Healthy Sacramento Coalition Meeting
April 23, 2014
Meeting Summary

Meeting Outcomes:
• To receive updates on the RFPs and proposal review process moving forward
• To receive updates from workgroups

Welcome and Overview
Ramona Mosley, Health Education Council, welcomed everyone and began the meeting by having everyone introduce themselves. She provided a brief overview of the day’s agenda.

Health and Place Framework
Robert Phillips, Sierra Health Foundation Director of Health Programs, revisited portions of his presentation from the March coalition meeting in order to address the number of questions that were brought forth during the previous meeting as well as to give context for the next steps of the coalition. He provided clarification and a framework for moving the coalition into the future.

For more information, refer to the presentation titled: Health and Place Framework Presentation online at: http://www.sierrahealth.org/hsc/2014-meeting-materials.

C: I really respect the context and direction. I would be interested in your further observations on the differences or balance between equity and equality. I would be interested in anyone else’s comments as well. I think it’s a deeper conversation.

Robert elaborated on the difference between being equal and being fair. Equity is trying to understand and give people what they need to enjoy full, healthy lives. Equality, in contrast, aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality aims to promote fairness and justice, but it can only work if everyone starts from the same place and needs the same things. Equality is the baseline that we want. We do not want anyone to be underinvested in or to fall below a baseline of well being. We also know that this standard (equality) is also the path of least resistance; it is the lowest common denominator that we (the coalition) can go after. While this may maintain equal investment, it does not necessarily do so for the areas of health or education. Equal investment may recognize that there will be some level of inequity and it is accepted. Accepting equal investment does not recognize prior history, social, political, or economic context or other things that have disadvantaged people far beyond the practical and logical concept of investing equally. The equality concept is about giving everyone the same amount of resources and the equity concept is about a different conversation. We have held equity as a principle in the coalition, but we have not asked the coalition if everyone agrees. This does not disadvantage one group of people to the benefit of another, but it does suggest that there be a heavier emphasis and focus on communities that are starting further behind than others. It also suggests that there be a focus on helping people meet the same standard level of health, such as those that would be set in certain communities over others. This does not mean that we are trying to disadvantage one community over another, but it does recognize that there are some structural and historical inequalities that

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have led to these differential outcomes that are not fair. We are engaging in a conversation on how to actually get to something that is not just equal but fair.

The big equity question for the coalition to consider is: how do we address something like knowing that rates of obesity in communities of color are higher, not just due to genetics, but due to the environment. This is due to the things structurally that we know lead to obesity and do not exist in other communities; how do we address these inequities? We know certain communities, at a data level, hold down the county’s health status average due to health inequities. Therefore, if the coalition wants to reduce the obesity rates in Sacramento and we know there are certain communities leading the bad indicator, but we continue to do the same thing for everyone and not recognizing their context, history, or the need for a different kind of approach and we are seeing the same outcome, are we actually getting to the goal that we want? And this is the struggle that we will have to have.

C: For example, I was at a Headstart preschool site for 3-5 year olds last week in Del Paso Heights, and these children have the same desire of wanting to read and live well as the kids in Granite Bay (an affluent community in the Sacramento region); I have to provide a contrast. When you look at equity versus equality, what they are starting from is far less than the kids that have more, but their desires and abilities are no less. So how do we make it where they are not just seeing the game, but that they are in the game? These kids, a lot of them, do not have meals from Friday night until Monday morning to be able to focus and concentrate; this is challenging. Additionally, there are no mainstream grocery stores or safe parks and there is an inequity issue there. Maybe we have to give them the $1.50 versus only giving them $0.25 in order for them to all get into the game. This is my analogy because this is where I live and where I grew up and I’m passionate because I see it every day and these kids have every desire to want to be well. They are just starting from a disadvantaged point, so if we can find a way to address equity then this is definitely in the right direction. I am so appreciative of the depth of this conversation and glad you brought this up. I believe this is going to be effective.

C: To me the biggest demonstration at the policy level was Prop 39, regarding upgrading California schools. Senator Kevin de Leon brought up the fact that we are equal because we have offered the opportunity for people to apply for bonds, but if you look at a map of which counties and school districts have applied, it was not the underserved, it was not the rural, and it was always the affluent. I think what you’re getting at between equal and equity is that some do not have the resources to go after what is offered.

C: My own thinking around equity is that I always framed it as an equal distribution of resources, if it is equitable and others get access; there would be something like redistribution of wealth. The growing gap is what I associate with equity. With the equality part, I believed that this is what happens if you establish that, than we have equality, if there is a fair distribution of resources. This is the concept in my mind and I appreciate the other observations as well.

C: My observation over the past years is that we talked about five-a-day nutrition and healthy eating. Most of our communities are living on a tight budget and do not have the resources or fresh produce available; then how are you supposed to be incorporating it into your diet? Also, when you buy food on a little bit of money, you are not buying things that you have to eat right away. You want stuff that will last forever, which is not healthy. So we have been talking about nutrition for many years, but it is not happening. I know that with our farmers markets, finally they are accepting EBT cards so that people could benefit, so that was an equal opportunity but it was not equitable; it was available but it was too expensive. Where I

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come from produce was free because we lived in it. When I moved here I was shocked to pay 50 cents for lettuce and now it costs a lot more. It (equity) is basically making things available without question.

C: When we talk about equality and equity, we have to allow for catching up because so many people are so far behind in the inequity that when we think that everyone is receiving at the same level, they are not and there has to be a catching up period and we do not allow for that. For example, before integration I was in a segregated school system when I was a kid. We all thought we were getting the same education as the Caucasian and affluent neighborhoods. But when integration occurred we discovered that we may have received the same books and supplies, but we were so far behind the curriculum that we had to be put back because the curriculum was too far accelerated for many of us. When we think about equality, we have to allow for the catching up and we have to allow for attitudes and realities to set in that some people are starting from zero and other people are already at 20.

Q: I love the last few slides of your presentation; they have been fantastic on how you laid out direction, where we have been and where we are going and the interactions between all of these different entities. This is a very theoretical framework and I am such an applied person, can you briefly comment on the interactions and how you see all of this going?

A: In the interaction between Healthy Sacramento Coalition and Communities Creating Health, there are two questions we have been trying to answer: 1) how are we going to connect to the neighborhoods in the 15 zip codes?, and 2) how are we going to make sure they are, either by proxy or directly represented, in our conversations? The practical connection is that the communities creating health conversation is a broader effort to bring that voice forward but also to have organizations through their networks and existing constituents to create an authentic connection. Bringing that into Healthy Sacramento answers the second question. Next, figuring out how their work matches what the coalition is up to is an ongoing conversation that we will have both in the workgroups and in the coalition general meetings, to understand what it means to have that perspective and those types of organizations in the room. A good number of them are focused on social and emotional wellness, so how does that tie into the coalition and match the criteria we set out for how we do work in the coalition and what we will actually do?

Lastly, we have often asked ourselves where the health care system fits into the health work we are doing. The place where we focused on this mostly is through the community and clinical health integration workgroup (CCHI). This was done for two reasons: first, as a practical matter because it was a CTG requirement, and second, because this felt like the appropriate setting to begin to understand the intersection and relationship between the clinical and community health efforts. There is a parallel effort around prevention and wellness taking place among the hospitals and the safety nets independently. We want to use the conversations taking place in the workgroups and on the parallel track and infuse them into the coalition.

Centers for Disease Control and Prevention
Audrey Williams, Public Health Advisor, Program Development and Implementation Branch: Division of Community Health, Centers for Disease Control, shared how impressed she is by the variety of coalition members in attendance today and how well represented they are. She encouraged dialogue with other colleagues in the state who are CTG recipients, such as San Francisco, Sonoma County and Stanislaus County.

The Healthy Sacramento Coalition and other sites are doing wonderful work. Sierra Health is doing fabulous work and on behalf of CDC, Audrey apologized for the various starts and stops in the process. However, the

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coalition is doing great work based on the work plan. Although the CTG program is ending at the end of September, the work of the coalition is good for the community and should be sustained and continued beyond CTG funding. Audrey mentioned there will be other FOA opportunities that the coalition can apply for. She encouraged the coalition to position itself to compete for these future opportunities. On the go forward, the coalition should continue to work to make a significant impact in Sacramento. Audrey is available to provide technical support as well.

Audrey shared the CDC Guide to Advancing Health Equity, a valuable resource for the coalition: http://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf

There are strategies across all of the pilots in the guide that can be used and applied to the coalition’s work. While a few of the coalition members may not understand the difference between health equality and equity, there is a big difference and it is very important for all coalition members to see the differences in their work and read about them in the guide and to implement them in respective communities. Although it may not be apparent, it exists in every community.

Audrey encouraged the coalition to celebrate the work completed thus far and to continue to champion the impact the pilots will make in the community. She suggested the coalition should continue to enhance and expand what’s been accomplished thus far and to determine what current partners can do to sustain the efforts beyond CTG. Also, to include new partners to come on board and determine what they can do to help the coalition’s efforts. The coalition should continue to develop success stories and to disseminate documents. Although these were not requirements in this CTG funding round, it will be important for morale and for the communities to know the work the coalition is doing. The coalition should also discuss and document the lessons learned from this process by reflecting on what has been learned during the bumpy journey through CTG. These lessons will help the coalition compete for other funding opportunities that are coming.

In regards to what the future direction is of the CDC, in particular for the Division of Community Health, where CTG is housed and the initiative is ending, there are new funding opportunity announcements coming soon.

Q: You mentioned other areas in California. What about the Public Health Institute, because they were able to get a grant for areas that did not get CTG funding? What kind of relationship do you have with them and will their work continue beyond this fiscal year? Second, we are missing the general business community. Are there ways to track them? We have employers in healthcare, but the non-healthcare are impacted because that is where people get their health insurance and we need healthy employees, so have you seen other grantees that have a lot of business or are able to attract them in? This is an area we do not have here. PHI has so many partners and they might be a good place to check for assistance that we may need.

A: Thinking about San Francisco, their coalition is varied, it spans across the health systems, including public health, clinics, hospitals, and other sectors. The particular work that they are doing is around community health workers and implemented a strong partnership with the health systems and college (SF State) and it is very active with a lot of buy in. Audrey is not sure about the level of involvement of the business community or chamber of commerce, but they do have a city-wide coalition. They have been very successful in implementing their projects (as an implementation grantee) and have collected data trending towards the impact their projects have had on their communities.

About PHI, there is a representative here from that organization. PHI was funded but everyone’s work is ending in September. PHI is well known and their work may continue but just not with CTG funding. The PHI
representative in the room shared some brief remarks: unfortunately, she does not work on this particular project and cannot speak to it. However, she can connect anyone to her colleagues should anyone be interested.

Audrey highlighted how California was far beyond most other states. There are many rich resources in California that the coalition can tap into such as PHI, The California Endowment and others. Many of the other California-based CTG sites are all using the same billboards and commercials to advertise. They are partnering together, so that they are not all spending their few dollars trying to put out commercials. They are collaborating together and this would be a great opportunity to piggyback and join what already exists.

**Q:** Given that the initiative is sun setting, what are CDC’s thoughts on defining success now, particularly in terms of capacity building?

**A:** Success is relative. Not everyone will start at the same position. As a capacity building award recipient, you were charged with building your infrastructure, and that is a success. Depending on who were the initial partners and even now, having this many various organizations and partners represented on their coalition is another success. What we were looking for from capacity building awardees was how their infrastructure was built and by succeeding in this you moved on to your pilot projects. The thought was to move everyone into implementation, but this did not happen. Because the coalition was successful in the capacity building phase is why the coalition was granted to implement pilots. In looking at our work plan and the work that is proposed, the coalition will be successful, but will have to stay the course, despite CTG funding coming to an end. With the number of partners in the coalition, the work can continue and get done. Also, the coalition can position itself in a way to compete for the future funding announcements that will be community-based.

Audrey pointed out one other important buzz word and theme at CDC: **collective impact.** This is the direction of public health because it is unrealistic to expect one organization to handle every aspect of a community. There is a need for various organizations to come together with a common goal in mind; to help reduce chronic diseases. The coalition should continue to move forward with its positioning.

**RFP Process Moving Forward**

*Connie Chan Robison, Steering Committee Vice Chair, Center for Collaborative Planning,* provided an update on the coalition’s progress over the course of the past six months, where the coalition is headed for the next six months, and the RFP review process moving forward.


**Workgroup Updates**

**Tobacco-Free Living Update:** *Myrna Rivas, chair,* provided a brief update on how the workgroup developed its recommendations for the Tobacco-Free Living RFP.

**Healthy Eating Active Living Update:** *Mary Helen Doherty, chair,* provided an update on how the workgroup developed its recommendations for the Healthy Eating and Active Living RFPs. The workgroup’s priority is emphasizing the promotion of water. If any coalition member has ideas or suggestions of who to invite to apply for the RFPs, please contact Mary Helen.

**Next Meeting**

*The Healthy Sacramento Coalition is made possible by funding from the Centers for Disease Control and Prevention and Sierra Health Foundation.*
Next meeting is scheduled for Wednesday, May 28, 2014, from 10:30 a.m. to 12 p.m. Registration is required. Visit the Healthy Sacramento Coalition web page at www.sierrahealth.org/healthysacramento and register today.