Public Health

Health Equity Plan

July 2023

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Record of Changes to the Plan

Date	Description of Revisions	Author	Approved by
04/04/19	Initial Release	HE Committee	Penny Borenstein
11/21/19	Added discussion of SLO Health Counts HE Dashboard, identified cycle for HE self-assessment, clarified committee makeup and added plan evaluation and reporting section.	HE Committee	Penny Borenstein
07/07/23	Added Foreword, added Diversity Statement, added Health Equity survey findings, updated priorities and strategies, updated evaluation and reporting section, contacts and appendices.	HE Program Staff	Penny Borenstein

Foreword

For many of its residents, San Luis Obispo County provides an ideal place to live, work, study and play—and an ideal place to lead a healthy lifestyle. But for others, it can be a difficult place to achieve or maintain health.

The COVID-19 pandemic exposed and exacerbated long-standing health inequities in SLO County, as it did across the nation. Different racial and ethnic groups faced disparate rates of COVID-19 infection and hospitalization. In many areas, these gaps persist in different levels of vaccination and access to treatment. Those who live in remote rural areas now contend not only with barriers to accessing health care, but also with lower community rates of vaccination. Residents who work in close proximity in agricultural fields or the region's large service industry continue to face more risk than those with the opportunity to work remotely.

SLO County's health disparities are not limited to the harms caused by COVID-19. Life expectancy today varies by as much as 14 years across different parts of the county; stark differences in life expectancy existed even before the pandemic.

These disparities are not the result of individual lifestyle choices or natural, inevitable forces. While it is easy to feel overwhelmed by the breadth of these disparities, it is important to remember that they result from a long history of many, sometimes small, actions and decisions. Today, we have the power to take thoughtful actions and make decisions that can begin ameliorating these disparities.

To effectively protect and promote the health of all residents, we must recognize and address the scale of these disparities and the factors that will continue to perpetuate them unless we intervene. This means taking into account the role of safe housing, education, economic opportunity, language and literacy, transportation, food security, access to health care and more.

To meaningfully address health disparities and work toward true health equity in SLO County, we have embarked on a process to honestly assess how we are doing as a department and to discover opportunities to grow and change so that our services are readily available to all members of our community. We have identified priority areas to guide our work, including those that focus on internal development and others that focus on community engagement. In collaboration with a consultant and with the support of state and national funding, we have developed this plan to guide our department's efforts based on these priorities.

This effort to achieve health equity will not be short or simple, but it is crucial. I encourage you to join us on this journey; together we have the opportunity to create a community where all residents can enjoy a healthy life and look ahead to a healthy future.

In health,

Dr. Penny Borenstein
San Luis Obispo County Public Health Director/Health Officer

Purpose

The purpose of this Health Equity Plan is to achieve health equity, eliminate health disparities, and to improve the health of all county residents by ensuring that services at the County of San Luis Obispo Public Health Department are delivered in culturally and linguistically equitable ways.

Health Equity is recognized as a guiding foundational principle underlying all policies and operations. The Plan complies with the Public Health Accreditation Board (PHAB) Measure 10.2.1.3, as well as federal, state, and local laws promoting equitable access to services (see appendix A).

Introduction

In San Luis Obispo County, the COVID-19 pandemic further highlighted stark differences which exist in residents' access to health care based upon their ethnic or racial identity, socioeconomic status, language, and zip code. It also became more apparent that increasing access to health care is only a small piece of the entire picture for designing strategies to improve the health of all community members. Public Health seeks to address current inequities, such as uneven access to healthy food and affordable housing in our county, as well as the factors which created them.

This Health Equity plan was developed as a road map to guide Public Health in its commitment to implement strategies for addressing health inequities based upon the priorities identified by staff from the health equity survey administered in 2022.

Defining and Achieving Health Equity

Health equity occurs when everyone has a fair and just opportunity to be as healthy as possible. This may mean using different strategies with different populations, and requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and a lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[1]

Public Health strives to support all San Luis Obispo County residents in having a fair, just opportunity for reaching their full health potential. In delivering services, the department recognizes that some community members confront financial, technological, and logistical hurdles such as a lack of transportation and conflicting work schedules when trying to access health care.

Public Health is embedding equity practices in strategic planning, health improvement measures and performance measures. Services must be provided with an eye toward cultural and linguistic diversity. From procurement practices and job applicant interview questions to program and

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[1]. Public Health Accreditation Board. *PHAB Glossary of Terms Inclusion, Diversity, Equity and Antiracism*. 2022. https://phaboard.org/wp-content/uploads/PHAB-IDEA-Glossary.pdf

procedure equity checklists, equity is recognized as a foundational element to service provision (Appendix D offers a tool to advance equity in Public Health Initiative Development).

The achievement of health equity is also being furthered when Public Health programs engage with partners from community groups who have been historically underrepresented for purposes of obtaining input on current practices as well as designing new initiatives. Public Health recognizes that another effective equity strategy is providing financial support to community organizations to build their capacity to remove obstacles to health, including poverty and discrimination and their consequences.

During the COVID-19 pandemic, with funding from state and federal grants, the Public Health Department established a Health Equity Program to guide an equity assessment and planning process to eliminate disparities in health and healthcare. The department also has a Health Equity Committee with one staff representative from each division within Public Health. The Health Equity Committee meets quarterly to review policy, advise on equity practices, and address staff development needs. Together, this team of people guide the department's efforts to ensure services are readily available to all members of the community.

Diversity Statement

The San Luis Obispo County Public Health Department commits towards making the County a place where all residents have the opportunity to live a healthy life. We will strive to achieve equity in the delivery and availability of our services to individuals and communities from all races, ethnicities, ages, religions, genders, sexual orientations, socioeconomic statuses, documentation statuses, abilities, and other social identities. We will increase representation and engagement of historically marginalized voices in our decision-making and information sharing and value our collaboration with community partners. We will work to communicate clearly in ways that respect the many languages, literacy levels and learning styles of our community. Finally, we commit to removing policy and institutional barriers towards an equitable health experience in our county.

Methodology

In 2022, under the guidance of equity consultant, Dr. Jennifer Teramoto Pedrotti, Public Health engaged in a multi-step process to assess where the department needed to grow and which changes should be implemented for services to be available to all community members inclusive of different races, ethnicities, sexual orientations, gender identities, primary languages, country of origins, socioeconomic statuses, ages, abilities, and other statuses.

Public Health staff conducted a literature review of four equity survey tools. In consultation with Dr. Teramoto Pedrotti, a survey was designed to assess staff capacity for addressing health inequities. The survey was designed to measure:

1. **Equity in Organizational Culture, Policies & Practices:** How is Public Health's commitment to equity perceived internally and externally? Is it reinforced in organizational policies, culture, and communication?

2. **Staff Training & Development:** What kind of support, training, or tools do staff need to equitably and professionally meet the needs of all community members?

3. **Diversity in the Workforce:** Does the Public Health workforce reflect the community we are trying to serve? Are BIPOC staff represented at all levels of the organization and are they included in decision making and program planning?

4. **Community Engagement & Collaboration:** Does Public Health staff know of and collaborate with external partners and community groups to meet clients' needs and to address health inequities in the community?

In August 2022, staff took the survey, and an extremely high response rate was achieved (92% of Public Health staff participated). The results were analyzed by Dr. Teramoto Pedrotti, who shared the data and her findings with the Health Equity Committee and Public Health leadership to obtain their feedback. Dr. Teramoto Pedrotti then developed recommendations which are incorporated into this plan and included as appendix E.

Health Equity Priorities and Strategies

Focus Area 1: **Equity in Organizational Culture, Policies & Practice**

How is Public Health's commitment to equity as an organization perceived internally and externally? Is it reinforced in organizational policies, culture, and communication?

Survey data showed that the employees surveyed had mixed opinions on this question. When asked "In your opinion, how much does Public Health focus on addressing health inequities?", the most common answer choice chosen was "the right amount," Yet those who answered this way were still less than half the employees sampled. A fair amount of employees felt like more could be done, and an almost equal group noted that they didn't know the answer to this question.

Employees were asked if there was a positive cultural climate for those from historically (and potentially currently) underrepresented groups. Overall, in this area most employees signaled that there was a positive climate. However, there were some differences found between those with minoritized backgrounds and those from majority backgrounds in this area. Though the most common answer in both groups was "agree" in answer to the question about whether a positive cultural climate for underrepresented people exists at Public Health, there was also a higher percentage of "strongly disagree" and "disagree" answers for those who identified themselves as BIPOC*, in comparison to those who did not. This is an area to look more closely at for the future; though results do seem to show that most minoritized employees feel welcome, some do not.

Key findings:

- 44% of employees feel Public Health shows the right amount of focus on health inequities.
- 20% of employees answered "I don't know" to whether Public Health focuses on health inequities.
- 76% of White respondents think Public Health has a positive cultural climate, compared to 64% of BIPOC* respondents.

*BIPOC – Black Indigenous People of Color; often used to encapsulate non-White groups as a whole

OBJECTIVE	MINIMUM STANDARD	PERFORMANCE MEASURES
1. Public Health leadership communicates commitment to equity and fosters a sense of belonging among staff.	• Develop departmental diversity statement and Health Equity Plan.	• By June 2023, Diversity Statement and Health Equity Plan are introduced at new employee orientation, publicly available, and referenced by staff.
2. Public Health utilizes multiple tools to assess morale, inclusion, supportive environment and cultural responsiveness.	• Ensure equitable, inclusive, and supportive workplace for all employees through policy change and training opportunities.	• Responses to staff survey in August 2024 show an increase in staff perception of inclusive/welcoming culture by 25%.
3. Public Health is committed to building the infrastructure to support equity practices, policies and programs at the departmental level.	• Health Equity Staff, in consultation with Health Equity Committee, examines policies and leads transformative change efforts.	• By December 2023, Health Equity Committee consisting of staff from front line, managers, supervisors and senior leadership will meet quarterly to review policy.

Focus Area 2: **Staff Training & Development**

What kind of support, training, or tools do staff need to equitably and professionally meet the needs of all community members?

Many employees noted that they have done some personal work toward educating themselves about health inequities. But less than half of staff reported that they had received some amount of training in equity as a part of their job at Public Health. Most respondents reported that they understood what health inequities exist and feel that social justice and racial equity are important considerations in their work; however, there is no way to know if the self-efficacy reflected on these topics is equal to actual knowledge in these areas. There is much less certainty noted in their answers in terms of their knowledge being parlayed into skill in imparting this information to others.

Training topics of highest interest to staff relate to the Social Determinants of Health. For staff who had been employed for three or less years, a large percentage of employees (39.5% or approximately 32 employees) noted that they “Strongly Agree” to the question “I understand how health inequities impact the community we serve.” This contrasted with only 21.9% (approximately 7 employees) of those who had worked at Public Health more than 7 years.

Key findings:

- 4 out of 5 staff say they have taken steps to enhance their own cultural humility, but only 41% reported receiving training on equity concepts at work.
- Staff understand that health inequities exist, state that social justice and racial equity are important, and report being committed to their own personal education.
- Staff understanding of how health inequities impact the community varied by length of service:
    - 72% of employees with 7+ years of PH service reported they understand how health inequities impact the community.
    - 96% of employees with 4-6 years of PH service reported they understand how health inequities impact the community.
    - 90% of newer employees with less than 4 years of PH service reported they understand how health inequities impact the community.

OBJECTIVE	MINIMUM STANDARD	PERFORMANCE MEASURES
1. Public Health dedicates resources toward developing a culturally responsive workforce that applies health equity principles.	• All current staff will participate in equity trainings offered in a variety of modalities as part of the normal expectations at work. • All new employees will complete a core health equity training within their first three months.	• By June 2024, all staff have documented training focused on increasing awareness of and shifting practice towards addressing health disparities.

Focus Area 3: **Diversify the Workforce**

Does the Public Health workforce reflect the community whom we are trying to serve? Are BIPOC staff represented at all levels of the organization and are they included in decision making and program planning?

Staff were asked if they felt the workforce at Public Health reflected the community the organization aims to serve. Employees sampled felt that staff demographics were fairly diverse in terms of race and ethnicity, and demographics of the survey appear to support this answer. For those surveyed, approximately 53% identified as White and 32% identified as Black, Indigenous, and People of Color (BIPOC) or multiracial including some BIPOC heritage. Another 15% declined to report their race. Regarding all other identities, the majority of employees sampled gave answers that appeared to signal that they did not know how diverse the workforce was with regard to sexual orientation, social class, religion, disability/ability, nation of origin, or gender. This aspect of the assessment did not differ significantly in populations who identified as BIPOC versus those who identified as White.

Employees were asked whether diversity was considered in hiring practices. While the most common answer for White employees in this group was "Agree", BIPOC employees most commonly answered "Disagree." Additionally, BIPOC individuals more commonly answered "Disagree" to items regarding interview questions related to DEI being a part of the hiring process, while White individuals did not have a common answer. Neither group felt that active recruitment of historically underrepresented folks was occurring in hiring management or leadership staff. This is an area of growth for Public Health.

Only 16 BIPOC employees answered "yes" to the question about whether they were involved in hiring decisions. This represented 34% of the total of BIPOC individuals sampled. In comparison, 34 White employees noted that they were involved in hiring decisions, which is 44% of the White sample. This data points to the fact that BIPOC individuals are not involved in this type of decision making as often as their White counterparts. It may also reflect a relative lack of BIPOC staff in management positions.

Key findings:

- 64% of hiring managers aren't sure or do not think interview panels are designed to recruit a more diverse workforce.
- "Do we use interview questions that assess applicants' capability to address health inequities?"
    - 50% of hiring managers who identify as BIPOC said "no"
    - 29% of hiring managers who identify as White said "no."

OBJECTIVE	MINIMUM STANDARD	PERFORMANCE MEASURES
1. Align Human Resources practices to support equity goals.	• Hiring managers are provided with a set of questions that can be utilized during the hiring process that reflect an assessment of competency working with a diverse group of employees and communities. • Interview panels are intentionally representative of the diversity of the workforce and community.	• By June 2024, all management level hiring processes include questions related to cultural responsiveness, cultural humility and awareness; and ascertain an understanding of the root causes of health inequities. • By June 2024, Human Resources will provide annual training and standards for hiring managers and panel interviewers on equitable hiring practices.
2. Increase cultural competence and demographic diversity at all levels of employment.	• Assess job minimum qualifications, including broadening skills and experiences, updating position descriptions with plain language, adding bilingual ability as a "preferred skill" when appropriate.	• HR Annual report shows increase in demographic diversity in the Public Health workforce. • Staff survey measures workplace climate and increase in knowledge and skills related to diversity, equity, and inclusion.
3. Develop workforce pipelines from racially minoritized and/or economically disadvantaged communities.	• Expand relationships with high schools, colleges, CBOs, professional associations, and other stakeholders to enhance diversity in applications. • Build capacity for the Community Health Worker/Promotores model.	• HR Annual report shows increased diversity in applicant pool and in candidates meeting minimum qualifications. • By December 2024, the Healthcare Workforce Consortium and the Promotores Collaborative have a formalized implementation plan in place for training and employment of CHW/Ps.

Focus Area 4: **Community Engagement & Collaboration**

Does Public Health staff know of and collaborate with external partners and community groups to meet clients' needs and address health inequities in the community?

For Public Health services to be accessible to all communities in the County, materials and services need to be offered in clients' primary language. However, just under half of staff responded that not all print materials and signage were provided in Spanish in their division. Though many employees knew of the Language Line, Mixteco Call Center, ASL and other services for translation and interpretation, the most common way employees got help with language was via a staff person, almost double the next most common response for those who used interpretation services in their role. It is important for the department to identify a process for clarifying which staff are qualified to work as translators and interpreters and are compensated for this work.

Public Health staff were asked about the department's commitment to collaborating with partners and community groups to meet clients' needs and address health inequities in the community. Results showed that while approximately half of those sampled noted that they agreed that Public Health had a commitment to this, a much smaller percentage agreed that Public Health "seeks input from people experiencing health inequities in program planning or decision-making" (31%). Lastly, over half those sampled didn't think it was necessarily part of the job of Public Health to bring diverse community voices into the decision-making process.

Key findings:

- Although most staff know about interpretation and translation services:
  - Only 56% of staff offer all print materials in Spanish.
  - Only 44% of staff use paid interpretation services.
  - Nearly 20% of staff use clients' relatives or friends as interpreters.
- Only 33% of respondents collect client feedback about cultural and linguistically appropriate service delivery.
- Most staff are unsure whether it is part of their role to include diverse community voices into decision-making processes.

OBJECTIVE	MINIMUM STANDARD	PERFORMANCE MEASURES
1. Public Health staff prioritize making public messaging accessible for all communities (including those for whom English is not their first language).	• Increase utilization of language access tools to support service provision for diverse populations. • Proactively provide culturally and linguistically appropriate outreach in priority areas to promote cross-sector partnerships, social connection and trust building. • Ensure all public facing materials are available in Spanish and English.	• By December 2023, increase utilization of Language Line and Mixteco Call Center, ASL & simultaneous interpretation by 50% compared to 2022, and a 20% increase each year thereafter. • Multilingual Outreach Coordinator participates in a minimum of 20 outreach events annually. • By June 2023, institutionalize a Translation Team and process to ensure professional level translation, peer-reviewed by certified bilingual staff.
2. Public Health staff engage community voices to inform the design of program, policy and system change.	• Collect community input on health equity priorities and strategies through surveys, listening sessions and focus groups and share results. • Increase community participation from diverse groups in decision making processes.	• By December 2023, conduct the Community Health Assessment and report results back to communities. • By December 2024, establish a process to provide stipends to community members with lived experience to advise on CHIP, equitable Public Health funding, practices, policies and service delivery.
3. Cultivate and expand community partnerships to promote community-led solutions which reduce health inequities.	• PH staff participate in community groups working with disproportionately impacted communities to identify needs, overcome barriers and build trust.	• By December 2023, support CBOs and partners with a framework, data, funding and technical assistance to address priorities identified in the Community Health Improvement Plan and achieve measurable, collaborative, data-driven change.

Plan Evaluation and Reporting

The Health Equity Program Manager will coordinate a review of the Health Equity Plan with input from the Health Equity Committee and will update it twice during a 5-year cycle (every 2.5 years). Health Equity strategies will be reviewed at that time as well, though minor updates may be made at other times as needed.

The Health Equity Workplan will be developed on a 2-year cycle by the Health Equity Program Manager, with measurable goals and objectives. It will be updated annually and revised every other year. The workplan, with performance measures will be posted to the Health Equity page of MySLO. The Health Equity Program Manager will provide briefings on the progress of activities outlined in this plan at annual meetings for all Public Health Department Supervisors and Managers.

This Health Equity Plan and the Work Plan will both be available to all Public Health employees.

Other Resources

A. Health Equity Hub: MySLO/HealthEquity
B. Resources for staff: MySLO/Resources
C. Trainings for staff: MySLO/Trainings
D. Interpretation and Translation Instructions: MySLO/HAInterpretation
E. Public Health Staff Survey on Health Equity: MySLO/EquitySurvey
F. Health Equity Workplan 2023-2024: MySLO/Workplan
G. Health Equity Training Plan 2023-2024: MySLO/Trainingplan

Acknowledgements

The Health Equity team would like to thank Dr. Jennifer Teramoto Pedrotti of JTP Consulting for her expertise and guidance through the staff assessment, analysis and planning process. Thank you to the Public Information team who piloted the survey and formatted the executive summary. Thank you to the staff who took the survey, and the Division Managers, Supervisors, Program Managers and the Health Equity Committee who provided feedback on survey results and priorities. And special thanks to the Health Equity Program for its commitment and to Dr. Penny Borenstein, Health Officer and Public Health Director, for her leadership on equity issues.

Contact

The Health Equity Program is the primary contact for cultural competency and health equity initiatives at the Department. For questions about these initiatives or this plan, please contact PH.HealthEquity@co.slo.ca.us.

Appendix A: **Federal, State and Local Laws Promoting Equitable Access to Public Health Services**

The Health Equity Plan will help the Department ensure compliance with the Public Health Accreditation Board (PHAB) Measure 11.1.4, as well as federal, state and local laws promoting equitable access to services, including:

- **Title VI of the 1964 Civil Rights Act,** which stipulates that no person in the United States shall on the ground of race, color, or national origin be excluded from participation in, denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

- **Americans with Disabilities Act of 1990 and 45 CFR Part 84**, which prohibits discrimination on the basis of disability in programs and activities receiving or benefitting from Federal financial assistance.

- **California Family Health Council (CFHC) Title X Family Planning Grant Requirements**, which outlines the Title VI prohibition against national origin discrimination affecting Limited English Proficient persons.

- **Culturally and Linguistically Appropriate Services (CLAS) Initiative**, which supports language provisions via the federal Culturally and Linguistically Appropriate Services (CLAS) Standards, created in 2001 by the federal Office of Minority Health (OMH).

Appendix B. **Glossary of Equity Terms**

Belonging – A sense of acceptance, inclusion, and identity that allows one to authentically express themselves in a particular environment.

Bias – Attitudes, judgements or stereotypes that affect our understanding, actions and decisions. Implicit or unconscious bias is often subtle, accidental, and/or unintended. Explicit, or conscious, bias is overt and intentional.

BIPOC – An acronym that stands for Black, Indigenous, and People of Color.

Cultural Humility – An attitude through which an individual learns about other cultures with a clear willingness to learn from others and an awareness that this is an ongoing process. Often this occurs in conjunction with becoming more aware of one's own beliefs and identities, intended to result in greater mutual understanding, equity, honesty, and trustworthy relationships.

Diversity – A range or variety of characteristics. Diversity encompasses the range of similarities and differences each person brings to society, including but not limited to national origin, language, race, ability, ethnicity, gender, age, religion, sexual orientation, gender identity, socioeconomic status, veteran status, and family structures.

Equity – The policy or practice of accounting for the differences in individuals' starting points when pursuing a goal or achievement, and providing support based on unique needs of individuals and groups to obtain fair and just results.

Health Equity – Everyone has a fair and just opportunity to access what they need to be as healthy as possible and thrive. This requires working to remove obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to well-paying jobs, quality education, housing, safe environments, and health care.

Health Inequity – Differences in population health status and mortality rates that are systemic, patterned, unfair, and actionable, as opposed to random or caused by those who become ill.

Inclusion – The act of welcoming, respecting, supporting, and valuing all people, all voices, and truly engaging them, listening to, and valuing their experiences and perspectives, to inform and drive decisions on collective priorities. Inclusion requires sustainable and meaningful engagement with people and organizations that represent diversity in experience, thought, and culture. Equitable inclusion may involve larger efforts at drawing in groups that have been historically kept out of some spaces or decision-making.

Justice – Actions toward challenging and diminishing barriers to equal access, and work towards creating opportunities for an equitable society so that all individuals and communities can live meaningful lives.

Social Determinants of Health – The conditions in which people are born, grow, live, work and age that impact a person's health outcomes. These circumstances are shaped by the distribution of money, power, and resources at global, national, local levels.

**Definitions adapted from the following sources: Public Health Accreditation Board, Public Health Alliance, California Department of Public Health-Office of Health Equity, Centers for Disease Control and Prevention.*

Appendix C. **Health Disparities by Population Group**

BLACK, INDIGENOUS, AND PEOPLE OF COLOR (BIPOC)	Out of 58 counties in California, San Luis Obispo County is ranked as the 54th most racially disparate county.[1] According to the American Community Survey 2017-2021, 67.5% of residents of San Luis Obispo County identified themselves as non-Hispanic or Latino White, 23.8% as Hispanic or Latino/a/x of any race, 4.1% as Asian or Asian American, 2.2% as Black or African American, 1.4% as American Indian or Alaska Native, 0.2% as Native Hawaiian or other Pacific Islander, and 3.7% as two or more races.[2] On a variety of health indicators, significant disparities among these racial and ethnic minorities continue to exist. For example, in California, Black (37.4%) and Hispanic (37.1%) adults had a higher prevalence of obesity than non-Hispanic White adults (24.8%) in 2021.[3] The prevalence of diabetes for adults in California were lower than the national figures, but still revealed disparities: 12.7% among Hispanic adults,15.5% among non-Hispanic Black adults, 10.5% among non-Hispanic Asian adults, and 8.6% among non-Hispanic White adults.[4] Differences between infant mortality rates per 1,000 live births were also notable among race and ethnicity groups in California: 9.2 among Black infants, 6.5 among Pacific Islander infants, 5.3 among multi-race infants, 4.0 among Hispanic infants, and 3.0 among White infants. [5]
PEOPLE WHO SPEAK LANGUAGES OTHER THAN ENGLISH, INCLUDING MIXTECO	17% of San Luis Obispo County residents speak a language other than English in their household.[6] Spanish is the primary language in 12.5% of households; [7] Tagalog, Farsi, Dari, Mandarin, and other languages comprise the remaining 4.5%.[8] Many Mesoamerican indigenous immigrants living and working in San Luis Obispo County speak Mixteco. Mixteco, Zapoteco, Trique and other indigenous Mexicans face systemic barriers to accessing healthcare.[9] Mixteco is a non-written language with 81 variants. [10] Those who speak Mixteco may have limited or no understanding of Spanish. [11] Mixtecs are the third largest group of indigenous people in Mexico.[12] Currently, no data is available on the number of Mixteco speakers who reside in San Luis Obispo County.
PEOPLE LIVING IN RURAL COMMUNITIES	Some San Luis Obispo County residents who live in isolated communities which lack proximity to health care providers and stores which sell healthy food also face the challenge of limited public transportation to access these services. Rural residents are more likely to be elderly, in poverty, in fair or poor health, and to have chronic health conditions. For example, the prevalence of obesity is higher in rural adults (40%) than urban adults (33%).[13] Adults living in non-metropolitan counties also have a higher average annual percentage of smoking (27%) than adults living in large metropolitan counties (18%).[14]
PEOPLE WITH DISABILITIES	Approximately 12.4% of persons in San Luis Obispo have a disability;[15] 10.6% of Californians have a disability in comparison.[16] Approximately 28% of adults with disabilities smoke, compared to 16% of those without a disability.[17] Adults with disabilities are more likely to be physically inactive (22%) than adults without disabilities (10%).[18] Obesity is also higher among adults with a disability (38%) compared to those without a disability (24%), according to self-reported data.[19]

PEOPLE WITH LOW-INCOME AND THOSE EXPERIENCING POVERTY	In 2021, 13% of San Luis Obispo residents lived below the federal poverty level.[20] About 56% of local renters spent 30% or more of their household income on rent.[21] Poverty is correlated with perceived and actual poor health outcomes. People living in poverty are five times more likely to report their health as “poor” compared to high-income individuals.[22] People with a household income below the poverty line (29%) have a much higher prevalence of smoking compared to people with household incomes at or above the poverty line (18%).[23] Healthy eating (specifically fruit and vegetable consumption) is also lower among low-income populations compared to higher income populations. [24]
PEOPLE WITH LESS THAN A HIGH SCHOOL EDUCATION	Approximately 8% of San Luis Obispo County residents who are 25 years old and older have not earned a high school diploma.[25] Those with undergraduate degrees have a lower prevalence of smoking (9%), compared to those with less than a high school education (25%) or only a high school diploma (24%).[26] Additionally, those with a GED have the highest prevalence of smoking (45%).[27] Regarding obesity, college graduates or above had the lower rates of obesity (28%) in 2009-2010, compared to those with less than a high school education (38%).[28]
OLDER ADULTS	Adults aged 55 years or older comprise 33.7% of San Luis Obispo County’s population and those 65 years or older are 20% of the population.[29] By 2030 the proportion of our county’s population aged 60 or older will be 29% which is a 61% increase from 2010.[30] Regarding inequities, older adults living in poverty and isolation may be particularly vulnerable. Between 2010 and 2020, among adults aged 65 to 74, drug overdose deaths increased 147% which was the largest increase compared with all other age groups.[31]
PEOPLE WHO IDENTIFY AS LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, OR ANOTHER NON-HETEROSEXUAL IDENTITY (LGBTQ+)	Lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) youth are at elevated risk for bullying and violence victimization, mental health problems, drug and alcohol use, and exhibiting poor performance in school. For example, analysis of the latest Biennial California Healthy Kids Survey (CHKS) data indicate that LGBTQ youth in SLO County are about 30% more likely than non-LGBTQ youth to experience harassment and bullying at school; 30% to 40% more likely to exhibit chronic sadness; 2 to 3 times more likely to smoke cigarettes, binge drink, and to have been drunk or high at school; and receive substantially fewer social supports from teachers and peers at school than their counterparts who do not identify as LGBTQ.[32]

***Note**: Though lower socioeconomic groups do often have higher numbers of BIPOC or other minorities groups, Public Health understands the importance of not confounding race and income level.*

This list is not exhaustive and the groups are not mutually exclusive. Individuals may belong to more than one group. More information can be found on https://www.slohealthcounts.org/

Health Disparities by Population Group References

[1.] “California Racial Disparity Rankings.” Race Counts. Catalyst California. Accessed March 24, 2023. https://www.racecounts.org/rankings/table/

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Appendix D. **Planned Approach to Public Health Initiative Development**

Initiative Name:
Initiative Goal:
Team Lead:

Objectives: What are we trying to achieve?

Consider: What do you want your target audiences to think, feel, or do after engaging with this initiative?

Alignment: Does the initiative support other department/community initiatives or needs?

Consider: Does the initiative support the department's mission, vision and values? Does it address one of the areas of need identified in the CHIP or Strategic Plan? Does local data support this as a need?

Target Audience: Who are we talking to? (and who haven't we talked to yet?)

Consider: Which individuals or groups are you trying to reach? Do any population groups experience health inequities?

Key Message Content: What are we going to say?

Consider: What themes and keywords will resonate best? What's our elevator speech? When someone asks what we are doing, have a message that uses no more than 27 words, 3 major points and you can deliver it in 9 seconds. Use CDC's preferred terms and the Do No Harm Guide to avoid stigmatizing language and visuals.

Site Selection: Does the strategy rely on site selection?

Consider: Do selection criteria for sites reflect populations/areas with the highest burden? If not, are selection criteria logical and justified?

Evidence Base: Is this initiative rooted in sound theory?

Consider: What evidence shows that this approach is the right one? Several websites are available for insight, including The Community Guide, Health Impact in 5 Years, County Health Rankings' Promising Practices, SLO Health Counts' Promising Practices Database, and more.

Equity: What issues need to be addressed in assuring equity in development of plan and/or implementation of services?

Consider: What populations are involved in the initiative? Does the team have knowledge of the needs of this community? Have minoritized communities been outreached to the same extent as majority groups?

Obstacles: What beliefs, literacy levels, social and environmental factors, etc., stand between your audience and the desired behavior?

Consider: Does their built or social environment limit their ability to be healthy? What cultural considerations are at play? What health literacy considerations are at play? Consider that individuals may belong to several groups that have historically experienced discrimination, and therefore, may have layered health and social inequities.

Communication Channels: What channels will you employ for the communication?

Consider: TV, Radio, Print ads, social media, newsletter, event, web page, etc. Consider culturally and linguistically appropriate practices that will build trust within communities and advance health equity. Tailor response to unique circumstances of different populations. Keep in mind Indigenous populations which rely on Mixteco languages which are traditionally spoken, not written.

Community Engagement: How will community input be sought in determining shared goals, design, implementation, and accountability of the program?

Consider: Will the population of focus be invited to the decision-making process during the development, implementation, and evaluation phases of this project? Do community members with lived experience have a voice in the creation of programs, initiatives or policies designed to serve them? How can all voices be represented at the decision-making table? Are translation or interpretation services needed?

Evaluation: How will you evaluate success?

Consider: How much did members of various communities participate? Have people's behaviors changed? How was the data shared with the community? Check out the Community Toolbox Evaluation chapter for ideas and think about what data you will need to collect to showcase success or tailor the next intervention. When communicating about the program's impacts, use CDC's preferred terms and the Do No Harm Guide to avoid stigmatizing language and visuals.

Partners: Which community partners will collaborate on this project?

Consider: Community engagement efforts can help strengthen cross-sector partnerships, ensure culturally and linguistically equitable practices, build trust within communities, promote social connection, and advance health equity. What nonprofits, faith-based groups, or coalitions also work with the population of focus? How can we work together to align messaging, identify trusted messengers, effective strategies, and build upon community strengths to move toward collective solutions?