California Pan-Ethnic
HEALTH NETWORK

PEOPLE POWER

FOR PUBLIC HEALTH

August 2022

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EXECUTIVE SUMMARY

People Power for Public Health aims to reform budget processes and reallocate resources to address longstanding health inequities and chronic underinvestment in the public health infrastructure in communities of color. COVID-19 racial and ethnic disparities in infections, hospitalizations, and deaths coupled with the murders of Breonna Taylor, George Floyd, Ahmaud Arbery, and many others helped to expose local budgets that prioritize law enforcement and criminal justice at the expense of public health and social determinants of health.

People Power for Public Health uplifts the theory of change that communities of color know exactly what they need to live in thriving and healthy neighborhoods and deserve the power to fund their own community solutions.

People Power for Public Health makes clear that change is needed in to ensure the just allocation of local resources to improve the health of communities of color. People living in communities of color are ready to be active participants in this change. In our People Power survey, 74% of respondents said they are interested in creating or changing local policies. But people of color need training on the policy making process to get involved. Communities and community-based organizations need to create opportunities for their residents to learn about and become engaged in local policy development and budgeting. And counties and local governments need to change their processes to ensure the active engagement of people of color in local policymaking and funding decisions now and in the future.

Key components of the research project:

- A statewide survey with 912 respondents
- 5 county listening sessions with 416 community residents
- In-depth discussions with 12 community leaders

1. **Reliable Access to High Quality Primary, Preventive, and Behavioral Health Care.**
   Participants expressed the need for better access to health care services to prevent the many physical and behavioral health emergencies they and their family's experience.

2. **Affordable and Accessible Emergency and Mental Health Crisis Response Services.**
   Participants wanted affordable access to appropriate and responsive emergency crisis response services when they or a family member experienced a crisis.

3. **Community-Connected and Culturally Responsive Care Workforce.**
   Participants overwhelmingly wanted care that was culturally and gender responsive and linguistically appropriate, and access to providers that shared similar lived experiences.

4. **Prioritized Investment in Social Determinants of Health.**
   Participants desired increased investment for social determinants of health such as affordable and quality housing, transportation, safety, parks and recreation, and healthy food availability.

FUNDING OUR HEALTH
FUNDING OUR POWER

People Power for Public Health explores how budget processes and just resource allocation can be used to alleviate racialized health disparities and how we can support communities of color in building power for public health.

In most California counties, local policy making, including budget development, often reinforces power structures, rather than addressing inequities and promoting inclusion and transparency. For example:

- **Local governing bodies (i.e. city councils, county supervisors) are predominantly white and do not reflect the diversity of the communities they represent**, even in progressive areas of the state like the Bay Area. (Bay Area Equity Atlas[1])

- **Communities of color are often subject to an explicit divestment of resources.** A prominent example is the racial covenants and redlining practices which prevented people of color from buying homes in certain neighborhoods. These practices barred communities of color from building generational wealth, concentrated communities of color in poorly resourced neighborhoods, and limited local capital to fund the infrastructure for critical social determinants of health such as schools, parks, and businesses. (Schaff et. al 2013, Bell and Lee, 2011)

- **Budget processes are largely inaccessible and hard to understand, thereby inhibiting communities of color from shaping local policies.** (Advancement Project, 2020) Our analysis of county budgets and pandemic relief funding uncovered a lack of transparency in how counties allocate county dollars, with some counties failing to share their most recent budget to the public six months later. (CPEHN, 2022)

These practices have inhibited the funding of systems that are critical to community wellbeing and individual health such as safe schools, public transportation, and access to healthy foods. The COVID-19 pandemic served to exacerbate, and shine a light on, this legacy of disinvestment. Black, Hispanic/Latinx, Indigenous, Pacific Islander, and Asian communities experienced higher rates of COVID-19 infections, hospitalizations, and deaths. (CA Department of Public Health). Communities of color were at greater risk due to overrepresentation in frontline work; overcrowded housing, chronic comorbidities such as hypertension, diabetes, and obesity; and poorer access to health care. (Lopez et. Al 2021)

Understanding the County Budget & Local Policy Making

Why do we care about county funding?

County budgets fund many public services and programs that affect broader social determinants of health such as healthy foods, parks and recreation, public assistance programs, and local law enforcement (Advancement Project, 2021). Along with state and federal funding, county budgets fund the local health and social safety net that many people rely on in their everyday lives. These budgets also support emergency response, mental health and substance use care, communicable disease control such as COVID-19 response, and population health management (CHCF, 2015).

County health services face many challenges such as long-term structural budget deficits and constantly changing funding priorities, as well as a lack of statewide standards and systems to monitor, evaluate, and improve local health programs and services. As a result, California's 58 counties provide an uneven patchwork of safety net services to their residents (CHCF, 2015).

Where do county budget funds come from?

State and federal funds make up nearly half of revenues (47%) for California counties, and as such dictate a large portion of county spending. However, 20% of county budgets are derived from property taxes that are discretionary for the county to allocate. The remainder of county budgets come from local business fees and other charges, some of which may be discretionary to spend (Graves, 2018).

Recently, county and local governments have received funding from COVID-19 relief bills such as the CARES Act and American Rescue Plan Act (ARPA). California has received $15 billion from the CARES ACT, and a portion of those funds were allocated to local governments (such as counties and cities) with populations in excess of 500,000 (Sacramento County). From ARPA, California received $27 billion in federal aid, with $16 billion allocated to California cities and counties. (CA Budget and Policy Center)

Why must we care about county budgets particularly now?

The murders of Breonna Taylor, George Floyd, Ahmaud Arbery and many others brought light to a racial reckoning that put local budgets in the spotlight. CPEHN's prior analysis, titled "At What Cost: How Local Governments Shortchange the Health of Communities of Color", explored local governments' funding decisions to invest heavily in law enforcement at the expense of public health funding (CPEHN, 2020). In 2018, counties

LAW ENFORCEMENT SPENDING VS PUBLIC HEALTH SPENDING

$ $
$ $
$ $
$ $
$ $
$ $ $
$ $ $
$ $ $
$ $ $ $
$ $ $ $ $ $

$25.2 Billion
ON LOCAL & COUNTY LAW ENFORCEMENT

$3.7 Billion
ON PUBLIC HEALTH

spent $6.2 billion on their Sheriff's Departments and $6.6 billion on detention and correction, while local police spending totaled $12.4 billion. In total, counties spent $25.2 billion on local and county law enforcement, compared to only $3.7 billion on public health. In other words, counties spent only 15 cents on the dollar for public health compared to law enforcement.

The underinvestment in public health combined with the overinvestment in law enforcement has led to environments that disproportionately harm communities of color. In a recent report, the California Budget and Policy Center noted, "[law enforcement] experiences put Black, Latinx, and other Californians of color at risk of experiencing poor long-term health outcomes and disproportionately facing the detrimental health effects that stem from justice involvement due to racist policies and practices." (California Budget and Policy Center, 2021).

COVID-19 relief funding is flowing directly to cities and counties with little oversight. Although COVID relief funding was intended to blunt the impacts of the pandemic, which have been felt most acutely in communities of color, there have been many cases of misuse. Examples of CARES Act funding misuse include:

- Riverside County buying office furniture for the Sheriff's office.

- The majority of Sacramento County's funding going to the Sheriff's department, resulting in an audit from a grand jury.

- State-level agencies failing to adequately oversee the use of the funds and failing to conduct effective outreach to Californians eligible for relief programs (California State Auditor, 2021).

Just Allocation of Government Dollars

CPEHN's racial equity analyses of American Rescue Plan Act (ARPA) spending by counties demonstrated that robust community engagement was positively associated with just funding allocations (CPEHN, 2022). A key tenet of People Power for Public Health is the need for a **just allocation of governmental spending at the local and statewide level to communities of color.** This is needed to help communities recover not only from the pandemic but also the systemic racism and disinvestment that have harmed the health and economic wellbeing of these communities.

In addition, we recommend statewide accountability measures to ensure that county budget allocations are responsive to community needs and that community members are involved in funding allocation decisions.

Throughout this report, CPEHN recommends specific investments that local governments should make to address racial inequities and to improve the health of communities of color, including specific recommendations related to allocating COVID-19 relief dollars.
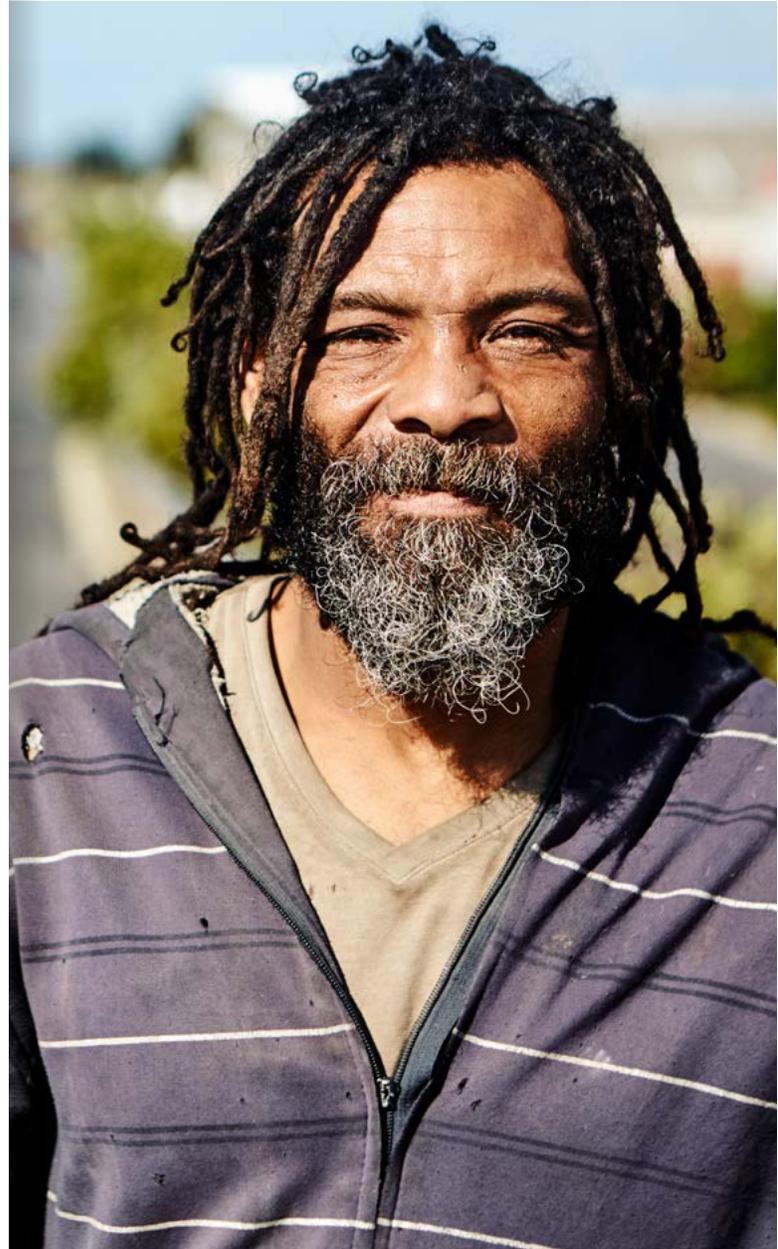
A JUST ALLOCATION MEANS

- ✓ **INCREASED AND CONTINUOUS INVESTMENT** in historically/currently disinvested communities and the organizations that serve these communities

- ✓ **DECREASED INVESTMENT IN SYSTEMS THAT ARE HARMFUL AND VIOLENT** towards marginalized communities

- ✓ **PARTICIPATORY BUDGETING PROCESSES** that meaningfully include communities in shaping their local budgets.

CENTERING
OUR STORIES

Methodology

This project aims to answer three primary research questions:

1 ***What are the current experiences of communities of color in California with accessing health care resources?***

For the purposes of this research, we included emergency and prehospital care, behavioral health services, and primary and preventive health care services as safety net programs related to health. We also collected data about community experiences with drivers of health such as food, housing, transportation, and the built environment.

2 ***What services, resources, and opportunities do people of color most want in their communities in order to improve their health?***

Our research focused both on identifying gaps and challenges and on highlighting the desires and ideas of communities of color.

3 ***What state and local budget investments are needed to improve the health outcomes of communities of color?***

We stress the importance of community-based resource allocation by highlighting desired investments to develop thriving neighborhoods. We also illuminate existing efforts led by community leaders that respond to local health concerns and empower communities to engage in local advocacy.

Data Collection Methods

STATEWIDE SURVEY

From September 2021 to January 2022, CPEHN administered a statewide "People Power Survey" and received 912 responses. The survey asked respondents how they access care in their counties, including emergency and prehospital care, behavioral health care, primary and preventive care, and other services related to social determinants of health. The survey also included questions related to engagement in local policy making and perspectives on community health priorities.

912
respondents

COUNTY LISTENING SESSIONS

In partnership with local grassroots organizations, we held five local listening sessions with a total of 416 community residents to dig deeper into community residents' experiences with accessing health care and to solicit proposed solutions to current barriers.

We partnered with the following organizations in these five counties:

- **Sacramento:** Decarcerate Sacramento & Community Care First Coalition
- **Fresno:** Central Valley Urban Institute
- **Kern:** Visión y Compromiso
- **Orange:** Multi-Ethnic Collaborative of Community Agencies (MECCA)
- **San Diego:** Visión y Compromiso

416
community residents

COMMUNITY LEADER INTERVIEWS

We conducted interviews with 12 key community leaders and advocates to uplift existing community-led solutions and best practices around local advocacy for public health. These interviews elucidated lessons and recommendations on leading successful local public health advocacy work.

12
community leaders

Demographics

People Power Survey

From September 2021 to January 2022, CPEHN fielded a statewide survey focused on people of color. The survey utilized an online platform and was conducted in English, Spanish, Traditional Chinese, Korean, Tagalog, and Vietnamese. Although the survey utilized a convenience sample, the responses offer key insights and testimonies around the experiences of people of color. Overall, the survey captured responses from 912 individuals.

RESPONDENT GENDER IDENTITY

49% FEMALE

38% MALE

2% GENDER NON CONFORMING

1% TRANSGENDER

1% OTHER *

10% NO RESPONSE

Two Spirit, Genderqueer, Genderfluid, Non-Binary

FIGURE 1

RESPONDENT RACE/ETHNICITY

31% **Black/African American** 284

23% **Asian** 206

13% **White** 122

14% **Hispanic/Latinx** 130

7% **American Indian/Alaska Native** 67

3% **Pacific Islander** 24

1% **Middle Eastern/North African** 12

1% **Native Hawaiian** 11

10% **No Response** 90

FIGURE 2

Note that numbers may not total 912 or 100% due to respondents indicating multiple races, ethnicities, or genders.

County Listening Sessions

COUNTY	PARTNER ORGANIZATION	# OF PARTICIPANTS	COMMUNITIES REPRESENTED
Sacramento	Decarcerate Sacramento/ Community Care First Coalition	130	Individuals experiencing homelessness and/or incarceration. Community leaders working with unhoused communities; residents affected by incarceration; Latinx communities; and local advocates, organizers, and community members.
Fresno	Central Valley Urban Institute	21	Black/African American Communities
Kern	Vision y Compromiso	9	Latinx communities, Community Health Workers
Orange	Multi Ethnic Collaborative of Community Agencies	229	Asian and Asian Immigrant Communities, Native Hawaiian & Pacific Islander, Multiracial Communities, White, Black/ African American, Latinx Communities.
San Diego	Vision y Compromiso	27	Latinx communities, Community Health Workers

Community Leader Interviews

From September 2021 to February 2022, in partnership with Health Access, CPEHN conducted interviews with twelve community leaders involved in local advocacy around community health issues. We interviewed the following leaders working in their respective counties:

Asantewaa Boykin
Anti-Police Terror Project
(OAKLAND & SACRAMENTO)

....

Roxanne Carrillo Garza
Contra Costa Cares
(CONTRA COSTA)

....

Megan Castillo
Reimagine LA County Coalition
(LOS ANGELES)

....

Dan Geiger
Contra Costa Budget Justice Coalition
(CONTRA COSTA)

....

Taun Hall
Miles Hall Foundation
(CONTRA COSTA)

....

Elizabeth Kroboth
Transitions Clinic Network
(SAN FRANCISCO, STATEWIDE)

Noe Paramo and Eduardo Ramirez Castro
Central Rural Legal Assistance Fund
(FRESNO)

....

Mari Perez-Ruiz,
Central Valley Empowerment Alliance
(TULARE, GREATER CENTRAL VALLEY)

....

Bella Quinto,
Justice for Angelo Quinto
(CONTRA COSTA)

....

Jane Smith,
CARESTAR Foundation
(SAN FRANCISCO, GREATER BAY AREA)

....

Vanessa Terán and Genevieve Flores-Havo,
Mixteco/Indigena Community Organizing Project (MICOP)
(VENTURA)

....

Kim Williams,
Sacramento Building Healthy Communities HUB
(SACRAMENTO)

How Are We Examining Our Research

*Moving from a Damage Centered Framework
to a Desire Based Framework*

> *Consider the long term repercussions of thinking of ourselves as broken."* **Eve Tuck (2009)**

In this report, we aim to avoid what Indigenous scholar, Eve Tuck, describes as "damage centered research," or research that intends to document peoples' pain and brokenness to hold those in power accountable for their oppression. Although it is key to highlight the ways in which communities have experienced oppression, such research can simultaneously exploit the same communities it is trying to help by defining communities solely by their trauma. The danger of this research is that oppression defines the community and comes from a theory of change that narrowly looks at community harm in order to receive reparation.

This report instead moves towards a **desire based framework:**

"Desire based research frameworks are concerned with understanding complexity, contradiction, and the self-determination of lived lives…It draws on a theory of change that posits a need to understand the intricacies of people's lives in order to point toward ways of becoming more of who we are" (Tuck 2009)

We hold true to the theory of change that communities most affected by health, racial, and gender injustices are the ones closest to the solution. **We honor this desire-based framework by highlighting that local communities know exactly what they need and uplifting their perspectives and ideas throughout the report.**

We want to note that communities of color, including the communities featured in this report, are not monoliths. We were humbled to hear many different and compelling stories from diverse participants across the state. However, there are also many communities that were not included in our research. **We hope advocates will further this work by examining the intersections that touch upon race, gender, class, citizenship, and region, as well as engaging with communities who are not included in this report.**

We encourage advocates, policy makers, funders, and community organizations to use a desire-based framework when working with communities of color and other marginalized communities to conduct community-based research or identify policy solutions.

COMMUNITIES SPEAK UP:
FINDINGS FROM OUR RESEARCH

What We Need: Listening to Communities of Color

Through our survey, listening sessions, and interviews, we heard from many people of color who shared similar challenges with accessing and receiving quality health care and who offered similar ideas for how their local communities could improve their access to health care and their health overall.

Four key areas for improvement stand out:

1 **Reliable Access to High Quality Primary, Preventive, and Behavioral Health Care.** Despite significant gains in health insurance coverage since the implementation of the Affordable Care Act, a substantial number of Californians of color still lack health insurance coverage. Even participants with coverage highlighted the need to improve access to quality physical and behavioral health care.

2 **Affordable and Accessible Emergency, Prehospital, and Mental Health Crisis Response Services.** Many research participants reported using emergency and urgent care providers. However, participants described many barriers that prevent them from accessing needed emergency and prehospital services, including concerns about cost and insurance coverage and fear of law enforcement involvement.

3 **Community-Connected and Culturally Responsive Care Workforce.** Participants overwhelmingly wanted care that was culturally and gender responsive and linguistically appropriate, and access to providers that shared similar lived experiences. However, too few said that they had access to this needed workforce.

4 **Prioritized Investment in Social Determinants of Health.** Participants desired increased investment for social determinants of health such as affordable and quality housing, transportation, safety, parks and recreation, and healthy food availability.

For each area, we lift up the voices of community members who participated in our research and share the challenges they face in living healthy lives and their desires for improving the health care systems in their communities. We then highlight innovative community models and provide local and statewide policy recommendations.

> "
>
> *"The community has the ideas, we're not funded, but we get it done. I think that instead of the continual recreating of the wheel, they [the county] should stop and listen for a while."*
> **Sacramento County Resident**

Reliable Access to High Quality Primary, Preventive, and Behavioral Health Care

> " *When businesses and places like the Wellness Center began to close, and people they knew died or got very sick, it was too late for an easy solution. We were never part of anything like this before. They were isolated from their community, and it was hard getting services and even going to the doctor or visiting the dentist. One of our participants mentioned that their son was not only upset, but he was unable to get treatment appointments for a chronic condition."*
> **Orange County Resident**

Throughout our research, people of color stressed the need for reliable access to high quality primary, preventive, and behavioral health care. Across counties and populations, participants described the preventable nature of many health and behavioral health emergencies that they experienced. Yet, our research revealed several common barriers to accessing quality health care in communities of color. And COVID-19 exacerbated these challenges, with respondents reporting limited appointment availability and long wait times for care.

Common Challenges Encountered

Coverage gaps persist, especially for individuals not eligible for Medi-Cal including the undocumented. Despite significant gains in coverage made since the Affordable Care Act, important segments of California's population still lack insurance coverage. In 2022, 8% of California's population, or over 3.2 million people, lacked health insurance. Those who remain uninsured primarily fall into three categories: undocumented immigrants who are ineligible for Medi-Cal; people whose income is too high for Medi-Cal but too low to afford the coverage available to them; and those who are eligible for Medi-Cal but not enrolled due to systemic barriers. In our research, the latter group included people who are experiencing homelessness and people who were previously incarcerated. Research participants who were uninsured shared that they

> " *We can't have the medications, we don't have access to a doctor, right? Because we don't make enough. We don't have it because we have to pay for a consultation. If you need to go there for exams, we don't have those possibilities right? We can't cover all costs, we don't have access to a dentist and it could be that we have teeth that are decaying, they are hurting... perhaps it is an infection that is making us lose teeth but it is avoidable, but since we don't have access it is not reachable."*
> **San Diego County Resident**

> "We are having a very hard time, especially around mental health. We just don't have the services. They're just leaving people to try to figure this out... Navigating the 211 system is so hard when you know that's the constant go to...it's not accessible. We just don't have the wraparound services and housing available at this point."
> **Sacramento County Resident**

SEEKING HELP FOR MENTAL HEALTH AND SUBSTANCE USE

% of respondents who sought support for MH and substance use issues

67% American Indian/ Alaska Native

63% White

53% Asian

52% Black/African American

52% Hispanic/Latino

FIGURE 3

often perceived discrimination in the care they received, and felt they were treated differently as a result of their immigration status, lack of insurance, housing status, or previous incarceration.

Cost concerns, affordability, and coverage misinformation can prevent people from seeking needed care. Many research participants expressed concerns about the costs of health care, including high deductibles and copayments. Furthermore, lack of information or misinformation about what their health insurance covered led participants to avoid care altogether, even when that care might have been included in their coverage. This was particularly true of behavioral health care.

Reliable access to and information about quality behavioral health care was lacking in many communities. Our research demonstrated an increased recognition and acceptance of behavioral health care in communities of color. Over half of all respondents (55%) sought support for mental health and substance use issues in the past year, with two-thirds of American Indian/Alaska Native respondents reporting that they sought support (see Figure 3).

Participants living with mental health conditions and/or substance use disorders reported barriers to both diagnosis and treatment, leading to an escalation of symptoms. Participants reported not knowing where to go for care, being turned away from care due to their level of need, poor experiences of care, and inadequate follow-up. Prevention and early intervention support for behavioral health care was particularly challenging to find in communities of color. And some participants shared stories of how traumatic conditions or experiences when seeking care triggered or worsened behavioral health conditions.

Complicated and strict coverage policies caused participants to delay and avoid care. Participants described having to jump through administrative "hoops" to receive health care services, including medical care, behavioral health care, and COVID-19 testing. They reported long wait times, having to be seen by multiple providers, and needing to fill out complicated paperwork in order to be seen. These barriers sometimes deterred participants from seeking care altogether. For those who did access care, many noted they needed to "fail first" in order to get services. In other words, participants had to be in crisis mode, and/or have a severe sickness or mental health issue to meet the criteria to receive care.

Formerly incarcerated individuals faced difficulties finding care after release: For participants who were formerly incarcerated or who had incarcerated loved ones, they noted concerns about seeking treatment after release. For example, participants who received treatment while incarcerated often were not provided with an adequate supply of medications or connected with health care providers for continuity in their care upon release. These individuals were left to find the services they needed on their own and often did not know how to access the care they needed.

Short-term programs left gaps in services, especially for people experiencing homelessness. While participants expressed a need for ongoing, reliable, low barrier access to care, many had difficulty finding this. People experiencing homelessness shared that many of the services they did receive were tied to specific, short-term programs and that they were bounced between services such as health clinics and shelter-based programs.

Innovative Community Models

Organizations across the state have implemented local advocacy work to expand local health care safety nets, especially for undocumented immigrant and low income communities, and particularly for behavioral health services. From

> **"** *"I literally know people who will go to jail just to get a readjustment on meds, because they feel like they don't know, they don't have any other place that they can go."*
> *Sacramento County Resident*

our conversations with local community leaders, we highlight three successful community programs that have expanded access to care for underserved individuals.

- **Sacramento Healthy Partners** provides primary and preventive care through a downtown clinic for those not covered in the 2014 ACA expansion. The program was created through a successful local campaign led by Sacramento Building Healthy Communities, the faith-based Sacramento Area Congregations Together (ACT), Alliance of Californians for Community Empowerment (ACCE), and other local groups. The campaign resulted in a limited-benefit pilot program to address insufficient access to primary care in Sacramento County. In 2017, the program had an enrollment cap of 3000 with over 500 individuals on its waitlist. In 2018, the Sacramento Building Healthy Communities team convened a group of advocates, hospital systems, and clinics to work together to increase enrollment. The coalition was able to raise the eligibility cap to 4000 and piloted increasing eligibility to health care to those age 65 and older. The program is now being advertised through resource navigators.

- **The Transitions Clinic Network (TCN) program** is an evidence-based program designed to improve the health outcomes and reentry success of people returning to their homes and communities from incarceration. The program trains people with lived experience with incarceration to work as community health workers (CHWs) as part of integrat-

ed medical teams. These CHWs help formerly incarcerated community members access comprehensive primary care and connect them with local reentry and social services organizations to address social determinants of health such as housing and employment. The TCN program has reduced emergency department visits, hospitalizations, and probation and parole violations. TCN runs 21 different clinics across 14 counties in California.

- **Reimagine L.A. County** is a coalition of advocates and organizations that push for divesting from incarceration and policing and investing in the health and economic wellness of marginalized people in their communities. The coalition advocated for LA County's $1.9 billion ARPA relief funding to be used for their Care First, Jails Last initiative. Care First, Jails Last is a collaborative effort rooted in an Alternatives to Incarceration model that developed policy and funding strategies to increase mental and behavioral health care and reduce the targeted incarceration of people of color. The Care First, Jails Last coalition ultimately received $87.7 million from the American Rescue Plan to support items such as closing the Men's Central Jail and diverting funding to mental health treatment. (County of Los Angeles 2021)

Recommendations for Local Policies and Investments

Based on our research with people of color and our conversations with local community leaders, we have identified several recommendations for counties, cities, and advocacy groups to provide reliable access to high quality care in their communities.

- **Increase spending on primary and preventive care, such as mobile clinics and care that can be accessed regardless of legal status and in various languages.** Primary care options with extended and weekend hours, walk-in availability, and virtual appointment options could also help avoid unnecessary use of emergency medical services.

- **Integrate comprehensive behavioral health services into the existing safety-net infrastructure.** Fund the expansion of services provided by community clinics and public hospitals to provide not just episodic and emergency behavioral health care, but upstream primary, preventive, and behavioral health care. Create true medical homes for communities of color where patients can feel a sense of belonging and trust. In addition, create low-barrier, walk-in, 24/7 behavioral health care options that can prevent the use of emergency medical services and arrests.

- **Remove administrative and financial barriers to accessing behavioral health services.** Create a seamless system for the administration and financing of behavioral health services so that individuals do not experience the distinction between health plan mental health services, county mental health services, and county substance use disorder treatment clinics.

Fund community health education, navigation, and care coordination that is culturally and linguistically responsive. Many respondents felt that community-based programs were an important intervention effort given the entrenched inequities that exist today. In San Diego and Kern counties, respondents highlighted community health workers as an effective intervention. In Sacramento, respondents described the need for a "one-stop" resource center that provides health services as well as resource navigation to access basic necessities.

- **Develop continuous care and follow-up treatment services and programs for marginalized communities.** This includes:

  » Provide **continuous treatment** services for people who are incarcerated and released back into the community so that they have access to care outside of the jail and prison systems.

  » Continue successful coverage expansions and flexibilities, such as those created to respond to the COVID-19 public health emergency.

> "
>
> *"I would like them to put more mobile clinics to check people without documents, those that don't have health insurance, and [clinics] that are free. Depending on what you earn, because sometimes they don't even earn minimum wage, sometimes they are not paid minimum wage those that cut grass. That means more mobile clinics for all people who haven't insurance."*
>
> **San Diego County Resident**

» Create a **Medi-Cal passport**, as suggested by California Legal Rural Assistance Foundation, to allow farmworkers and transitory workers to take their care coverage with them as they move, rather than lock them into a specific provider in a specific county.

Recommendations for State Policies and Investments

While local and county policies and budget allocations can go a long way towards improving access to quality health care for communities of color, state action is also needed to address gaps in health insurance coverage and access to care. We recommend allocating a combination of local, state, and federal dollars (through funding streams similar to the prior Global Payment Program) to establish and expand programs that close access gaps. Specific actions needed to increase coverage include:

- **Remove barriers to coverage based on age, immigration status, and income,** including for the population not eligible for expanded Medi-Cal due to income but unable to access Covered California due to immigration status.

- Develop **coverage continuity and transition processes** that prevent individuals from becoming uninsured, especially as income or employment changes.

Affordable and Accessible Emergency and Prehospital Care

Emergency and prehospital services were identified as an important source of health care in our research. Nearly half of survey respondents (45%) accessed emergency or prehospital services in the last three years, and more than half of American Indian/Alaska Native (58%), White (51%) and Latino/x (50%) respondents accessed emergency or prehospital services (see Figure 4).

In addition, both the emergency room and urgent care centers were relied upon as regular sources of care even in situations that were not an emergency. More than one in four survey respondents (28%) reported going to the emergency room when they were sick or needed care, and the same portion reported going to urgent care.

Overall satisfaction with emergency and prehospital services among survey respondents who used those services was high. Forty-three percent of survey respondents rated their overall experience with emergency services "very good," and 33% rated their experience as somewhat good (Figure 5).

Despite these high levels of satisfaction, many research participants also shared negative experiences with emergency and prehospital services and concerns about accessing such services. In addition, participants described avoiding calling for an ambulance or paramedic even when experiencing a crisis.

Common Challenges Encountered

Participants were frustrated by the lack of information about when, how, and where to access emergency and prehospital services. Respondents had many questions about emergency and prehospital services including who

ACCESSING EMERGENCY SERVICES IN THE LAST 3 YEARS

58% American Indian/Alaska Native

51% White

50% Hispanic/Latino

39% Asian

38% Black/African American

FIGURE 4

OVERALL EXPERIENCE WITH EMERGENCY SERVICES

43% Very Good

33% Somewhat Good

16% Neutral

7% Somewhat Bad

<1% Very Bad

FIGURE 5

TOP CONCERNS RELATED TO EMERGENCY SERVICES

American Indian/Alaska Native	Not Sure Who to Call **40%** Concerns About Transportation **38%** Language **33%**
Black/African American	Cost **52%** Not Sure if Insurance Covers **47%** Transportation **37%**
Hispanic/Latino	Cost **55%** Not sure if Insurance Covers **47%**
Asian	Cost **76%** Not Sure if Insurance Covers **55%** Fear of Law Enforcement **33%**
White	Cost **50%** Not sure if Insurance Covers **37%**

FIGURE 6

to call, who would respond, where one might be taken for care, and whether services were available to all. Many respondents who lacked good information about an appropriate place to seek care ended up in the emergency department, even when that was not the most appropriate place for them to receive the care they needed.

Cost concerns and coverage uncertainty caused people to avoid emergency and pre-hospital services. Actual and perceived cost is a top concern for communities of color in accessing emergency services. Nearly three in five survey respondents (57%) and three in four Asian respondents (76%) expressed concerns about the cost of emergency and prehospital services. And nearly half of respondents (45%) reported they were unsure if their insurance would cover emergency or prehospital care (see Figure 6). Many research participants who were uninsured avoided emergency and prehospital services entirely. Even those with insurance coverage noted concerns about the costs of an ambulance ride or paramedic response. Participants also worried about

the cost of hospital treatment because they were unsure where an ambulance would take them, which diagnostic or treatment procedures would be needed, and what would be paid by insurance.

Fear of law enforcement and lack of trust in first responders deterred participants from calling 911 and seeking emergency services. More than 20% of survey respondents from each racial and ethnic group reported fear of law enforcement as a concern when they or a loved one needed emergency or prehospital services (see Figure 7). Listening session participants expressed concerns about losing agency over

"
I often feel that law enforcement is put in a position to do a job that they are not trained to do. Law enforcement is often put into situations of social service versus doing the law enforcement element of it."
Sacramento County Resident

their own care due to calling 911. Specific concerns included having the police involved, being placed on an involuntary psychiatric hold, and not being able to decide what kind of facility would provide needed treatment.

Respondents also described the importance of having trust in first responders and health care providers and their desire to engage with people connected to their community for support, particularly for behavioral health support. Respondents of color believed they would not find this with most paramedics or other first responders, who are predominantly white and male. In addition, some respondents described the confusion, fear, and alienation they felt not receiving language assistance during these stressful times.

Respondents would prefer first responders with expertise handling behavioral health crises. Instead of having police respond to behavioral health crises, participants expressed a desire to engage with first responders who have expertise in behavioral health, including social workers, peer support specialists, and community health workers. More than two in five (44%) survey respondents noted that community-connected providers* were most helpful when they or a loved one experienced a mental health crisis.

Availability of alternative destinations for behavioral health crises was lacking in many communities. Respondents shared concerns about whether a destination treatment facility would be appropriate to meet their needs. For many behavioral health emergencies, an emergency department may not be most effective, or most supportive destination for those who have experienced historical and present-day injustices, including those who have been involved with the criminal justice system or lack stable housing. Respondents noted the lack of availability of alternative destinations for behavioral health crises, including low-barrier drug treatment facilities.

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* We define community-connected providers as providers sharing the lived experiences and/or living in the same community as their patients. For the purposes of this survey, we define CCPs as peer support workers and chaplain/spiritual advisors, although we recognize that other types of providers may come from the same background as their patients.

> "
> "When a family member was going through a mental crisis, we had called many agencies to get in-person mental health crisis mobile support but all they could do was call the police. Police [came] but were of no help."
> – People Power Survey Respondent

FEAR OF LAW ENFORCEMENT INVOLVEMENT IN EMERGENCY SERVICES

% Reporting Fear of Law Enforcement Involvement in Emergency Services

23%   **Black/African American**

25%   **Hispanic/Latino**

33%   **Asian**

22%   **White**

12%   **American Indian/Alaska Native**
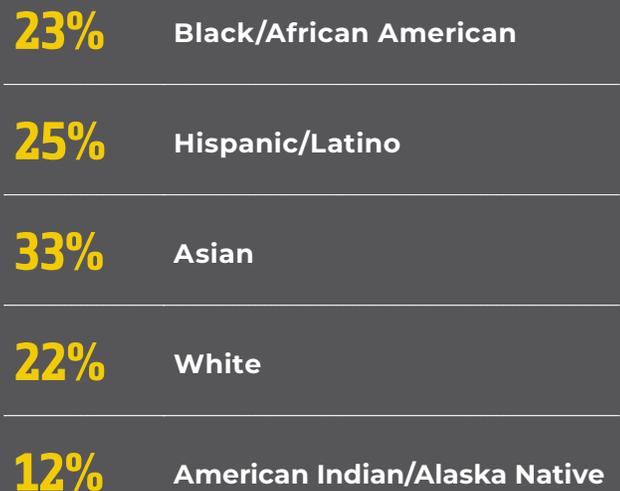
FIGURE 7

> "
> [I had] difficulty receiving attentive care to help fight my addiction. I also had difficulty with finding social alternatives for drinking/using, since I am a member of the LGBTQIA+ community and substance use is very normalized."

Emergency departments often not the right choice.

Many respondents reported frustrating experiences seeking care at hospital emergency departments. This could be due to the fact that for non-emergency care, an emergency department is not the appropriate type of facility. Respondents described long wait times, discrimination, including stigma related to perceived medication seeking, and a lack of culturally and linguistically responsive care as major challenges. For many health issues, including urgent and behavioral health care needs, an emergency department may not be the most appropriate facility. As a result, care may not be effective.

> *And you prefer not to go. You know, to spend, I don't know, five, ten hours, in an emergency room for them to tell you everything is okay, ma'am, go home. You avoid going and you no longer want to go because you are not receiving proper care."*
> **Kern County Resident**

> *I saw that an American woman arrived with her child and he didn't look sick or anything, but I saw that she was seen quickly. I said, well, maybe he's sick but she was seen quickly and saw that as discrimination, because people that look different than me are seen very quickly. And those that don't we are in the waiting room waiting and waiting."*
> **San Diego County Resident**

Urgent care centers can provide a viable alternative to emergency services for many, but participants could not find information about available services, costs, and coverage.

Many insured respondents described using urgent care clinics both as an alternative to calling 911 or visiting an emergency department, and as an alternative to primary care when they needed care outside of traditional hours or were unable to secure a timely appointment. Other respondents had challenges in understanding which urgent care clinics were covered within their network or experienced long wait times. Additionally, some respondents worried whether their health issue warranted going to urgent care or reported that they avoided going to urgent care due to potential high costs.

> *The list of urgent cares was not current, and we learned that not all urgent cares have the same equipment. In this case, the urgent care room where we waited for an hour did not have an ultrasound machine so we were referred to the ER down the street that was not in-network. The potential cost of the ER for an ultrasound scared us so we left without even signing in."*
> **People Power Survey Participant**

Patients who received emergency services receive insufficient discharge instructions and follow-up.

Many respondents shared that they were not given sufficient information regarding their recovery or home care following the receipt of emergency services. And many also had challenges arranging follow-up appointments with a primary or specialty provider. Without comprehensive follow-up care, experts warned that episodic emergencies were more likely to continue to occur.

> *They didn't tell me what to do, they sent me home with a torn ligament and they only gave me pain pills for 1 week. The cost was exaggerated and high so that they did not solve the problem."*
> **People Power Survey Participant**

Positive Experiences with Emergency and Prehospital Services

Research participants shared positive experiences they had with emergency and prehospital services, including caring providers and fast treatment.

> " *[The] provider listened carefully and referred me to a quality facility. The check-in process was reasonable, and the wait time was reasonable. The physician and clinical care were excellent, all questions were answered, and the discharge was handled with care."*

> " *The therapist understood the immediate needs of the mental health crisis, made themselves available, and helped find resources that did not activate the client's trauma (e.g., 5150 hold, etc.)"*

> " *I called 911 when I first injured my back. The paramedics who showed up were able to identify the problem that I had and told me what to do. They were upfront in letting me know that there is no emergency treatment for herniated discs or sciatic nerve injuries. They also said that if they took me to the hospital, I would be sent a big bill. Their advice was sound because the doctors I saw soon after told me the same thing."*

> " *My mom had a mini stroke and speed of care helped prevent it from causing permanent problems."*

> " *She was attended to promptly, and comprehensive diagnostics run even though she was uninsured. The diagnosis was received, and her treatment was initiated quickly."*
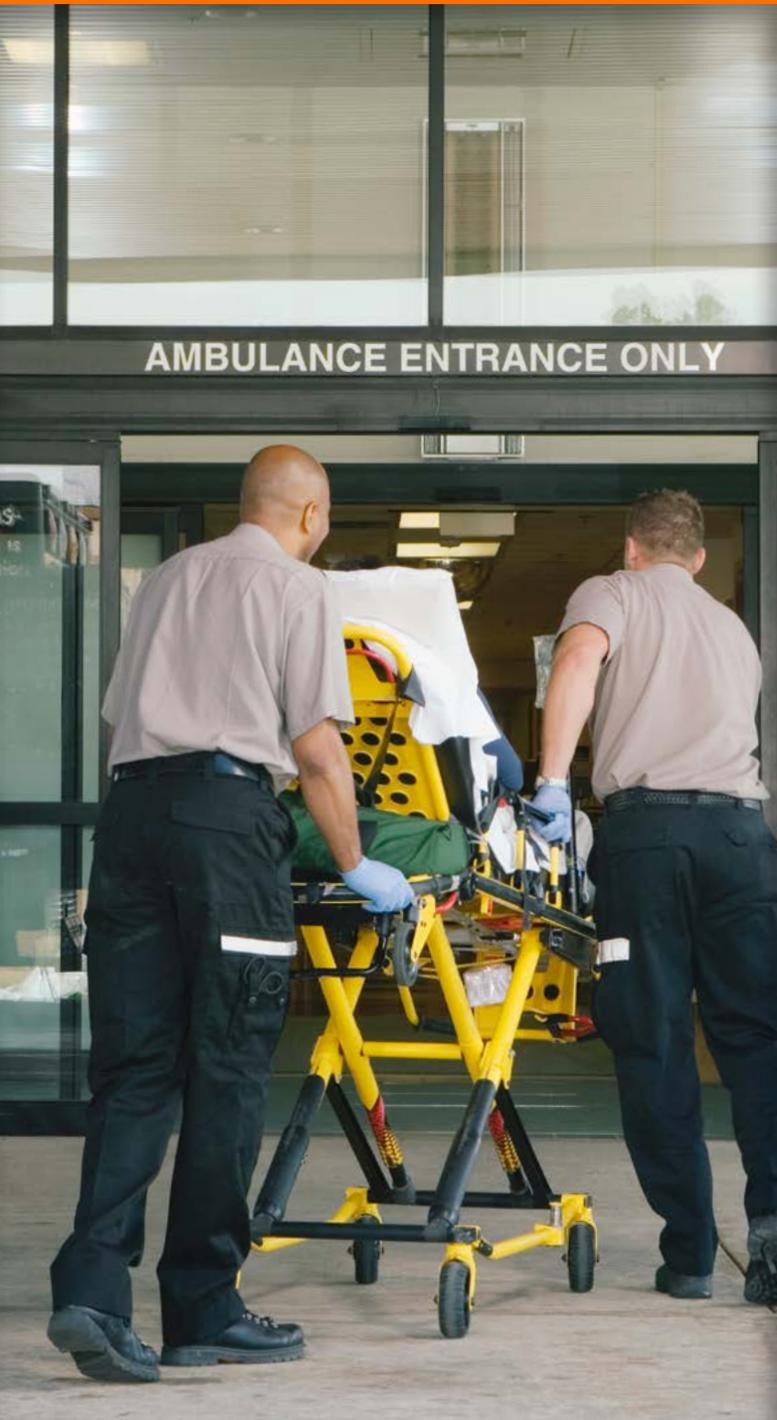
Innovative Community Models

Our conversations with community leaders highlighted the importance of using trained, trusted, community-based emergency responders for both medical and behavioral health crises. Two successful community programs are profiled below.

- **San Francisco's Division of Emergency Medical Services** runs a community paramedicine program to serve disinvested populations in San Francisco that may not be served best by standard emergency care response. Their EMS-6 program primarily serves community members who frequently use the 911 system (four or more times in a 30-day period or 10 or more times in a year) and provides wrap-around services to connect these community members to the resources they need, such as housing, primary and mental health care, and detox services. Providing targeted care this way helps to alleviate emergency room misuse and overcrowding and to connect community members with the most appropriate care and services they need.

- **Mental Health First (MH First)** is a program started by the Anti Police Terror Project (APTP), a Black-led, muti-racial, intergenerational coalition that seeks to eradicate police terror in communities of color. Mental Health First is an independent mental health crisis response service that does not rely on 911 or the police. Instead, MH First provides mobile peer support, including de-escalation assistance and life-affirming interventions, in Oakland and Sacramento. MH First volunteers also provide substance use support and domestic violence safety planning.

Recommendations for Local Policies and Investments

Based on our research with people of color and our conversations with local community leaders, CPEHN has identified a number of recommendations for counties, cities, and advocacy groups to address the barriers raised in our research and

improve the quality and responsiveness of emergency and prehospital services in their communities.

Increase targeted investment in equitable behavioral health services that prevent crises.
Local policymakers and community advocates should conduct county-level equity analyses of the full continuum of public behavioral health services to determine the current level of investment in services that meet the needs of communities of color. These analyses can be used to develop and implement action plans to make substantial investments in programs and services that are likely to prevent behavioral health crises in communities of color.

Improve multi-sector collaboration to reduce the need for emergency services and increase effective follow-up.
Local communities could pursue multi-sector collaboratives including local accountable communities for health (ACH) models that include EMS and focus on reducing the incidence of behavioral health or other crises.

Support emergency response partnerships that build trust.
Local policymakers and providers should create partnerships between local emergency medical services agencies (LEMSAs) and community-rooted organizations in order to build trust, provide a community feedback loop, and improve the delivery of care.

Expand first response system to include community-based providers.
Local governments should fully fund community-based, first response, mental health crisis intervention teams. In addition, community-based providers should be deployed to ensure that there is appropriate follow-up after a crisis or emergency. For example, community health workers who are deployed to assist in an emergency situation could also coordinate and provide follow-up care to individuals.

Improve consumer education and system navigation related to emergency medical services.
Local governments should consider culturally and linguistically appropriate outreach strategies to ensure that community residents understand their options in an emergency medical situation. Outreach should utilize trusted community messengers and clear and concise information. Linking 911 to other resource navigation systems could be helpful in order to direct people to the appropriate level of care.

Recommendations for State Policies and Investments

Beyond local policy solutions, we recommend state policies and investments to improve the quality and responsiveness of emergency services in California.

- Evaluate and improve the current training of paramedics, particularly related to behavioral health and implicit bias.

- Consider state policy change or oversight to regulate the cost of ambulance services and the cost and scope of urgent care clinics.

Community-Connected and Culturally Responsive Care Workforce

Listening session participants described the importance of connection and familiarity with their care providers. Investing in the health care workforce in communities of color is a key strategy to both improve the quality of care and to promote job opportunities and economic security. Health care workforce shortages are widely recognized as a primary barrier to meeting the needs of local community members, as is the availability of culturally and linguistically concordant providers. However, less attention has historically been paid to creating the conditions that allow people of color, in particular those with fewer resources, to receive education and training to become health care providers who can use their lived experiences to serve their own communities.

Our research illuminated four primary barriers to providing a community-connected and culturally responsive care workforce to all communities of color.

Challenges Encountered

Insufficient supply of providers who shared similar lived experiences negatively impacted care experiences and quality.
Across communities, participants shared the need for culturally responsive care from providers who share similar lived experiences as their patients. Forty percent of survey respondents "strongly agreed" and 43% "agreed" that it is important to see health workers who have a similar cultural background or life experiences as their community.

Participants reported feeling shamed, discriminated against, or misunderstood by providers who lacked shared lived experience, which impacted participants' willingness to seek future services and trust in their care plans. This was true regardless of the type of care needed, and particularly salient in behavioral health care where a trusted relationship between provider and patient is paramount for effective treatment.

Inadequate language assistance and supply of bilingual providers impeded delivery of effective, high quality care.
Research participants shared difficulties in accessing care due to a lack of language assistance. Most participants strongly preferred to see a bilingual provider who could communicate directly in their preferred language. While some participants were

> "
>
> *I have not had a doctor that looks like me in probably 20 years. So for me as I'm getting older, that is of concern to me."*
> **Fresno County Resident**

40%
STRONGLY AGREED

....

43%
AGREED

....

that it is important to see health workers who have a similar cultural background or life experiences as their community

> ❝ *"I am so glad that a Spanish speaking outreach worker was able to help navigate our family through the COVID-19 vaccination process. Without them, I wouldn't know what to do."*
> **Orange County Resident**

> ❝ *"[We need to fund] outreach workers who do outreach with the community and help connect people into care and come in with their visits and go to their pharmacy with them. Harm reduction services, like a buprenorphine treatment navigator, who will get people into suboxone or substance use disorder care. They come with them to their appointments and get them [residents] back and forth. These little interventions make huge improvements."*
> **Sacramento County Resident**

comfortable with and often used an interpreter, not all were aware of their right to interpreter services or received them when needed. Based on our survey, **71%** of respondents reported that their providers spoke their preferred language, while **22% of respondents** reported that an adult family member interpreted. **Seventeen percent of respondents** used an interpreter by phone or video, **15%** used an in-person interpreter, and **6%** had their child help with interpretation. Hispanic/Latinx respondents were more likely to utilize an **in-person interpreter (20%)** while Asian respondents were more likely to have a **family member or friend (18%) interpret**. Lack of language access was a particular problem for those participants who speak a language other than Spanish, for which accessing bilingual providers or interpreter services was even more difficult.

Importance of community and cultural centers often underappreciated and under supported. Participants noted the importance of community-based organizations as trusted health care providers that provide culturally and linguistically responsive services. Community organizations, as well as family resource centers, youth programs, and spiritual centers, were seen as important sources for accessing health

information, enrolling in services such as Medi-Cal, accessing mental health services, accessing food, and providing a sense of safety and belonging for communities of color. Thirty-seven percent of all survey respondents and 46% of Black respondents reported that community and cultural centers served as an important source of support for mental health and substance use issues.

These institutions and their staff are often not considered a formal part of the health system and struggle to have reliable resources with which to sustain services. Participants strongly recommended more support for community-based organizations to do what they do best, without having to subscribe to the rigidity of the traditional health care system. Community-based organizations were trusted by participants because they provide culturally competent support throughout all aspects of the experience - from registration through care and follow-up.

Despite strong interest in health-related jobs, people of color often lack opportunities. According to our survey, **70% of respondents expressed interest in working at a job that provides health services to their community.** This was particularly high with Black/African American (73%), Asian (76%), and American Indian and Alaska Native (74%) respondents (Figure 8). Yet, while the interest exists, the opportunity often does not. Many participants saw formal or licensed health care jobs as out of reach based on their limited access to education and training options. Others felt that their immigration or incarceration history would preclude them from pursuing these employment pathways. However, participants recognized that their lived experience would be an asset in a health career with skills such as relationship and trust building, system navigation, and motivational coaching.

Those currently working in health careers, in particular community health workers, described both the opportunities and the difficulties of their path. Community health workers described

> "My son participated in those fire lines, he was an incarcerated individual who worked on the fire lines. He can't get a job with CalFire. He can't approach any of these fire agencies and look for real employment. But he has certificates that said he did a really, really good job."
> *Sacramento County resident*

INTEREST IN WORKING IN HEALTH SERVICES

% Interest in Providing Health Services

73%   **Black/African American**

76%   **Asian**

68%   **Hispanic/Latinx**

59%   **White**

74%   **American Indian/ Alaska Native**

75%   **Pacific Islander**

75%   **Middle Eastern/North African**

73%   **Native Hawaiian**

FIGURE 8
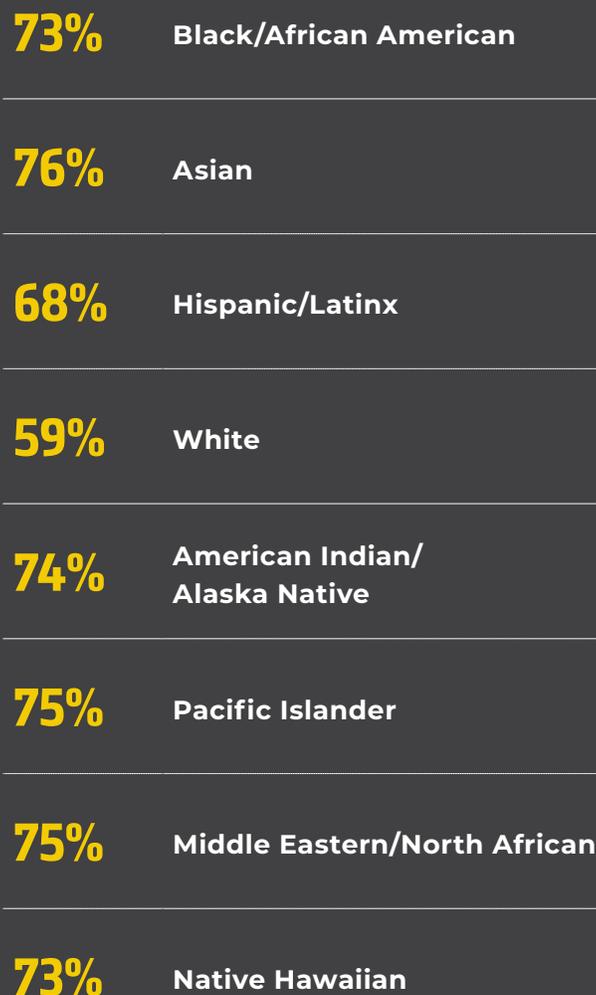
experiencing high rewards from working with their community and patients, but encountered barriers in working within the broader health system to meet the needs of their patients. In addition, they expressed frustration with low pay and few formal opportunities for advancement.

Innovative Community Models

- **The [Mixteco/Indigena Community Organizing Project (MICOP)](#)** works and serves Indigenous migrant communities primarily from southern Mexico in Ventura County. MICOP has developed multiple programs to build culturally responsive care and a linguistically competent workforce for Indigenous migrants, as well as collaborated with other organizations to meet the diverse needs of Indigenous migrants. They have successfully advocated for interpretation services at county clinics and private hospitals. In addition, MICOP is developing the next generation of interpreters using Indigenous languages through in-house trainings.

- **[Visión y Compromiso (VyC)](#)** is a nationally respected organization dedicated to improving the health and well-being of underrepresented populations through developing a community-connected workforce. In California, VyC has provided comprehensive and ongoing leadership development, capacity building, advocacy training, and support to over 4,000 *promotores* and community health workers.

Recommendations for Local Policies and Investments

The majority of funding for workforce development is provided by federal and state governments. However, federal relief dollars provide counties with an opportunity to make strategic investments in developing and diversifying their local health care workforce. Specific recommendations include:

- **Utilize COVID-19 relief dollars and other local fund sources to invest in local health care workforce development efforts such as:**

  » Raise minimum wage for non-licensed health care providers employed by county government entities and contracted providers.

  » Partner with school districts to provide career technical education (CTE) programs for students to enter health careers with local safety net providers.

  » Develop advanced training programs for community health workers to specialize in particular areas including behavioral health, emergency response, and navigation for people experiencing homelessness.

- **Build the capacity of community-based organizations to employ health care providers and staff with lived experience, to serve as health homes, and to provide care coordination services.** CBOs are uniquely positioned to fill this role because of their deep connections to community, but their capacity to employ health care providers and other health care workers must be built and sustained. It is also important to recognize the needs of people with lived experience as employees and provide flexibility and resources to community-based organizations to address these needs. In addition, it is necessary to build the capacity of the health system to responsibly partner with community-based organizations.

- **Support the development of interpreter networks** that ensure the availability of in-person interpreters for multiple languages and with specialization in a variety of clinical and non-clinical settings.

Recommendations for State Policies and Investments

Workforce shortages persist across the state, making this an important area of focus and investment for state government.

- Provide workforce development funding for **community health worker recruitment and training** that is inclusive of community health workers providing behavioral health, public health, and in other roles and settings beyond primary care and health promotion.

- Prioritize the **recruitment of bilingual individuals and people** with lived experience in workforce development programs and ensure that grants, scholarships, and fellowships include both educational expenses and a living wage. Ensure opportunities for fully paid field training.

- Establish **training and hiring programs for monolingual, non-English speaking individuals** to provide health care services, and for health systems to support these employees.

- Evaluate and maximize scope and licensing for key provider types such as dental therapists, nurse practitioners, and community health workers.

- **Remove barriers to licensing and certification** associated with arrest and incarceration records, immigration status, and educational attainment.

- Establish an annual fund, such as the Health Equity and Racial Justice Fund, in the California state budget to **support and invest in nonprofit clinics, tribal organizations, and community-based organizations.**

Investment in Social Determinants of Health

> " *Housing is a big problem and for that reason, many people decide to live in cars. I know people that are living in their cars, they park in places where families allow them to spend the night and they sometimes have up to a month living there because they can't pay the rent. It is very expensive to get an apartment, they ask for a lot of requirements, and a lot of money. So, I would like to see that regulated to have a better San Diego."*
> **San Diego County Resident**

Health outcomes are deeply influenced by upstream drivers of health, also referred to as social determinants of health. While this project does not delve deeply into policy recommendations for each issue, we do uplift the top priorities raised by respondents.

Community residents overwhelmingly reported that social determinants of health, or the "conditions in the environments where people are born, live, learn, work, and play," play an integral role in their families' and neighborhoods' wellbeing.

When asked what would make their neighborhoods a healthier place to live, more than half of respondents indicated better safety (51%), followed by parks and green spaces (48%), public transportation (43%), and grocery stores and farmers markets (42%).

Participants in the Listening sessions echoed these same priorities, as they discussed key challenges in their communities that made it difficult to live healthy lives.

Challenges Encountered

Lack of affordable, quality housing.
Participants expressed the need for affordable and good quality housing. High living costs are displacing residents out of the area, increasing housing instability, and causing homelessness. Participants also noted difficulty finding housing resources and insufficient tenant protections and assistance.

WHAT WOULD MAKE NEIGHBORHOODS A HEALTHIER PLACE TO LIVE?

51%
BETTER SAFETY

48%
PARKS & GREEN SPACES

43%
PUBLIC TRANSPORTATION

42%
GROCERY STORES & FARMERS MARKETS

Lack of safe environments and concerns about community safety.

Community safety was a key issue across participants. Many participants noted the lack of safe environments in their neighborhoods, such as after-school programs and community centers. Some participants shared stories of law enforcement harassment towards activists, advocates, community-based organizations, service providers, and the unhoused community.

> *A lot of schools are safe places from their home life, some people's home lives are a little rough."*
> **Orange County Resident**

Insufficient access to healthy foods.

Participants had trouble accessing healthy foods in their communities often due to the lack of nearby markets with fresh fruit and vegetables, and the high cost of healthier options compared to processed foods.

> *Well, you know, in our urban and rural areas, we have nutrition deserts. Easy-to-find, unhealthy foods [are] cheaper; the unhealthy high sugar, high salty foods, you know, sugar and salt addictions that are very easy and very common."*
> **Fresno County Resident**

Lack of green spaces and parks.

Participants, particularly in Kern and Fresno Counties, desired more green spaces and parks in their communities including community gardens. Participants also expressed a desire to have more options to engage in safe physical activity throughout their communities.

> *When I got to the park where I usually take [my daughter], the playground was burned down and melted…however the parks in the nice areas are farther away. So, you can tell the difference, the difference between zip codes is noticeable."*
> **Kern County Resident**

Innovative Community Models

Community organizations often fill gaps in addressing to address social drivers of poor health outcomes and to improve community conditions and community health. There are many examples across the state, but one from the Central Valley stands out.

The **Central Valley Empowerment Alliance (CVEA**) is a multi-ethnic group with grassroots community membership stretching across five counties (Madera, Fresno, Tulare, King, and Kern) within the Central Valley. CVEA serves various communities within these regions including Indigenous communities living in the Tule River Indian Reservation, Mexican, Mayan, Mixteco, and Filipino farmworkers, and residents who are undocumented.

CVEA addresses social determinants of health through various initiatives:

- **LUPE's Promise Youth Leadership Center:** In Spring of 2022, they officially opened the doors to LUPE's Promise Youth Leadership Center providing 13 internships to youth ages 11 to 24 with stipends of $17/hour up to 20 hours a week for service work including distributing food, conducting COVID-19 vaccine education outreach, planting giant redwoods at Sequoia National Monument, and advocating for green spaces in rural communities without local parks.

- **La Clinica Del Pueblo:** Through a partnership with Street Medicine Kaweah, Central Valley Empowerment Alliance hosts from 7 to 25 doctors, medical students and resident doctors from rural communities to return to the Central Valley to provide urgent medical care twice a month, including dental and mental health.

- **Food Access: CVEA** was able to connect with FoodLink Tulare and Central California Food Bank to provide fresh fruits, bread, and non-perishable food items weekly to nearly eight hundred families.

- **Community Engagement Around Parks and Recreation:** Most recently, the Poplar community received a $1.4 million Proposition 68 grant from the state to build a park and CVEA has engaged local youth to help shape the new parks.

Recommendations for Local Policies and Investments

There are many ways that local governments can reprioritize and reinvest in communities in order to address the social determinants of health. Listed below are the most frequently referenced solutions from community Listening sessions.

Housing:

- Pass local tenant protections to protect people from displacement and homelessness such as rent control, just cause ordinances, eviction moratoriums, and local rent caps.

- Continue to provide tenant relief similar to COVID-19 rent relief for tenants struggling to pay for rent.

- Invest in publicly-owned housing and housing managed by non-profit organizations to develop housing that is safe, dignified, and affordable.

- Develop opportunities for homeownership especially for excluded and underserved marginalized communities.

Community Safety:

- Decrease county and city spending for local law enforcement, and increase revenue for other services that address social determinants of health.

- Increase county and local spending on after-school youth programs, violence prevention programs, and trauma-informed services.

Food Access:

- Increase local investments towards culturally appropriate food access such as community-owned markets and local farmers markets, healthy food programs including free nutritious meals for youth and families, and opportunities for neighborhoods to grow their own foods.

Green Spaces:

- Invest in green spaces, parks, and safe areas in disinvested communities. City & County Parks and Recreation Departments should use community advisory committees to involve residents in shaping parks and green spaces in their neighborhoods.

Recommendations for State Policies and Investments

In addition to investments at the local level, community Listening session participants pointed to specific action steps needed from state government.

Housing:

- Pass statewide protections for renters and unhoused communities such as extending eviction protections and rent relief.

Community Safety:

- Decrease over-bloated state spending on prisons and jails, and increase investments in safe community spaces, violence prevention programs, trauma-informed services, and healthy community alternatives to incarceration, as led by statewide organizations such as Californians United for a Responsible Budget (CURB).

Food Access

- Invest in Food For All and expand access in the California Food Assistance Program (CFAP) to those ineligible for CalFresh due to their immigration status.
- Increase investments in the state budget towards healthy food access and security, climate-resilient farms, and regional food economies, as led by the Food and Farm Resilience Coalition.

Green Spaces

- Increase state sources of funding (such as grants) for counties and cities to develop parks and green spaces in historically disinvested communities and communities disproportionately affected by climate issues.

CONCLUSION

> **"**
> *I think that we have to get involved more as a neighborhood and participate more in the decisions, because sadly it's a handful of people that decide where those resources go."*
> **Kern County Resident**

Communities for Community Health:
Embedding Long-Lasting Change

People Power for Public Health uplifts the theory of change that communities of color know exactly what they need in order to live in thriving and healthy neighborhoods and deserve the power to fund their own community solutions. And our research revealed strong community interest in policy making.

In our People Power survey, **74% of respondents said they are interested in creating or changing local policies.** Respondents shared that training on the policy making process was needed for them to get involved.

Communities and community-based organizations need to create opportunities for their residents to learn about and become engaged in local policy development and budgeting. We recommend that counties lead townhalls, community education, and other stakeholder gatherings to ensure residents understand local decision-making processes and the county budget cycle and to ensure that resident voices are included in local policy and budget making. Suggestions include developing budget documents that are available in non-English languages and working with trusted community organizations to lead local engagement programs, such as workshops on the county budget.

One model for engaging community members in county budgeting is the <u>Contra Costa Budget Justice Coalition</u>. Since their founding in 2017, they have focused on building out values-based local budgeting towards safe and affordable housing, essential health care, access to critical social services, and quality early care and education.

Since their launch, they have developed several initiatives around local advocacy towards community health:

- **County Budgeting Education & Town Halls:** The coalition has led town halls, hosted a budgeting 101 workshop, and developed stakeholder processes to ensure that community residents are involved in the budget making process.

- **Measure X:** In 2020, the Coalition helped pass Measure X, a countywide general sales tax that would bring in $80 - $100 million a year to fund a system of prevention, care, and social and public services. The measure also included establishing a Measure X Community Advisory Board to develop an annual needs assessment to determine where tax dollars should be funded.

Our research makes clear that change is needed to ensure the just allocation of local resources to improve the health of communities of color. And effective change will require the active involvement of people of color in local policymaking and funding decisions.

Endnotes

Bay Area Equity Atlas. (2021). "Diversity of Electeds." Retrieved from https://bayareaequityatlas.org/indicators/diversity-of-electeds#/

Schaff, K., Desautels, A., Flournoy, R., Carson, K., Drenick, T., Fujii, D., … & Yamashita, B. (2013).

Bell, J. (2011). Why Place & Race Matter. California Endowment.

Smith, C., & Dobard J. (2020). Budgeting for Justice. Participatory Budgeting As A Means of Advancing Racial Equity in California. Advancement Project. Retrieved from https://www.advancementprojectca.org/tools-we-use/publications/budgeting-for-justice-participatory-budgeting-as-a-means-of-advancing-racial-equity-in-california

California Pan Ethnic Health Network. (2022). American Rescue Plan Act Scorecards for California Counties. Retrieved from https://www.cpehn.org/ARPAscorecards/

California Department of Health. (2022). "California's Commitment to Health Equity." Retrieved from https://covid19.ca.gov/equity/#overview-of-disparities

Lopez, L., Hart, L. H., & Katz, M. H. (2021). Racial and ethnic health disparities related to COVID-19. Jama, 325(8), 719-720.

Kelch, D. (2015). Locally Sourced: The Crucial Role of Counties in the Health of Californians. California Health Care Foundation. Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-LocallySourcedCrucialRole-Counties.pdf

Graves, S. (2018.) County Budgets: Where Does the Money Come From? How is it Spent? California Budget and Policy Center. Retrieved from https://calbudgetcenter.org/resources/county-budgets-where-does-the-money-come-from-how-is-it-spent/

Sacramento County. (2021). CARES Act Funding and the Coronavirus Relief Fund. Retrieved from https://www.saccounty.gov/COVID-19/Pages/CARESActFunding.aspx

California Budget and Policy Center. (2021). Fiscal Aid to State and Local Governments. Retrieved from https://calbudgetcenter.org/resources/american-rescue-plan-provides-assistance-to-millions-of-californians/#S1

California Pan Ethnic Health Network. (2020). At What Cost? How Local Governments Shortchange the Health of Communities of Color. Retrieved from https://cpehn.org/publications/at-what-cost-how-local-governments-shortchange-the-health-of-communities-of-color/

American Civil Liberties Union. (2021). Federal Complaint Filed Over Misuse of Funds Used for Furniture, Office Upgrades. Retrieved from https://www.aclusocal.org/en/press-releases/riverside-sheriffs-department-gets-millions-meant-covid-relief

Sacramento County. (2021). CARES Act Funding and the Coronavirus Relief Fund. Retrieved from https://www.saccounty.gov/COVID-19/Pages/CARESActFunding.aspx

California State Auditor. (2021). "State High Risk Audit Program." Retrieved from http://auditor.ca.gov/reports/2021-601/index.html

Tuck, E. (2009). Suspending damage: A letter to communities. Harvard Educational Review, 79(3), 409-428.

Legislative Analyst's Office. (2022). The 2022-23 Budget Health Care Access and Affordability. Retrieved from https://lao.ca.gov/Publications/Report/4560

County of Los Angeles (2021). "Transformative $187.7 Million "Care First Community Investment" Spending Plan Invests in Equity and Community." Retrieved from https://ceo.lacounty.gov/2021/08/10/ati-newsroom/care-first-community-investment-spending-plan-invests-in-equity-and-community/#:~:text=The%20Board%20of%20Supervisors%20today,just%20and%20equitable%20Los%20Angeles