse staff from the communities they serve	1	2	3	4	5
Hiring linguistically diverse staff from the communities they serve	1	2	3	4	5
Recruiting diverse people into positions of leadership	1	2	3	4	5
Ensure transparency around funding/decision-making	1	2	3	4	5
Fostering authentic community partnerships	1	2	3	4	5

Additional comments:

ADDITIONAL COMMENTS (OPEN ENDED)

Q39. Is there anything else you would like to share that has not been captured in your responses already?

APPENDIX I - SURVEY RESULTS SUMMARY

Local Public Health Department Executives

OVERVIEW

Survey Collection Timeframe – 10/13/20- 11/16/20

Number of respondents – 58 total responses, 42 unique, 8 duplicates, 8 anonymous

- 67% of respondents were a Public Health Director or Designee
- 30% of respondents were a Public Health Officer or Designee

Jurisdiction Characteristics

- 40% of respondents represent small jurisdictions (<100,000)
- 34% of respondents represent medium jurisdictions (100,001 – 500,000)
- 36% of respondents represent large jurisdictions (>500,000)

Geographic Distribution

- 23% Far North
- 15% Bay Area
- 21% Greater Sacramento Area
- 17% Central Valley
- 23% Southern California

STAFFING

Q1. Our department has had a sufficient workforce to respond to the needs of communities most vulnerable to the impacts of COVID-19 throughout the pandemic

- 12% of respondents strongly agree
- 29% of respondents somewhat agree
- 21% of respondents somewhat disagree
- 37% of respondents strongly disagree

Q2. Our staff have the cross-cutting skillsets to adequately respond to the needs of communities most vulnerable to the impacts of COVID-19 throughout the pandemic.

- 26% - Strongly agree
- 54% - Somewhat agree
- 9% - Somewhat disagree
- 9% - Strongly disagree
- 2% - No opinion/ Did not know

Q3. Approximately how many staff have been diverted from their standard roles in your Department to assist with the COVID-19 response?

- Responses ranged from 5 to 300 staff public health staff diverted to the COVID-19 response

Q4. Approximately what percentage of your overall workforce has been diverted?

- Responses ranged from 10% to 100% of staff diverted to COVID-19 response, with an average of 50-70%

Q5. How, if at all, has this impacted your department's ability to support communities most vulnerable to the impacts of COVID-19? Check all that apply:

- 82% - Gaps in critical dept functions that support impacted communities
- 82% - Impacts on community outreach/engagement
- 60% - Administrative delays impacting service delivery
- 38% - Delays in contracting/procurement with community-based partners

Q6. Besides diverting internal department staff, what staffing support did you utilize to fill your critical staffing needs? Check all that apply:

- 91% - External support from other departments/agencies within our jurisdiction
- 40% - State of California
- 28% - Medical Reserve Corps or other external supports
- 9% - CDC Foundation
- 2% - California Health Corps

Q7. Which of these skills did your department find most critical in supporting communities most vulnerable to the impacts of COVID-19? Check all that apply:

- 87% - Community engagement/partnerships
- 82% - Multilingual speakers
- 82% - Communications/media outreach
- 65% - Knowledge and partnership/utilization of non-profit organizations
- 62% - Public Health nursing
- 60% - Finance/Funding
- 58% - Data analysis
- 47% - Epidemiological training
- 36% - Advanced equity understanding
- 35% - Administration
- 5% - Coding

Q8. Internal human resources policies/processes (e.g. hiring, onboarding, recruiting, etc.) have facilitated our ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 15% - Strongly agree
- ○ 35% - Somewhat agree
- ○ 31% - Somewhat disagree
- ○ 16% - Strongly disagree
- ○ 4% - No opinion/Do not know

Q9. Internal contracting/procurement policies/processes facilitated our ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 20% - Strongly agree
- ○ 44% - Somewhat agree
- ○ 24% - Somewhat disagree
- ○ 5% - Strongly disagree
- ○ 7% - No opinion/Do not know

FUNDING

Q10. The funding we have received throughout the pandemic has been sufficient for addressing the needs of communities most vulnerable to the impacts of COVID-19 throughout the response.

- ○ 22% - Strongly agree
- ○ 40% - Somewhat agree
- ○ 20% - Somewhat disagree
- ○ 15% - Strongly disagree
- ○ 4% - No opinion/Do not know

Q11. To what extent has a lack of funding flexibility acted as a barrier to responding adequately to the needs of communities most vulnerable to the impacts of COVID-19 throughout the response?

- ○ 11% - Not a barrier
- ○ 18% - Minor barrier
- ○ 40% - Moderate barrier
- ○ 24% - Major barrier
- ○ 7% - No opinion/Do not know

DATA

Q12. How effective have your existing (in place pre-COVID) data systems/surveillance been in supporting communities most vulnerable to the impacts of COVID-19 throughout your response?

- ○ 13% - Very effective
- ○ 37% - Somewhat effective
- ○ 31% - Somewhat ineffective
- ○ 13% - Very ineffective
- ○ 6% - No opinion/Do not know

Q13. How effective have your new/modified/adapted data systems/surveillance been in supporting communities most vulnerable to the impacts of COVID-19 throughout your response?

- 13% - Very effective
- 59% - Somewhat effective
- 15% - Somewhat ineffective
- 2% - Very ineffective
- 11% - No opinion/Do not know

Q14. Where did you have the biggest challenges with your data infrastructure? Select your top 3:

- 50% - Production/reporting of State -required metrics
- 40% - Case reporting, investigation, and management
- 40% - Collection of demographic data (e.g. race/ethnicity, age, gender)
- 35% - Production/reporting of local dashboard metrics
- 35% - Collection of lab data
- 33% - Contact tracing
- 25% - Collection of hospital data
- 17% - Collection of death data

TESTING & CONTACT TRACING

Q15. What COVID-19 testing strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 72% - Expanding testing access in communities most impacted by COVID-19
- 63% - Partnering with community-based organizations/trusted messengers in communities most impacted by COVID-19
- 56% - Communications/messaging campaigns
- 41% - Partnering with community clinics in areas most impacted by COVID-19
- 26% - Pop-up testing sites in non-traditional areas (e.g. bus stops, parks, etc.)
- 22% - Coordination with other City/County agencies
- 20% - Political partnerships/support in conducting outreach (with local electeds, etc.)

Q16. What additional testing support is needed for your jurisdiction to best support communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 66% - Resources to expand testing access
- 49% - Additional staffing
- 45% - Resources to partner with community-based organizations to conduct outreach and provide resources
- 43% - Culturally informed communication/outreach
- 30% - Enhanced lab capacity
- 25% - Relationship/partnerships with trusted messengers
- 15% - Enhanced coordination
- 13% - Enhanced data support to support decision-making
- 9% - Support from electeds

Q17. What case investigation strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 80% - Multilingual case investigators
- 57% - Relationship building before and during crisis
- 48% - Partnering with community-based organizations to support case investigations
- 33% - Hiring case investigators from communities disproportionately impacted by COVID-19
- 24% - Equity-informed staff training
- 13% - Ability to provide incentives

Q18. What type of additional case investigation support is needed to best support communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 49% - Culturally informed communications/outreach
- 45% - Additional staffing support
- 43% - Support partnering with community-based organizations to conduct case investigation and provide additional resources
- 37% - Additional resources for incentives
- 24% - Assistance in identifying case investigators with needed qualifications
- 22% - Equity-informed staff training
- 22% - Enhanced coordination
- 12% - Support form electeds

Q19. What contact tracing strategies have been most effective in supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 66% - Multilingual contact tracers
- 51% - Partnering with community-based organizations to conduct outreach and provide additional resources
- 51% - Additional wraparound resources to support individuals/families
- 38% - Relationship building before and during crisis
- 36% - Ability to provide isolation/quarantine housing support
- 23% - Hiring contact tracers from communities disproportionately impacted by COVID-19
- 17% - Equity-informed staff training

Q20. What type of additional contact tracing support is needed to best support communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 55% - Additional wraparound resources to support individuals/families
- 53% - Culturally informed communications/outreach
- 43% - Additional staffing support
- 37% - Support partnering with community-based organizations to conduct outreach and provide resources
- 35% - Isolation/quarantine housing support
- 20% - Assistance in identifying contact tracers with needed qualifications
- 14% - Equity-informed staff training
- 14% - Enhanced coordination
- 10% - Support from electeds

COORDINATION

Q21. How effective has coordination with the Federal government been?

- 4% - Very effective
- 20% - Somewhat effective
- 14% - Somewhat ineffective
- 25% - Very ineffective
- 37% - No opinion/Do not know

Q22. How effective has coordination with the State government been?

- 12% - Very effective
- 60% - Somewhat effective
- 23% - Somewhat ineffective
- 6% - Very ineffective

Q23. How effective has coordination with your region been?

- 29% - Very effective
- 55% - Somewhat effective
- 10% - Somewhat ineffective
- 2% - Very ineffective
- 4% - No opinion/Do not know

Q24. How effective has coordination within your own jurisdiction been?

- 36% - Very effective
- 54% - Somewhat effective
- 10% - Somewhat ineffective
- 0% - Very ineffective

Q25. How effective has coordination within your own department been?

- 52% - Very effective
- 46% - Somewhat effective
- 2% - Somewhat ineffective
- 0% - Very ineffective

Q26. How effective has coordination with community-based organizations representing the communities most vulnerable to the impacts of COVID-19 been?

- 33% - Very effective
- 52% - Somewhat effective
- 10% - Somewhat ineffective
- 0% - Very ineffective
- 6% - No opinion/Do not know

Q27. The COVID-19 pandemic has given our department new opportunities to form cross-sector and external partnerships and be seen as leaders in work outside of traditional public health response, specifically in regards to supporting communities most vulnerable to the impacts of COVID-19?

- ○ 31% - Strongly agree
- ○ 58% - Somewhat agree
- ○ 0% - Somewhat disagree
- ○ 4% - Strongly disagree
- ○ 8% - No opinion/Do not know

OPPOSITION & POLITICAL BARRIERS

Q28. Did you or anyone else publicly leading your pandemic response receive any threats or harassment?

- ○ 71% - Yes
- ○ 29% - No

Q29. To what extent have political pressures and/or the political environment in your own jurisdiction acted as a barrier to your ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 during the crisis?

- ○ 21% - Not a barrier
- ○ 23% - Minor barrier
- ○ 33% - Moderate barrier
- ○ 23% - Major barrier

EQUITY STAFFING & INFRASTRUCTURE

Q30. Approximately what proportion of your staff deployed to support the COVID-19 response, were previously trained in foundational equity principles (e.g. racial and/or health equity in government, community-based decision-making, anti-racism and bias, etc.)?

- ○ Ranged from 0-100% of staff, on avg about 50% of staff trained in some kind of equity principle

Q31. A - Our Department has funded equity staff in place whose primary role was to support the advancement of equity in our department and/or jurisdiction:

- ○ 41% - Yes
- ○ 59% - No

Q31. B - If no, do you believe additional funding for dedicated equity staff would better support your department's ability to support communities most vulnerable to the impacts of COVID-19?

- ○ 83% - Yes
- ○ 17% - No

Q32. A - If your department had funded staff in place in your department/jurisdiction whose primary role was to advance equity before the crisis began, were those staff deployed to the emergency operations center to help direct response?

- ○ 43% - Yes
- ○ 57% - No

Q32. B - If no, do you have staff in the leadership of your ICS who are trained to meet the immediate/long-term health needs of groups most impacted by inequities during an emergency?

- 66% - Yes
- 34% - No

Q33. How often are COVID-19 response related materials developed and/or reviewed by equity staff/team

- 12% - Always
- 33% - Often
- 25% - Rarely
- 18% - Never

Q34. How often is an equity tool used to inform decision-making

- 2% - Always
- 29% - Often
- 20% - Rarely
- 41% - Never

Q35. How often are COVID-19 response related materials developed and/or reviewed by community advisors

- 4% - Always
- 34% - Often
- 32% - Rarely
- 22% - Never

Q36. How often are community groups/members most vulnerable to COVID engaged in decision-making process

- 43% - Often
- 31% - Sometimes
- 24% - Rarely
- 2% - Never

COMMUNICATIONS

Q37. What are the biggest communications challenges your department has faced in regards to supporting communities most vulnerable to the impacts of COVID-19? Select the top 3:

- 64% - Insufficient staffing to provide multilingual and culturally informed information/ outreach
- 58% - Difficulty outreaching to traditionally hard to reach communities
- 32% - Difficulty creating culturally appropriate messaging
- 28%- Limited/no funding for internal communications staff/messaging development
- 24% - Lack of effective language contractors/staff
- 22% - Lack of sufficient translation funding
- 16% - Regional coordination
- 16% - Lack of sufficient interpretation support
- 10% - Lack of pre-existing relationship with media

COMMUNITY ENGAGEMENT

Q38. How critical were established community partnerships in supporting the most vulnerable communities?

- ○ 65% - Very critical
- ○ 31% - Somewhat critical
- ○ 4% - No opinion/Do not know

Q39. The COVID-19 pandemic has given our department the opportunity to establish new community partnerships that have been critical in supporting communities most vulnerable to the impacts of COVID-19 during the crisis.

- ○ 41% - Agree
- ○ 47% - Somewhat agree
- ○ 4% - Somewhat disagree
- ○ 8% - Disagree

SOCIAL DETERMINANTS OF HEALTH

Q40. What social determinants of health issues have emerged as the most critical issues for communities most vulnerable to the impacts of COVID-19 throughout your City/County's response? Rank in order of most to least critical:

- ○ #1 – Economic
- ○ #2 – Housing
- ○ #3 – Education
- ○ #4 – Nutrition
- ○ #5 – Transportation
- ○ #6 – Neighborhood

Q41. How effective has your department been at advocating for the policy changes needed (local, state, federal) to better support communities most vulnerable to the impacts of COVID-19 throughout this crisis?

- ○ 10% - Very effective
- ○ 45% - Somewhat effective
- ○ 22% - Somewhat ineffective
- ○ 12% - Very ineffective

Q42. Our department was able to provide and/or ensure adequate PPE for internal and external essential workers.

- ○ 43% - Always
- ○ 55% - Often
- ○ 2% - Rarely

APPENDIX J - SURVEY RESULTS SUMMARY

Local Public Health Department Data Experts

OVERVIEW

Survey Collection Timeframe – 12/14/2020 – 12/20/2020

Number of Responses: 22

- 39% - Epidemiologists
- 28% - Branch Director
- 17% - Public Health Nurses
- 6% - Health Officer
- 6% - Communicable Disease Coordinator
- 6% - Contact Tracing Unit Lead

Jurisdiction Characteristics

- 25% of respondents represent small jurisdictions (<100,000)
- 35% of respondents represent medium jurisdictions (100,001 – 500,000)
- 40% of respondents represent large jurisdictions (>500,000)

Geographic Distribution

- 14% - Far North
- 14% - Bay Area
- 18% - Greater Sacramento Area
- 18% - Central Valley
- 26% - Southern California

DATA INFRASTRUCTURE CHALLENGES

Q1. Overall, where have you had the biggest challenges with your data infrastructure? Select all that apply.

- 62% - Collection of demographic data (e.g. race/ethnicity, age, gender)
- 57% - Collection of hospital data
- 52% - Case reporting, investigation, and management
- 48% - Collection of lab data
- 33% - Production/reporting of State-required metrics
- 29% - Contact tracing
- 24% - Production/reporting of local dashboard metrics
- 24% - Communicating data to the general public

SUCCESSES AND BEST PRACTICES

Q2. What aspects of your data infrastructure have improved over the course of the pandemic? Select all that apply.

- 69% - Case reporting, investigation, and management
- 69% - Contact tracing
- 69% - Production/reporting of local dashboard metrics
- 50% - Communicating data to the general public
- 38% - Production/reporting of State-required metrics
- 25% - Collection of death data
- 25% - Collection of demographic data (e.g. race/ethnicity, age, gender)
- 13% - Collection of hospital data
- 6% - Collection of lab data

Q3. For those things that improved, what contributed to the improvement? Select all that apply.

- 80% - Increased staffing/capacity
- 60% - New tools
- 47% - New funding
- 40% - Guidance from CDPH

DATA & EQUITY IMPACTS

Q4. A – Does your jurisdiction track indirect COVID-19 impacts (such as job losses or housing/food insecurity) in your vulnerable communities?

- 24% - Yes
- 76% - No

Q4. B – If not, please select the reasons:

- 100% - Limited staff capacity
- 38% - Lack of funding
- 85% - Data limitations

Q5. Q5 – Are there other data that would be helpful for your jurisdiction's COVID-19 response, particularly among your vulnerable communities?

- 29% - No
- 72% - Yes

APPENDIX K - SURVEY RESULTS SUMMARY

Community-Based Organizations

OVERVIEW

Survey Collection Timeframe – 11/2020 – 01/2021

Number of Responses: 30

Community Respondent Characteristics

- 83% - Independent 501c3
- 17% - Program administration/sponsored by fiscal intermediary
- 7% - Other organizational structure

Jurisdiction Characteristics

- 3% of respondents represent organizations in small jurisdictions (<100,000)
- 13% of respondents represent organizations in medium jurisdictions (100,001 – 500,000)
- 47% of respondents represent organizations in large jurisdictions (>500,000)
- 23% of respondents represent organizations that work across multiple countiesw
- 13% of respondents represent organizations that work statewide

Geographic Distribution

- 0% - Far North
- 13% - Bay Area
- 3% - Greater Sacramento Area
- 27% - Central Valley
- 57% - Southern California
- 3% - Central Coast
- 10% - Statewide

Role and Focus of Organization

- 33% - An organizing and/or advocacy group
- 57% - Direct service organization
- 10% - Other
- 20% - Behavioral health
- 20% - Economic security
- 40% - Education
- 30% - Environmental/Climate Justice
- 33% - Housing Stability
- 23% - Homelessness
- 33% - Immigration
- 13% - LGBTQ+ Rights
- 53% - Public Health/Community Health
- 40% - Racial Justice
- 23% - Transportation
- 20% - Workforce Development
- 33% - Youth Development

COVID-19 IMPACTS – ON YOUR ORGANIZATION

Q1. What are the top 3 things that have most impacted your organization throughout the crisis?

- 45% of respondents identified funding, grants, and other types of emergency aid from individual donors, local government, philanthropy, and federal government as the #1 support
- Other important and frequently cited supports for community-based organizations during the COVID-19 pandemic include:
- Flexibility and adaptability ranging from adjusting to remote work, the proliferation of telehealth services and ability to reimburse for telehealth, reworking programming for populations served, and flexibility from grantors/funders for existing funds and how to use future funds;
- Partnerships, collaboration, and coalitions with other local organizations or with government agencies; and
- People, ranging from community organizers, staff, community, and leadership, all working together diligently and tirelessly to continue providing services and programs.

Q2. How has COVID-19 most negatively impacted your ability to carry out your mission-driven work (select top 3):

- 52% - Inability to hold trainings or events in person
- 45% - Inability to see clients in person
- 45% - Lack of community cohesion due to isolation
- 38% - Communication difficulties with clients most vulnerable to the impacts of COVID -19
- 38% - Mental health impacts
- 34% - Staff and client health impacts
- 34% - School closures
- 31% - Technology barriers
- 28% Loss of funding
- 17% - Inability to respond quickly to priority needs
- 7% - Food and housing barriers
- 7% - Job loss
- 4% - Domestic violence

Q3. A – Are you providing specific services related to COVID-19?

- 68% - Yes
- 21% - No
- 11% - Other

Q3. B - If Yes, which resources are you providing for your community members being impacted by COVID-19 (check all that apply)? If No, select “Does not apply”.

- 63% - Outreach
- 41% - Education
- 33% - Housing/rental assistance
- 26% - Financial assistance
- 22% - Food
- 15% - Legal Support
- 15% - Worker’s. rights education
- 4% - Childcare

Q4. Which of the following would be most impactful in terms of how government and philanthropic funding should be directed to organizations like yours to combat COVID-19 and its impact (select top 3):

- 93% - General operating support
- 43% - Undocumented resident support
- 39% - Individual financial support
- 36% - Technology support
- 29% - Mental health support
- 25% - Healthcare
- 18% - PPE Provision
- 18% - COVID-19 related testing or treatment
- 14% - Language translation/interpretation assistance
- 14% - Education/teacher support
- 14% - Homeless housing support
- 11% - Small business support
- 11% - Basic needs
- 11% - Childcare

Q5. A - Have you entered any contracts with your local public health department or other local government agencies during the pandemic in order to support the communities you represent and/or serve:

- 70% - No
- 19% - Yes, the local public health department
- 11% - Yes, with another government agency

Q5. B - If Yes, who initiated the contracting conversation? If No, select “Does not apply”.

- 60% - Does not apply
- 30% - Local health department/government agency
- 10% - Or organization

Q6. How would you rate the ability of your organization to navigate local governmental contracting processes?

- 32% - Can navigate without difficulty
- 36% - Can navigate with very little difficulty
- 20% - Can navigate but with difficulty
- 4% - Cannot navigate at all
- 8% - No opinion/ Do not know

Q7. Have your local public health department or other local government agency contracting/ procurement processes facilitated your ability to respond effectively to the needs of communities most vulnerable to the impacts of COVID-19 throughout your response?

- 16% - Greatly facilitated
- 28% - Somewhat facilitated
- 12% - Somewhat impeded
- 4% - Strongly impeded
- 40% - No opinion/ Do not know

Q8. To what extent would technical assistance around local government contracting/procurement processes positively impact your ability to quickly apply for and receive funding needed to support the communities you represent and/or serve?

- 8% - Strongly impact
- 40% - Somewhat impact
- 12% - Would not really impact
- 12% - Would not impact at all
- 28% - No opinion/ Do not know

Q9. What are the top 3 things have gone well in terms of working with your local public health department to respond to the needs of the communities you represent and/or serve?

- 53% of respondents indicated that communications was the top thing that went well when working with LHDS, including critical information, notifications about surges, exposure notices, and reaching the greater public.
- When asked about their top 3 things that have gone well working with LHDs communication, data dissemination, and responsiveness rose consistently rose to the top with over half listing it as #1 and nearly 40% listing it as their #2 thing that went well.

Q10. What are the top 3 things your health department could have done that would have better supported your ability to respond to the needs of the communities you represent and/or serve?

- 30% of respondents said that local public health departments could have done better by acting quickly and timely to ensure that they were responsive to pressing community needs.
- 25% of respondents identified the need to coordinate messaging in a quick, clear, unified, and consistent matter in order to reach the community as a way that LHDs could improve.
- 25% of respondents identified the need for increased and widespread access to testing and PPE as another way that LHDs could do better.

Q11. How helpful were the health department or other local government partnerships established before the pandemic in supporting the communities your organization represents and/or serves throughout the crisis?

- 41% - Very helpful
- 41% - Somewhat helpful
- 9% - Not very helpful
- 5% - Not helpful at all
- 5% - No opinion/ Do not know

Q12. To what extent do you agree that the COVID-19 pandemic has given your organization the opportunity to establish new partnerships with your health department or other local government entities that have been essential in supporting the communities you represent and/or serve?

- 23% - Strongly agree
- 36% - Agree
- 18% - Disagree
- 5% - Strongly disagree
- 18% - No opinion/ Do not know

Q13. Throughout the pandemic, how often has your organization, or other organizations representing communities disproportionately impacted throughout this crisis, been engaged in decision-making processes by your local public health department?

- 14% - Always
- 18% - Often
- 32% - Sometimes
- 27% - Rarely
- 9% - Never

Q14. What data sources/tools have you found most helpful for understanding the impact of COVID-19 on the communities you represent and/or serve?

- 41% - Local health department website
- 23% - CDPH website
- 23% - Local news website
- 9% - Other
- 5% - Other State/national databases

Q15. A - Are you familiar with the data being provided by your local public health department/ jurisdiction on the impact of COVID-19 on the communities your organization represents and/ or serves.

- 83% - Yes
- 17% - No

Q15. B - If Yes, to what extent are the data being provided by your local public health department sufficient for understanding the health impact of the pandemic on the communities your organization represents and/or serves. If No, select "No opinion/Do not know"

- 41% - More than sufficient
- 23% - Somewhat sufficient
- 14% - Somewhat insufficient
- 9% - Very insufficient
- 14% - No opinion/ Do not know

Q16. Q16 - What additional data and/or data support would be most useful in your work to support the communities you represent and/or serve (select top 3):

- 73% - Further disaggregation of data by place
- 55% - Further disaggregation of data by race/ethnicity
- 36% - Further disaggregation of data by age
- 32% - Data interpretation/ explanation support
- 14% - Further disaggregation of data by SOGI
- 5% - Enhanced technology support

COVID-19 IMPACTS – ON THE COMMUNITIES YOU REPRESENT AND/OR SERVE

Q17. Based on what you have learned so far, what COVID-19 testing strategies appear to be most effective in supporting the communities you represent and/or serve? Select the top 3:

- 86% - Partnering with CBOs/trusted messengers in communities most impacted by COVID -19
- 81% - Expanding testing access in communities most impacted by COVID-19
- 38% - Pop-up testing sites in non-traditional areas
- 38% - Partnering with community clinics in areas most impacted by COVID-19
- 38% - Communications/messaging campaigns to reduce stigma/discrimination
- 33% - Communications/messaging campaigns
- 19% - Political partnerships/support in conducting outreach
- 5% - Coordination with other City/County agencies

Q18. What resources would best support the communities you represent and/or serve to increase the awareness and accessibility of testing? Select the top 3:

- 77% - Partnering with CBOs to conduct outreach and provide additional resources
- 64% - Culturally informed communications/outreach
- 59% - Resources to expand testing access
- 59% - Relationship/partnerships with trusted messengers
- 27% - Enhanced coordination
- 14% - Support from elected officials

Q19. Based on what you have learned so far, what COVID-19 contact tracing strategies appear to be most effective in supporting the communities you represent and/or serve? Select the top 3:

- 64% - Additional wraparound resources to support individuals/families
- 55% - Ability to provide isolation/quarantine housing support
- 50% - Multilingual contact tracers
- 50% - Hiring contact tracers from the neighborhoods/communities disproportionately impacted by COVID-19
- 50% - Partnering with community-based organizations to conduct outreach and provide additional resources
- 45% - Relationship building before and during crisis
- 27% - Equity-informed staff training

Q20. What type of additional support and/or strategies would best support awareness and openness to contact tracing efforts in the communities you represent and/or serve? Select top 3:

- 68% - Culturally informed communications/outreach
- 64% - Additional wraparound resources to support individuals/families
- 59% - Partnering with CBOs to conduct outreach and provide additional resources
- 41% - Isolation/quarantine housing support
- 32% - Additional staff to conduct outreach/education
- 18% - Equity-informed training
- 14% - Enhanced coordination
- 9% - Support from elected officials

Q21. What are the biggest communications challenges the communities you represent and/or serve have faced throughout this crisis? Select the top 3:

- 53% - Outlets for communication are not reaching the communities we represent and/or serve
- 42% - Fear of stigmatization/discrimination
- 37% - Insufficient multilingual and culturally informed information/outreach
- 32% - Lack of sufficient language translation
- 32% - Messaging is not culturally appropriate or relevant
- 5% - Lack of effective language translation
- 5% - Lack of sufficient interpretation support

Q22. What strategies would best support outreach and/or communications to the communities you represent and/or serve? Select the top 3:

- 67% - Hiring outreach workers from the neighborhoods/communities disproportionately impacted by COVID-19
- 67% - Partnering with CBOs to conduct outreach and provide additional resources
- 48% - Diversifying outlet for outreach/communications
- 38% - Relationship building before/during crisis
- 29% - More direct outreach from local public health department staff/officials
- 24% - Stronger partnerships with ethnic media outlets

Q23. Do you represent and/or serve community members who are considered essential or frontline workers?

- 90% - Yes
- 5% - No
- 5% - Other

Q24. How often have the frontline or essential community members you serve had access to adequate PPE throughout the crisis?

- 21% - Always
- 26% - Often
- 37% - Sometimes
- 16% - Rarely

Q25. How often have the frontline or essential community members you serve been made aware of their rights as employees (as they related to COVID-19) throughout this crisis?

- 22% - Always
- 6% - Often
- 44% - Sometimes
- 22% - Rarely
- 6% - Never

Q26. How often have the frontline or essential community members you serve and their families been able to safely isolate or quarantine when needed without fear of losing their employment?

- 24% - Always
- 12% - Often
- 29% - Sometimes
- 29% - Rarely
- 6% - Never

Q27. Recent policy changes in response to COVID-19 have been sufficient for responding to the needs of the communities you represent and/or serve:

	Strongly agree	Agree	Disagree	Strongly disagree	No opinion/ Do not know
At the ***local*** level	11%	33%	39%	11%	6%
At the ***state*** level	12%	35%	41%	6%	6%
At the ***federal*** level	6%	11%	17%	61%	6%

Q28. Based on the needs of the communities you represent and/or serve, what policies have not been implemented that would be most helpful in supporting communities most vulnerable to this crisis? Please list and/or describe:

- 29% of respondents indicated that at the federal level there is a notable sense of the recognition the government's failings to respond adequately and timely to the COVID-19 response. More than anything, CBOs are asking for stimulus, both individually and at the organizational level. They are also asking for public safety net support to include undocumented immigrants.
- 23% of respondents indicated that at the state level this is a similar sentiment that more needs to be done to get cash assistance and support out to communities. But there is also support to make permanent changes to Medi-Cal to facilitate telehealth reimbursements.
- 27% of respondents indicated that at the local level, CBOs want to see more being done to keep community members stably and safely housed. In addition, a similar number want to see more accountability and enforcement of local laws, mandates, and health order.

Q29. Top Housing Issues for Communities

- 90% - Inability to pay rent
- 75% - Threat of eviction
- 45% - Inability to pay utilities
- 45% - Tenant protections
- 40% - Ability to safely isolate/quarantine
- 40% - Overcrowded housing
- 35% - Homelessness and shelter access
- 10% - Inability to pay mortgage

Q30. Top Economic Issues for Communities

- 85% - Unemployment
- 80% - Accessing financial support
- 35% - Industry/worksite COVID-19 regulations
- 35% - Business closures
- 30% - Access to PPE
- 25% - Occupational health protections
- 15% - Paid Family Leave benefits

Q31. Top Education Issues for Communities

- 75% - School closure
- 70% - Child care
- 65% - Access to stable internet
- 35% - Parental Supports
- 30% - Homeschooling
- 30% - Access to other needed technology
- 25% - Education gap
- 15% - School meals
- 10% - School reopening

Q32. Top Nutrition Issues for Communities

- 95% - Healthy food access
- 74% - Increase demand on emergency food resources
- 26% - Changes to SNAP benefits
- 21% - Closure of local food retailers
- 11% - Changes to WIC benefits

Q33. Top Transportation Issues for Communities

- 50% - Changes to public transportation schedules
- 50% - Ability to access PPE while using public transportation
- 44% - Accessing drive-thru medical services
- 38% - Concern about using shared mobility options
- 31% - Changes to public space to accommodate outdoor dining/retail

Q34. Top Neighborhood and Community Issues for Communities

- 58% - Restrictions on community/social gatherings and support
- 53% - Separation from family
- 47% - Closure of recreation centers, trails, beaches, other outdoor facilities
- 32% - Park access
- 32% - Limited access to senior centers
- 26% - Limited cooling centers

HEALTH DEPARTMENT PRIORITIES DURING COVID-19 & BEYOND

Q35. How much of a priority, if at all, should it be for your local public health department to focus on the following:

	High priority	Somewhat of a priority	Lower priority	Not a priority	No opinion/ Do not know
Addressing differences in health based on race and place	80%	20%	0%	0%	0%
Addressing differences in health based on economic inequities	80%	20%	0%	0%	0%
Hiring diverse staff from the communities they serve	80%	15%	5%	0%	0%
Hiring linguistically diverse staff from the communities they serve	95%	5%	0%	0%	0%
Recruiting diverse people into positions of leadership	74%	21%	5%	0%	0%
Ensure transparency around funding/decision-making	55%	40%	5%	0%	0%
Fostering authentic community partnerships	95%	5%	0%	0%	0%