CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE

Staff Report[1] to the Health in All Policies Task Force: Integrating health and equity considerations into grant programs from "non-health" sectors

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This report was written by HiAP staff from the California Department of Public Health and the Public Health Institute. While several agencies and departments have reviewed this document for accuracy, it is a staff report and not a statement on behalf of the Task Force.

I. Introduction

Government systems, decisions, and actions shape the determinants of health and equity; the social, economic, geographic, political, and physical conditions that lead to the creation of a fair and just society (AB 1467, 2012). While the values of fairness, justice, and equity have long been considered by government, California state government increasingly recognizes the impact that social and environmental factors such as climate change, housing, transportation, air quality, land use, and education have on both health and equity. In fact, health and equity are inextricably linked, and agencies across sectors are increasingly integrating both health and equity considerations into state grant programs and funding decisions outside of traditional health fields. The term "health equity" is gaining popularity as a way of describing conditions in which all people have full and equal access to opportunities that enable them to lead healthy lives (AB 1467, 2012).

HiAP staff and agency partners have made it a priority to learn about and promote health, equity, and health equity, and are continually looking for opportunities to learn from our experiences and refine our approach. One essential strategy for promoting these principles is to ensure that state dollars have the largest possible impact and serve the communities with the greatest need. The following staff report reviews a sample of state funding programs that have integrated health and equity considerations into grant guidelines or criteria, and shares lessons learned and areas for further inquiry that can support California government in pursuing this approach.

II. HiAP Task Force Background

Shortly after its formation in 2010, the Health in All Policies (HiAP) Task Force established an aspirational goal that "California's decision makers are informed about the health consequences of various policy options during the policy development process." In support of this goal, the HiAP Task Force prioritized the following recommendation for early action, "Incorporate health and health equity criteria into State

[1] The HiAP Task Force is staffed by a joint team from the Public Health Institute and California Department of Public Health, with support from The California Endowment, the Kaiser Permanente Community Benefit, and the Pew Charitable Trusts.

grant Requests for Applications, review criteria and scoring, technical assistance, and monitoring/performance measures, where feasible and appropriate."

In October 2011, the HiAP Task Force finalized the development of an Action Plan on Health and Health Equity Criteria in State Grants[2] and committed to two relevant actions: 1) Evaluate health, equity, and sustainability criteria in a handful of state issued Requests for Proposals (RFPs), and 2) Develop recommendations to assist state agencies in incorporating health and equity criteria into grant applications.

Since that time the HiAP Task Force and staff have built on the efforts of agencies to incorporate the values of fairness, justice, and equity by integrating health and equity considerations into several grant programs, and have taken early steps to evaluate impact and identify success factors.

III. Methods

The findings in this report are informed by two inquiry periods. In 2011 and 2012, two research assistants[3] examined a small convenience sample of state grant programs to identify best practices. They looked at how agencies had included language addressing health and/or equity in grants, and interviewed grant program staff to learn about the factors that supported those staff in prioritizing health or equity in grant guidelines.

In 2015, HiAP staff examined a small set of grant programs that integrated health and/or equity considerations since 2010. HiAP Staff reviewed documents and held conversations with staff and leadership in the agencies administering the grant programs, as well as with external stakeholders involved in developing and submitting grant applications for the programs. Local health departments were consulted through the California Conference of Local Health Officers, with individual follow-up discussions with select health departments that have a particular interest in this topic.

IV. Key Findings to Date

Below is a summary of key findings identified through this process.

a) Including **health goals or objectives** in enabling legislation for grant programs has provided administering agencies with justification to include health considerations, and has led "non-health" sectors to invite public health to contribute to the program's development and implementation.

b) Public health **staff have experience and expertise** in highlighting health equity considerations relevant to the development, dissemination, and scoring of non-health grant programs, and partner agencies have found public health input to be useful during program development and implementation.

[2] https://www.sgc.ca.gov/docs/Health_and_Health_Equity_Criteria_in_State_Grants.pdf
[3] Thank you to Paige Kruza and Alcira Dominguez who provided research consultation.

c) Grant administrators and applicants report that grant programs with **a requirement to collaborate** with public health (e.g., including a letter of intent to participate and/or letters of support or assistance from local health departments that also include health or population demographic data) have led applicants to reach out to and work with their local health departments in application development and ultimately implementation. This requirement has also led applicants to bring additional essential partners to the table that historically may not have been involved, such as schools, transit agencies, and/or job development organizations.

d) **Local health departments report that they are eager to be included as partners** in non-health grant applications. In addition to population health outcome data, local health departments often have valuable data on broad community indicators and demographic projections, long standing relationships across communities, skills in a variety of community engagement techniques, and a deep understanding of the demographics of and challenges facing socially, economically, and otherwise disadvantaged communities in their jurisdictions.

e) Administering agencies report that by recruiting a team of **cross-sectoral state agency staff to develop grant guidelines and score applications**, they increased cross-sectoral understanding and awareness of state priorities, enhanced the ability of their grant programs to address inter-related state priorities, built capacity and expertise in developing grant programs across participating agencies, and broadened their networks which helped to ensure a well-subscribed grant program. It should be noted that this strategy is not unique to the topic of health or equity, and has been established as a best-practice through a number of efforts including the Caltrans Regional Blueprint Grant Program and the Strategic Growth Council's Proposition 84 funded Modeling Incentive grants to Metropolitan Planning Organizations.

f) Grant programs have elevated considerations of equity in a variety of ways, including establishing dedicated **set-asides for economically or otherwise disadvantaged communities**; requiring applicants to demonstrate how proposed projects will benefit those communities; providing technical assistance to those applicants as they are planning, drafting, submitting, and implementing proposals; holding input workshops during grant guideline development; and reducing or eliminating financial match requirements for those communities.

g) Public health has supported agencies in grant guideline development, as well as applicants in developing strong proposals, by **identifying and disseminating best practices** that highlight exemplary cross-sectoral collaboration, creative and effective community engagement approaches, effective local health department partnerships, and appropriate and measurable health, equity, and/or health equity indicators.

Example: Disadvantaged Community Liaisons. Through the Greenhouse Gas Reduction Fund grant programs, California government is piloting a technical assistance component to build the capacity of potential applicants to compete for these state resources by assisting them with plan development, data collection, and the actual writing of the application, to ensure that disadvantaged communities can access these programs. Disadvantaged Community Liaisons are now placed within three state organizations to pilot this approach. Focusing additional resources to ensure that disadvantaged communities can apply and compete in State grant programs is another method of promoting equity.

V. Snapshots: Integrating health and equity into grant programs

The following tables briefly describe the handful of state grant programs examined for this report, that have integrated health and equity considerations into guidelines development, award criteria, application review, and scoring processes.

Administering Organization: Strategic Growth Council

Sustainable Community Planning Grant and Incentives Program (SCPGI) 2010-2013: Approximately $66 million awarded
Grant Goal. Support the development and implementation of plans that reduce greenhouse gas emissions (GHGs) and achieve additional objectives including to promote public health, equity, and other characteristics of environmentally sustainable communities. **Health and Equity Lens Outcomes.** • Applicants were required to identify potential health and equity co-benefits and unintended consequences of their proposed plans. • Applicants had the option of articulating the expected benefits that economically disadvantaged communities would receive. • The guidelines designated 20% of all program funds for economically disadvantaged communities (median household income less than 80 percent of the statewide average). In 2013, the guidelines established a financial set-aside of 25% for environmental justice communities as defined by CalEnviroScreen 1.0. • Applicants could earn points for addressing objectives including "promote public health" and "promote equity." • Public health representatives and HiAP Task Force members representing other sectors provided input into the development of program guidelines and scored applications. • Upon request by the Strategic Growth Council, HiAP staff provided community engagement resources, input on a series of indicators to measure objectives and co-benefits, additional resources for on state public health priorities, and the HiAP Task Force's definition of a healthy community.
Urban Greening Grants (UGG) (inclusive of the Planning and Project grant programs) 2010-2013: Approximately $50 million awarded
Grant Goal. Assist entities to preserve, enhance, increase or establish community green areas such as urban forests, open spaces, wetlands, and community spaces (e.g., community gardens). These greening projects will incrementally create more viable, healthy, and sustainable communities throughout the state. **Health and Equity Lens Outcomes.** • Public health representatives and HiAP Task Force members representing other sectors provided input into program guideline development and scored applications.

- Public health input contributed to the inclusion of a healthy community definition, inclusion of the 2010 Health in All Policies Task Force Report to the Strategic Growth Council as a resource for applicants, and a grant objective in which applicants demonstrated how the greening plan will promote public health and the development of a healthy community.
- Applicants could earn up to 15 points out of 100 for demonstrating involvement of public health officials and progress on advancing healthy communities.
- Priority consideration was given to applicants vulnerable to climate change as well as to applicants identified as a disadvantaged or severely disadvantaged community as defined by a median household income threshold.

Affordable Housing Sustainable Communities Grants (AHSC)
2014-ongoing: $120 million awarded cycle 1, approximately $400 million allocated for cycle 2

Grant Goal. Fund land-use, housing, transportation, and land preservation projects to support infill and compact development that reduces GHGs. Projects will facilitate the reduction of GHGs by improving mobility options, increasing infill development, and reducing land conversion.

Health and Equity Lens Outcomes.

- Enabling legislation identified public health and equity as priorities for this program.
- Fifty percent of these funds must benefit disadvantaged communities, as identified using CalEnviroScreen 2.0.
- Representatives from the Department of Public Health and HiAP Task Force provided input during guideline development and scored applications.
- In cycle 1 of the AHSC, applicants could identify "improved public health" as a target co-benefit.
- In cycle 2, the co-benefits section has been changed to focus on identified community needs and benefits. Instead of predetermined "co-benefits," applicants are required to describe their community engagement process, including how they engaged vulnerable or hard-to-reach populations, and how the proposed project is meeting identified community needs beyond affordable housing and improved transportation infrastructures and programs.

Administering Organization: California Transportation Commission

Active Transportation Grant Program (ATP)
2013-ongoing: Approximately $215 million ongoing appropriation

Grant Goal. Combine federal and state funding programs into a single program to promote walking and bicycling by investing in infrastructure, non-infrastructure programs, and plans.

Health and Equity Lens Outcomes.

- Enabling legislation named both public health and equity as priorities for this program.
- A minimum of twenty-five percent of the ATP funds must benefit disadvantaged communities. In cycle 3 applicants had four options to identify disadvantaged communities: 1) those with a Median Household Income less than 80% of the statewide median, 2) among the most disadvantaged 25% in the state according to CalEnviroScreen 2.0, 3) at least 75% of public school students in the project area are eligible to receive free or reduced-price meals under the National School Lunch Program, or qualify under regional definitions of disadvantaged

communities as adopted in a Regional Transportation Plan, or 4) are within Federally Recognized Tribal Lands).

- The Department of Public Health has been involved in the ATP cycles 1-3 providing input into program guidelines development, scoring applications, and in 2015 served as a member of the ATP Technical Advisory Committee.
- Local health departments have been involved both as direct applicants for non-infrastructure Safe Routes to School programs as well as in providing input to the grant guidelines and serving as reviewers.
- In cycle 2 the ATP had specific questions about the current health status of the target population and how the proposed project or program is intended to enhance public health.
- Applicants must respond to questions and can earn points for describing how applicants engaged vulnerable populations and how the proposed project is meeting a community identified need.

VI. Staff reflections and discussion

The following discussion is based on HiAP staffs' reflections, observations, and experiences gathered in staffing the HiAP Task Force and serving as health equity practitioners.

Consider health and equity explicitly in grant programs. Some have argued that if a grant program promotes actions that are likely to support health and equity, such as reducing GHG emissions, promoting affordable housing, and increasing active transportation, it is not necessary to reference health explicitly because the program will automatically result in health and equity benefits. However, staff have found that it is important to consider both of these goals explicitly and together.

Considering health without equity may unintentionally exacerbate inequities by concentrating benefits or harms in certain communities. For example, applying a health lens to an active transportation project or program without also considering equity impacts may overlook the different baseline social and economic conditions that drive population health outcomes and mode choice.

Similarly, employing an equity lens without health considerations may result in specific health benefits being overlooked or undervalued. There may be tremendous health benefits to minor adjustments to a proposed plan, that may not be realized without an explicit health focus. For example, encouraging projects with a green infrastructure component (e.g. trees and landscaping) to plant as early as possible in project implementation so that the vegetation has more time to take root and mature before the project is complete can maximize vegetation's' ability to provide shade and filter pollution. In fact, it seems necessary to have both health and equity (or health equity) explicitly identified as goals and objectives in grant programs in order to ensure that those benefits are maximized and harms minimized.

The role of public health. By involving public health practitioners in the development and scoring of applications or providing consultation to the staff completing these functions, grant programs can better ensure that the grant guidelines development and scoring rubrics support health and equity goals and objectives. Further, local health department involvement in non-health grant applications can help build

understanding of the linkages between the project and health and equity, and result in projects that are more responsive to community needs and priorities. Some administering agencies require grant applicants to demonstrate their partnership with local health departments. While it has been difficult to point to clear health impacts that have resulted from these partnerships, staff have heard anecdotally that this is a promising practice for enhancing collaboration and alignment between sectors, ensuring that applicants have an understanding of local health and equity considerations, and identifying potential partners to support implementation.

Measuring and scoring health inequity data. It is nearly impossible to measure the individual, neighborhood, and population health impacts of small, one-time, built environment improvements or plans, or even to attribute any measurable health impacts directly to those improvements. This can make it difficult to evaluate grant proposals based on their projected health impacts. The temporal and spatial scale of health (and equity) data contributes to these challenges. Most chronic disease health data are not available at the project level. Chronic disease data are often only available at the county level, and in limited circumstances for smaller geographical areas such as zip code, city, or possibly school catchment area. Even if a grant program has a significant health impact, there is often a time lag between implementation of grant deliverable and health impacts, such that impacts are not likely to be measurable within the timeframe of most grants.

Community and stakeholder engagement requirements can implicitly promote health, equity, and health equity. Community engagement may not explicitly call out health or equity, but when plans and projects have inclusive, accessible, transparent processes that truly engage the community in identifying the problems and solutions, the resulting plans and projects are better designed to meet the needs of the community. For example, a bike or walking path that a community has identified as a priority will likely result in higher utilization, which then results in greater physical activity and lower obesity rates and the associated chronic diseases. Agencies administering grant programs can increase health and equity benefits by ensuring community engagement requirements are resourced and appropriate, developing methods for scoring community engagement, and outlining how and what community benefits or co-benefits are measured or included. Additionally, public health departments and other non-profit health organizations can be valuable partners in assisting with community engagement because public health practitioners often serve and have long-standing relationships with harder to reach, vulnerable communities.

Barriers to communities of need participating in state grant programs. Many economically and socially disadvantaged communities lack both financial and technical resources to compete with larger, more resourced communities. In addition, grant applicants have reported that the reimbursement-based state grant structure poses a barrier for low-income and smaller communities and organizations that lack the capital to pay for services up front. Technical assistance to these communities could include identifying possible other local government funding sources that could be leveraged by completing the grant application. Further, these same communities with the greatest economic and social disadvantage also often have the greatest health inequities and should be prioritized.

Unintended consequences. While "disadvantaged community" set-asides have been created to ensure that a minimum portion of grant funds reaches designated communities, it is not sufficient to accomplish equity. Many of the most disadvantaged communities within California have faced decades if not centuries of under investment and/or disinvestment, and grant set asides are not sufficient to level the playing field with some of the more advantaged communities. As California is experiencing a wave of gentrification and displacement of urban core populations, there is a growing concern that grants with targeted set asides for built environment improvements, may in fact be exacerbating displacement and furthering inequities. Anti-displacement policies for businesses and residents are a first line defense for this unintended consequence, and further research and consideration about how funds are distributed (e.g. competitive grants or need based programs) and what strategies are effective to ensure that long-term residents are not being disproportionately displaced are needed.

Defining equity. When directing resources to support progress towards equity, the definition of equity has a huge impact on investment outcomes and which communities benefit. There are many approaches to defining communities experiencing inequities, some in statue, some tied to funding streams. Some programs define their target populations as socially or economically disadvantaged, while others direct resources to benefit communities that are underserved, low-resource, marginalized, hard-to-reach, or vulnerable. It is important to acknowledge that these communities may have some overlap but are very likely not always be the same.

VII. Conclusion

There are numerous benefits of embedding health and equity considerations into grant programs that have primary goals outside the scope of public health. By infusing health and equity considerations into these programs the state can avoid and/or mitigate unintended negative health and equity impacts, highlight project co-benefits that have positive health and equity impacts, and foster cross-sectoral collaboration at state and local levels. Given that equity and health have been named as priorities by many governments, and that several major public health foundations and government agencies have identified Health in All Policies and similar approaches as an important strategy for promoting these goals, there is a need for research to develop an evidence base and identify best practices, and tools to aid government entities in ensuring that their programs best promote equity and health. This staff report is an early step in what we hope will be a broad area of inquiry within California state government and across the field of public health.