Building California's Equity Infrastructure:

Insights from the California Equitable Recovery Initiative (CERI)

Office of Health Equity, Advancing Community Equity Branch

CDPH
California Department of Public Health

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Message From the Deputy Director

Dear Colleagues,

The California Equitable Recovery Initiative (CERI) represents more than a funding stream; it reflects a shared commitment to equity during one of the most challenging chapters in public health history. Our work was never about a single project or timeline. It was about building trust, strengthening systems, and centering community voices in decisions that shape health outcomes.

Together with Local Health Jurisdictions, community-based organizations, and partners across the California Department of Public Health, we worked principles into practice. We invested in lasting infrastructure, strengthened data systems to illuminate inequities, and elevated community leadership to work to implement solutions that were culturally responsive and locally grounded. We learned the power of deep listening, transparency, and pairing data with lived experience. These lessons have reshaped how we understand our roles, how we show up for communities, and how we measure progress. What remains from these efforts is more than improved systems—it is a sustained commitment to equity that continues to guide our work.

I appreciate our partners' achievements and recognize there is more to do. Equity requires ongoing changes in thought, behavior, and daily actions. We must apply this commitment by allocating resources, designing programs, sharing stories, building a strong workforce, and valuing the lived expertise of California's diverse communities. The Office of Health Equity remains committed to walking alongside our partners, supporting local health jurisdictions, and reinforcing and modeling collaborations across the state so that the practices we strengthened in crisis become the standard in everyday public health.

To the local leaders, community-based organizations, Tribes, data teams, outreach workers, and all LHJ program staff who made this work possible, **thank you**. Your dedication has shaped a more resilient, responsive, and just public health ecosystem. The promise of CERI is not only improved outcomes today, but also the shared commitment to ensure that **health is a right, not a privilege** that every community in California can thrive.

With gratitude and resolve,

Stephanie Weldon, MSW (Citizen of the Yurok Tribe)
Deputy Director, Office of Health Equity (OHE)
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Acknowledgments

Group photo of CDPH and California LHJ Equity Staff at the 2023 Statewide Equity Convening.

The Equity Technical Assistance Team extends our deepest gratitude to the Local Health Jurisdictions (LHJs) across California whose dedication and innovation have been the cornerstone of the California Equitable Recovery Initiative (CERI). Your commitment to advancing health equity during an unprecedented time has not only strengthened local equity infrastructure but also inspired statewide progress.

We acknowledge the invaluable contributions of our community-based partners, equity leads, and champions across the state who worked tirelessly to ensure that equity remained central to recovery efforts. In particular, we acknowledge the ongoing partnerships, dialogue, and collaboration between our grant recipients and the following Tribal nations and representatives: The Yurok Tribe, the Tolowa Dee-Ni' Nation, the Toiyabe Indian Tribe, the Bridgeport Indian Colony, the Karuk Tribe, the Chumash Tribe, the Indigenous Oaxacan Community, the Southern Sierra Miwuk Tribe, and the Native Wellness Coalition.

The Bay Area Regional Health Inequities Initiative (BARHII), the California Center for Rural Policy (CCRP), the Central California Public Health Consortium (CCPHC), California for Health (CA4Health), and the Public Health Alliance of Southern California served as true partners in this work. Their regional leadership, shared vision, and deep collaboration were essential in guiding CERI's implementation and strengthening equity-driven efforts.

Special thanks to the Office of Policy and Planning (OPP) and the Division of Communicable Disease Control (DCDC) within the California Department of Public Health (CDPH) for their guidance and support throughout this initiative. Finally, we recognize the resilience and collaboration that made this project possible—your voices and experiences illuminate the path toward a healthier, more equitable California.

Executive Summary

The California Equitable Recovery Initiative (CERI) was created to help Local Health Jurisdictions (LHJs) strengthen their health equity efforts as California recovered from the COVID-19 pandemic. CERI offered funding, tools, and technical assistance to help LHJs build systems that address long-standing inequities and improve health outcomes for communities most affected by the pandemic.

This Executive Summary gives a brief overview of CERI's goals, what the initiative supported, the challenges it faced, and its impact across the state.

Purpose

CERI aimed to expand local capacity to embed equity into public health operations by helping LHJs hire dedicated equity staff, conduct organizational equity assessments, develop Health Equity Plans, and implement targeted community engagement and workforce development strategies.

Building Equity Infrastructure Across Local Health Jurisdictions

To strengthen equity practices within LHJs, CERI supported efforts such as:

- Hiring or establishing Equity Leads and expanding other equity-focused staffing
- Creating community engagement structures, including advisory boards, co-design processes, and multi-sector partnerships
- Conducting organizational assessments to identify gaps and guide planning
- Strengthening equity-focused policies, language access, and inclusive communication
- Developing community-informed Health Equity Plans aligned with statewide frameworks

Priority Populations and Community Voice

Aligned with statewide equity goals, LHJs focused on communities hit hardest by the pandemic and long-standing inequities. They centered engagement on the lived experiences of residents, Tribes, community health workers, and community-based organizations to ensure strategies reflected local needs and supported culturally responsive solutions.

Statewide Challenges in Implementation

LHJs faced several barriers that affected their ability to advance equity:

- Staffing shortages, vacancies, and high turnover
- Fragmented data systems and limited capacity for data analysis
- Limited programmatic capacity and competing community demands
- Geographic isolation and resource constraints, especially in rural jurisdictions
- Disruptions from the temporary federal termination of CERI funding in 2025, which paused activities and required rapid re-planning once funds were reinstated

Statewide Equity Lessons and Opportunities

CERI elevated the importance of sustained leadership support, cross-sector collaboration, and shared decision making with communities. LHJs learned that advancing equity requires long term investment, structured engagement practices, and accountability mechanisms that integrate equity into daily operations.

Connection to Statewide Health Equity Planning

CERI supported activities that directly informed statewide health equity planning, including elevating key issues and opportunities, successes and lessons learned, and promising practices that could be replicated and scaled across California for greater impact.

Looking Forward

CERI strengthened essential equity infrastructure across LHJs. While challenges remain, it helped LHJs build sustainable systems, deepen partnerships, and increase capacity to continue advancing equity beyond the grant period. These lessons position California to further embed equity in public health practice and improve outcomes for communities most affected by long-standing inequities.

Overview of Statewide Equity Activities and Challenges at a Glance

This table provides a streamlined, snapshot of statewide equity activities and challenges organized by domain. It is not an exhaustive list, but a high-level summary of common themes observed during the CERI funding period.

Domain	Key Activities	Challenges
Workforce and Capacity	• Hiring and establishing equity positions (e.g., Equity Leads, Coordinators, small equity units) • Workforce development trainings (racial equity, DEI, implicit bias, cultural humility, cultural competency, harm reduction etc.) • Workforce pipelines with colleges/universities	• Recruitment and retention issues; staffing shortages and turnover • Hiring freezes, leadership transitions, fixed-term limits • Paused activities due to vacancies or limited internal capacity
Collaborative Partnerships	• Strengthening partnerships with CBOs, Tribes, CHWs/Promotoras, multisector teams • Advisory committees, community coalitions, resident engagement structures (e.g., Healthy Communities workgroups, Live Well models) • Listening sessions, focus groups and co-design processes with communities	• Engagement barriers: limited CBO capacity, leadership turnover, survey fatigue • Challenges building/maintaining trust with Tribes or historically underserved groups • Geographic isolation and uneven capacity
Equity in Organizational Policies and Practices	• Organizational equity assessments and audits to identify gaps and set priorities • Development of strategic plans, racial equity roadmaps, and policy templates	• Fragmented data systems and approval bottlenecks slowing policy implementation • Delays due to governance resistance, limited staffing, or capacity constraints

	• Embedding equity into contracting, performance measures, resource allocation processes • Language Access Plans, multilingual communications, interpretation services	• Difficulty standardizing equity practices across programs or counties
Planning and Shared Decision Making	• Development/updates of Community Health Assessments and Community Health Improvement Plans; "boots on the ground" data collection models • Community facing dashboards (e.g., equity dashboards, COVID-19 Impact Hub) integrating qualitative and quantitative data • Health in All Policies initiatives and multisector planning on social determinants of health • Place-based engagement and cross jurisdiction collaboration efforts	• Data instability in small population counties • Limited resources to sustain data collection, analysis, and planning • Emergency events (e.g., wildfires and storms) disrupting planning cycles and engagement

Introduction

The California Equitable Recovery Initiative (CERI) began in 2021 as the state worked to recover from COVID-19 and address the unequal impacts the pandemic had on communities that have long faced barriers. CERI was created to strengthen equity in our public health systems. It supported 47 of California's 61 Local Health Jurisdictions (LHJs) in building long-term staffing, systems, and structures to support this work. Through CERI, LHJs hired staff focused on equity, built stronger partnerships with community-based organizations, and made equity a core part of their planning, policies, and services.

This report shares the approaches LHJs used to build and strengthen equity infrastructure during the COVID-19 response and recovery. Together, these efforts reflect a shared commitment to removing systemic barriers and creating long-term pathways to healthier, more resilient communities. The report also describes the challenges LHJs faced, the common practices that emerged across jurisdictions, and key lessons learned throughout the initiative. It ends with considerations to support future efforts and maintain momentum toward greater equity in public health.

Equity

Fair access to resources and opportunities by meeting people and communities where they are, recognizing historical and current disparities.
(Source: California Health & Safety Code §131019.5)

Health Equity

A fair and just opportunity for all people to achieve their highest level of health by removing preventable, unjust barriers.
(Source: CDC – Health Equity)

Equity Infrastructure

The systems, staff, policies, and processes that sustain ongoing equity work within an organization.
(Source: NACCHO – Health Equity Infrastructure Guide)

Health Inequities / Disparities

Preventable, unjust differences in health outcomes among groups that arise from structural factors and conditions.
(Source: WHO Health Inequities)

Overview of the California Equitable Recovery Initiative

This section provides a detailed overview of CERI, outlining how the initiative was structured and implemented statewide. It describes the purpose of CERI and summarizes the funding provided to LHJs including the total grant amount, allocation of resources, and participation across the state. The section also explains key components of the initiative—such as establishing dedicated equity leadership positions, completing CDPH's Organizational Assessment for Equity Infrastructure, and developing local Health Equity Plans aligned with statewide frameworks.

Funding:

CERI was funded through the CDC's OT21-2103: National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities. California used this funding to strengthen equity infrastructure within LHJs. Of the total $32 million award, the Office of Health Equity allocated $20 million to 47 of the state's 61 LHJs to support their equity efforts.

Eleven LHJs received funding directly from the CDC, and three declined funding due to limited capacity to meet grant requirements. This funding structure enabled broad statewide participation while still allowing LHJs flexibility to tailor activities to local needs. For a full breakdown of funding allocations, see Appendix A.

Timeline:

CERI was created to address the disproportionate impacts of COVID-19 on historically marginalized communities and to strengthen equity within local public health departments. In September 2021, funds were rapidly distributed to LHJs to build equity capacity, with flexibility to adapt activities to local needs through May 2023.

To maintain progress as needs evolved, the grant received two no-cost extensions—first through May 31, 2024, and then through May 31, 2026—ensuring continued support for developing and sustaining equity infrastructure.

Requirements for Local Health Jurisdictions:

Participating LHJs were required to establish a dedicated Equity Lead at the leadership level to elevate equity across their jurisdiction. They also completed CDPH's 2022 Organizational Assessment for Equity Infrastructure to evaluate their capacity and identify areas for improvement. Additional expectations included contributing to the State Health Equity Plan (SHEP) and implementing local equity activities aligned with the COVID-19 Health Equity Playbook. Together, these requirements ensured LHJs built lasting equity capacity and advanced structural change statewide.

What We Measured:

LHJs reported progress to CDPH twice a year using CDC-defined performance measures, tracking improvements to equity infrastructure such as expanding equity staff, embedding equity in policies, conducting equity-focused assessments, and building community engagement structures. See Appendix B for a summary of completed measures.

Key Performance Measure Categories:

- **Staffing:** Number of dedicated health equity staff hired or expanded.
- **Organizational Assessments:** Completion of equity-focused organizational assessments.
- **Health Equity Plans:** Number of local-level health equity plans completed.
- **Community Health Improvement Plans:** Number of completed community health improvement plans.
- **Policy Updates:** Organizational policies updated to embed equity principles.
- **Community Engagement:** Number of community advisory committees or engagement venues established.
- **Cross-Sector Initiatives:** Local-level Health in All Policies initiatives or collaboratives.
- **Trainings:** Number of equity trainings provided.
- **Resource Allocation:** Budgeting, contracting, and resource allocation processes updated for equity.
- **Partnerships:** Active partnership initiatives with Tribes and other community partners.

Development of the Equity Technical Assistance Team:

The Office of Health Equity (OHE), established under California Health & Safety Code § 131019.5, actively provides technical assistance to state and local agencies to build organizational capacity, train staff, and facilitate communication that reduces health and mental health disparities.

To fulfill this mandate, OHE created the Equity Technical Assistance (TA) Team, which delivers statewide resources and support including CERI grant management, the Organizational Assessment for Equity Infrastructure, a Virtual Equity Toolkit, Equity Learning Collaboratives, newsletters, and forums to promote knowledge-sharing and capacity building.

Regional Technical Assistance Partners:

Recognizing the unique needs and challenges of each jurisdiction, OHE partnered with five regional subject matter experts to deliver additional tailored technical assistance across California's five regions from 2022-2024.

- **Rural North:** California Center for Rural Policy (CCRP)
- **Greater Sierra Sacramento:** California for Health (CA4Health)
- **Bay Area:** Bay Area Regional Health Inequities Initiative (BARHII)
- **Central California:** Central California Public Health Consortium (CCPHC)
- **Southern California:** Public Health Alliance of Southern California (PHASC)

Regional TA partners promoted innovation by facilitating knowledge exchange between jurisdictions, identifying emerging practices, and helping LHJs address region-specific challenges.

Key Activities:

- Delivered trainings for LHJ staff on effective use of the Healthy Places Index (HPI) platform and data tools.
- Developed and launched an Equity Officers Support Circle, a statewide peer-learning network with access to health equity experts to help LHJs design and implement outcomes focused equity strategies.
- Created structured opportunities for LHJs to share data regionally, identify barriers to sharing, establish regional equity principles for data governance, and ensure metrics remain meaningful for rural and frontier jurisdictions.

Collectively, these activities supported regions in accelerating their equity initiatives, aligning strategies, and strengthening the systems needed to sustain equity work beyond the grant period. These activities were not funded by CERI.

At the local level, the Equity TA Team provides ongoing one-on-one consultations, site visits, and inquiry resolution through the Equity Technical Assistance and Grant Management Portal.

These actions support OHE's legislative mandate to "provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities," ensuring consistent guidance and sustainable equity practices for all LHJs.

Unexpected Termination of Funding and Legal Challenges

In March 2025—nearly a year before the initiative's planned end date—the U.S. Department of Health and Human Services unexpectedly terminated funding for CERI. The decision, which coincided with the loss of other key funding streams, disrupted equity activities, created staffing uncertainty, and raised concerns among LHJs about meeting their commitments. In response, the Equity Technical Assistance Team quickly convened a webinar to explain the impacts and guide LHJs on submitting final invoices while awaiting further instructions.

California joined six other states in challenging the termination. In April 2025, the court issued a temporary restraining order, followed in May by a memorandum confirming the termination could not be enforced. Funding was officially restored on May 16, allowing LHJs to resume their equity work. By October 2025, CDPH's legal team had completed consultations, and planning began to help CERI-funded LHJs continue spending under the reinstated grant.

Resuming planned activities revealed several challenges:

- Some LHJs experienced significant setbacks, especially those with major workstreams paused during the funding termination.
- Some chose not to restart spending immediately, leaving funds unused due to shifting priorities or limited internal capacity.
- Others had reassigned staff and resources during the pause, requiring additional adjustments once funding was restored.
- LHJs had to renegotiate timelines, vendor contracts, and outreach plans, adding administrative burden and slowing progress.
- Ongoing uncertainty affected long-term planning, leading some LHJs to scale back their goals to avoid future disruptions.

The funding termination also disrupted CERI's performance-measure data collection, limiting the Equity TA Team's ability to gather complete statewide information and interrupting LHJs' regular reporting, as reflected in Appendix B. Although funding was later restored, the abrupt stop-and-restart created ripple effects that required significant adjustments. The experience also prompted broader conversations about how to sustain equity work with limited resources and underscored the need for contingency planning, flexible funding, and innovative strategies to maintain momentum during periods of uncertainty.

Landscape of Equity Infrastructure by Region Before Receiving Funding

This section provides an overview of the equity landscape across California's LHJs before the launch of CERI in 2021. It describes existing capacities, gaps, and partnerships that influenced how LHJs approached equity efforts prior to receiving CERI funding.

The regional structure shown in the map above is defined by the Office of Health Equity within the California Department of Public Health and is used to guide technical assistance and equity planning statewide.

Rural North Region

Eleven LHJs in the region received CERI funding:

Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Tehama and Trinity Counties.

Across California's most remote and geographically expansive counties, the Rural North region faced significant barriers to health equity. LHJs struggled with workforce shortages, geographic isolation, and limited infrastructure, making it difficult to deliver equitable public health services.

Equity capacity varied widely across counties. Most LHJs lacked the dedicated funding and staffing needed to fully integrate equity into their work. Only a few had begun implementing tools—such as Community Outreach Teams or internal equity checklists—to guide programs and policies.

Before CERI funding, many LHJs had limited internal resources and relied heavily on county and community-based partners to address needs like wildfire preparedness, substance use, behavioral health, and food security. These partnerships filled urgent gaps but were difficult to sustain without stable funding or dedicated staff.

Greater Sierra Sacramento Region

Nine LHJs in the region received CERI funding:

Alpine, Butte, Colusa, El Dorado, Nevada, Placer, Plumas, Sutter and Yolo Counties.

Home to both small rural counties and major metropolitan areas, the Greater Sierra Sacramento region faced uneven capacity for equity work before CERI. Staffing shortages and limited resources made it difficult for many LHJs to build or sustain consistent equity infrastructure.

Partnerships were often informal or ad-hoc, and LHJs lacked the coordinated frameworks needed to scale equity initiatives across programs or counties. These gaps limited their ability to establish shared practices or advance collaborative efforts.

Before receiving CERI funding, most LHJs were in the early stages of embedding equity into policies and practices. Many lost community trust during the COVID-19 pandemic, and ongoing staffing and retention challenges further slowed progress.

Bay Area Region

Nine LHJs in the region received CERI funding:

City of Berkeley, Contra Costa, Marin, Monterey, Napa, San Mateo, Santa Cruz, Solano and Sonoma Counties.

As one of California's most populated and economically dynamic regions, the Bay Area faced deep-rooted health disparities and barriers including language gaps, climate risks, siloed systems, and fragmented data. These challenges limited LHJs' ability to consistently put equity into practice.

Few LHJs created or designated new equity roles, and many were shaping the scope and support needed for these positions to be effective. The region's diversity, evolving structures, and varying capacity levels made it challenging for staff to consistently coordinate equity efforts across departments.

Before receiving CERI funding, equity infrastructure varied widely in the region. Few LHJs had dedicated roles or formal frameworks, and many remained in early or undefined stages of centering equity. Partnerships provided a foundation, but most lacked the resources needed to support sustained collaboration.

Central California Region

Eleven LHJs in the region received CERI funding:

Calaveras, Kern, Kings, Madera, Mariposa, Merced, San Benito, San Joaquin, Stanislaus, Tulare and Tuolumne Counties.

As California's agricultural center, the Central California region faced longstanding inequities linked to poverty, limited educational opportunities, and environmental stressors. These conditions created an urgent need for equity-focused strategies even before the California Equitable Recovery Initiative.

Underfunded and fragmented community partnerships limited LHJs' ability to engage communities consistently. Many efforts to address disparities were reactive, responding to urgent needs instead of long-term planning.

Before receiving CERI funding, most LHJs lacked dedicated equity staff and formal infrastructure. Equity was not embedded in organizational practices, and longstanding inequities—such as low educational attainment, high poverty, and limited access to healthcare—continued to drive poor health outcomes.

Southern California/Los Angeles Region

Seven LHJs in the region received CERI funding:

Imperial, Inyo, Mono, Pasadena City, San Luis Obispo, Santa Barbara and Ventura Counties.

Spanning border, coastal, urban, and rural areas, the Southern California region includes diverse communities with wide differences in resources and capacity. These variations created ongoing challenges for building consistent and sustainable equity infrastructure.

LHJs engaged communities more effectively in places with strong CBO networks but struggled where partnerships were limited. Resource disparities, including unequal funding, limited health services, and workforce shortages, continued to hinder equitable service delivery.

Before receiving CERI funding, larger jurisdictions had already integrated equity practices through community health programs and inclusive policies, while many smaller LHJs were only beginning to establish equity approaches.

Four Essential Domains: The Organizational Assessment for Equity Infrastructure Framework

CDPH's Organizational Assessment for Equity Infrastructure outlines four core domains that embed equity into everyday public health practice: **Workforce and Capacity, Collaborative Partnerships, Equity in Organizational Policies and Practices, and Planning and Shared Decision-Making**.

These domains were shaped by feedback from Local Health Jurisdictions (LHJs) during early engagement in 2021, ensuring the framework reflects local realities and priorities.

By centering LHJ voices, the framework helps jurisdictions assess their internal capacity, identify gaps, and strengthen efforts that keep equity at the center of public health practice.

Four Essential Domains

The following section summarizes each domain, highlighting shared practices, challenges, and lessons learned from LHJs from CERI. The Equity Infrastructure framework guided and shaped every stage of the initiative, ensuring equity was integrated throughout implementation.

Domain 1: Workforce and Capacity

Build a skilled, supported, and diverse public health workforce that can effectively meet the needs of the communities they serve.

This domain includes three core competencies:

Build organizational capacity by having **dedicated equity staff** to lead equity focused practices.

Ensure staff have equity competencies and skills through **training, development & support**.

Recruit, hire, and develop a **diverse & inclusive** workforce that reflects the populations served.

Shared Practices for Workforce and Capacity

1.

Workforce Development and Equity Trainings

- LHJs invested heavily in training to build staff capacity and a shared understanding of equity, offering ongoing educational experiences on topics such as racial equity, implicit and unconscious bias, harm reduction, othering and belonging, and inclusive communication.
- Through tailored workshops and multi-session training series, LHJs created opportunities for staff and community partners to learn about and discuss equity topics. In several cases, LHJs partnered with community-based organizations to deliver training grounded in community-informed methods and outreach.
- By collaborating with consultants and academic institutions to provide specialized courses and leadership development programs, LHJs advanced goals such as implementing results-based accountability (RBA) systems and achieving Public Health Accreditation Board (PHAB) accreditation.

- LHJs also established ongoing learning spaces—such as cross-department workgroups, affinity groups, talking circles, and health equity committees and cohorts—to help staff integrate equity knowledge into daily practice.

2.

Hiring Dedicated Equity Staff

- To strengthen their equity infrastructure, LHJs created and filled dedicated roles such as Equity Coordinators, Program Managers, and Health Equity Leads.
- By hiring bilingual and multilingual staff, LHJs expanded their capacity to meet community needs through culturally responsive outreach, program delivery, and engagement.
- Dedicated equity staff provided strategic oversight—guiding equity planning, coordinating implementation, and ensuring accountability across programs and policies.
- Through internships and career pipeline partnerships with colleges and universities, LHJs increased workforce diversity and supported the development of the next generation of equity-focused public health practitioners.

3.

Cultural Responsiveness as a Statewide Equity Standard

- By providing training in cultural awareness, responsiveness, and humility, LHJs strengthened staff understanding, sensitivity, and accountability needed to effectively respond to community needs.
- By sending full teams to national equity conferences (e.g., *Facing Race, Belonging Without Othering*), LHJs expanded workforce skills and strengthened cultural responsiveness through high-impact professional development.
- By developing equity terminology guidelines, branding and style guides, and incorporating community values into communications, LHJs improved culturally responsive public health messaging. LHJs also worked closely with public information teams to ensure materials reflected cultural humility and community voice.

Challenges in Building and Sustaining Workforce Capacity

Staffing shortages, turnover, and lengthy hiring processes across LHJs slowed workforce progress, as vacant or shifting positions created gaps and stalled momentum. Many staff were balancing equity responsibilities alongside other priorities, limiting their capacity for training and sustained implementation. These challenges were especially acute in smaller jurisdictions, underscoring the need for stable roles and protected time to maintain progress.

Domain 2: Collaborative Partnerships

Establish the foundation for building and sustaining relationships with Community Based Organizations (CBOs), residents, and cross-sector partners to advance equity.

This domain includes three core competencies:

Unite diverse voices, resources, and expertise by establishing **structures to build collaboration.**

Ensure efforts are grounded in community priorities through transparent and inclusive **engagement** with **CBOs and residents**.

To address social determinants of health, **partner across sectors** with other agencies and organizations.

Shared Practices for Collaborative Partnerships

1. Co-Designing Community Power Structures

- LHJs formed advisory groups that brought together CBOs, residents, and other partners, for shared governance and promoting equity-centered decision-making across recovery efforts. Some LHJs offered stipends to community and resident participants to recognize their time and expertise.
- LHJs contracted with CBOs to serve as key partners in planning and implementing equity initiatives, often formalizing these relationships through a Memorandum of Understanding (MOU) or service agreements.

2. Expanding Community Reach Through Culturally Responsive and Meaningful Engagement

- LHJs partnered with CBOs and grassroots leaders to design and deliver outreach that was culturally and linguistically tailored, ensuring engagement strategies resonated with local communities and addressed barriers such as language, trust, and access.

- LHJs leveraged Community Health Workers (CHWs) and Promotoras as trusted messengers, using their relationships and presence at community events such as schools, churches, food distributions sites, and cultural festivals to build trust, gather input, and co-create solutions that informed program design.

3. **Aligning Public Health with Other Sectors Through Joint Planning and Action**

- LHJs initiated and maintained regular collaboration with other sectors such as behavioral health, housing, education, and emergency services to address shared priorities.
- LHJs participated in regional coalitions and workgroups to coordinate specific projects and share actionable data with partners.

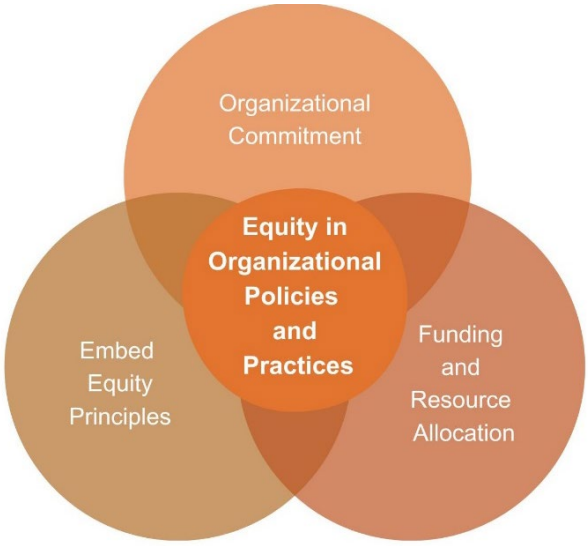
Challenges in Maintaining Community and Cross-Sector Engagement

Statewide, LHJs strengthened partnerships, but struggled at times to maintain consistent engagement. Capacity constraints, leadership transitions, and competing priorities made it difficult for partners to stay involved in advisory groups and co-design activities. In rural areas, distance and limited infrastructure further shaped collaboration, underscoring the need for flexible, relationship-centered approaches.

Domain 3: Equity in Organizational Policies and Practices

Embed equity into policies and practices to ensure organizational operations are equitable, inclusive, and regularly evaluated for efficacy.

This domain includes three core competencies:



Organization demonstrates **commitment** internally and externally, evident through culture and

Embed equity principles throughout the organization's programmatic and operational plans/policies.

Strategically direct **funding and resource allocation** to build capacity to address equity.

Shared Practices for Equity in Organizational Policies and Practices

1. Conducting Organizational Equity Assessments

- LHJs conducted regular equity-focused assessments to identify structural gaps and used the findings to inform workforce development, policy updates, and resource allocation.
- Assessment results guided decisions on equitable resource distribution, staffing expansion, language access improvements, workforce training enhancements, and support for community-driven partnerships.

2. Embedding Equity in Policies and Processes

- LHJs applied an equity lens to contracting and budgeting, prioritizing resources for communities facing the greatest inequities. This ensured staff time, funding, and organizational resources were intentionally directed toward equity-related efforts.
- LHJs updated emergency response documents to integrate equity into protocols so that future emergencies would be met with systems that account for access, disparities, and community context.

- By creating equity-centered strategic plans, roadmaps, and templates, LHJs embedded equity into hiring practices, data processes, and organizational commitments. These policies strengthened long-term equity infrastructure designed to endure staffing changes, political shifts, and grant cycles.

3. **Developing Local Health Equity Plans**

- Drawing on community events, meetings, advisory committees, and other cross-sector touchpoints, LHJs used CERI-supported engagement efforts to inform the development of comprehensive local health equity plans.
- Centering marginalized communities, Health Equity Plans (HEPs) statewide were grounded in the needs and lived experiences of populations historically excluded from planning—not just quantitative data—ensuring that community priorities translated into policy action.
- To strengthen statewide alignment, LHJs connected their local health equity plans to frameworks such as the State Health Equity Plan (SHEP) to guide goal setting.

4. **Language Access in Service of Underserved Communities**

- By offering live translation during focus groups, human-centered design sessions, and community meetings, LHJs advanced language justice and ensured equitable access to public-health information for Limited English Proficient (LEP) individuals.
- By implementing or strengthening policies aligned with Culturally and Linguistically Appropriate Services (CLAS) standards, LHJs improved service quality and reduced disparities through respectful, clear, and accessible communication.
- Through developing or expanding Language Access Plans, LHJs ensured that services, communications, and outreach were consistently accessible in residents' preferred languages.

Challenges in Advancing Equity-Focused Policies and Processes

Multiple layers of review and staff reassignment to urgent priorities slowed the implementation of equity-focused policies. Fragmented data systems and limited capacity also hindered efforts to standardize equity practices in contracting, language access, and internal procedures. These challenges underscore the need for clearer processes and sustained leadership support.

Domain 4: Planning and Shared Decision-Making

Use the most accurate information to make decisions jointly with organizational staff and the communities they serve.

This domain includes three core competencies:

Data collection and usage should be accessible and reflect the experience of communities impacted by inequities.

Conduct **shared analysis** with staff, multisector partners, and community/residents to co-develop solutions.

Partner with community members for **inclusive decision making** about program and evaluation activities.

Shared Practices for Planning and Shared Decision-Making

1. Making Data Accessible and Actionable

- LHJs built or enhanced public-facing dashboards and data tools to make local health equity indicators easier for staff, partners, and community members to access. Many included disaggregated data by race, ethnicity, and geography to support transparency and inform grant writing, advocacy, and program design.
- LHJs updated Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) with current equity data, ensuring local priorities reflected emerging conditions. Draft findings were often reviewed with advisory groups before finalizing reports.
- When needed, LHJs provided tailored datasets—such as neighborhood-level or demographic-specific statistics—to guide targeted outreach, resource allocation, and collaborative grants.
- Using local data, LHJs identified priority neighborhoods or populations and directed interventions such as language access services or mobile clinics to areas with the highest need.

- LHJs applied an equity lens to funding and resource distribution by prioritizing contracts and budgeting decisions that support communities facing the greatest inequities.

2.

Establishing Ongoing Mechanisms for Shared Analysis and Inclusive Decision-Making

- LHJs established advisory panels, equity cohorts, and planning committees to bring together staff, community partners, and resident leaders for shared problem-solving, exchange of promising practices, and alignment of strategies across program design, implementation, and evaluation.
- Many LHJs participated in regional and statewide networks, sharing strategies, training materials, policy templates, and collaborative frameworks to strengthen health equity approaches. Ongoing collaboration with community and LHJ partners helped build strong relationships and streamline information sharing for continuous improvement.

Challenges in Implementing Equity-Centered Planning and Engagement

LHJs advanced planning and shared decision-making unevenly as they navigated data gaps, shifting capacity, and emergency-driven disruptions. Small counties often worked with unstable datasets, and many LHJs experienced fluctuating community participation due to competing obligations. Environmental events further interrupted planning cycles, underscoring the need for adaptable timelines and strong, sustained relationships.

Lessons Learned from Local Health Jurisdictions

Across California, Equity Leads from Local Health Jurisdictions (LHJs) reflected on what they gained, what challenged them, and what will guide their future equity work. Their insights offer a grounded, practice-based understanding of what it takes to build and sustain equity infrastructure, emphasizing trust, community partnership, intentional leadership, and long-term investment. The following section summarizes key lessons learned, organized by the reflection prompts and illustrated with de-identified quotes that capture the lived experience and expertise of LHJs.

What We Achieved

LHJs were asked to reflect on the successes they are most proud of that have come about from the California Equitable Recovery Initiative.

What We Learned

LHJs were asked to reflect on the lessons learned throughout the California Equitable Recovery Initiative.

What We Recommend

LHJs were asked to share recommendations for other public health practitioners seeking to implement similar equity efforts.

Advice for New Equity Practitioners

LHJs were asked to share advice for new equity practitioners entering the public health field.

What We Achieved

"One of the successes [our LHJ] is most proud of has been the opportunity to invest in our staff through meaningful training and professional development. We were able to provide trainings in cultural competence, cultural humility, implicit bias, CLAS standards, and ethical standards."

"One of the most significant successes was establishing a full-time Health Equity Lead position. This role allowed us to coordinate multi-program mobile outreach efforts to historically underrepresented communities across the county."

"The CERI grant allowed us to conduct an organization-wide assessment to identify staff needs and provide targeted education in response... By keeping all participation and responses anonymous, [our LHJ] demonstrated how evaluation processes—when designed to protect confidentiality—can build trust and create safe spaces for staff to share their experiences."

"[Our LHJ] successfully established a Public Health Bilingual Subcommittee and supported the development of our division's first-ever Language Access Plan."

"The CERI grant has allowed [our LHJ] to strengthen and integrate equity principles into our work. This has led to several successes including funding a community health data dashboard. With this dashboard, we have been able to provide more equitable, assessable, and up to date health data for the community."

What We Learned

"...equity work is never truly complete. It's not a one-time effort or something you can check off a list. It requires continuous learning, reflection, and growth – both individually and as an organization. This grant created space for important conversations and strengthened our ongoing commitment to serving our community more thoughtfully and equitably."

"Collaboration is key. Make decisions that are data-based and data-driven. Supportive leadership is important. Evaluation and communication platforms are essential tools."

"A key lesson learned is the importance of sustaining trust-based, relationship-centered engagement with community partners. Establishing equity infrastructure requires more than new roles or tools. Lasting change depends on visible leadership support, alignment across divisions, and clear accountability mechanisms that move Equity recommendations into action."

"Our communities know their needs best, and equity work should reflect and respond to those needs. And our frontline staff are closest to the work and our community members, and their input and contributions are key for buy-in and sustainability of system-wide equity implementation."

"Effective equity work requires shared decision-making with community-based organizations, advisory groups, and residents with lived experience to ensure programs are relevant, grounded in community priorities, and responsive to real needs."

What We Recommend

"...approach this work with humility and patience. Addressing inequities takes time, and trust isn't built overnight. Be willing to truly listen to the communities you serve, reflect on your own practices, and make adjustments along the way."

"[Our LHJ] recommends other public health practitioners to focus on embedding equity principles into organizational standards. This strategy enabled the organization to operationalize equity, leverage resources, increase capacity and embrace a continued effort towards change management across the branch."

"Meeting communities where they are and maintaining consistent engagement strengthens trust and impact."

"Be persistent. One approach may get a 'no' but try another."

"Practitioners benefit from building foundational equity infrastructure early - dedicated roles, organization-wide assessments, and communications frameworks that establish shared language and expectations. These elements create conditions for long-term cultural and operational change."

"Listening sessions, ambassador programs, and advisory groups ensure interventions reflect community priorities and the lived experiences of those most affected by structural inequities. Transparent feedback loops reinforce trust and support meaningful partnership."

Advice for New Equity Practitioners

"Be open to learning constantly. The more you understand disparities, systemic inequities, and the lived experiences of the communities you serve, the more effective and compassionate you'll become."

"...equity work is a journey, not a destination."

"Sustainable change takes time. Public Health has been serving vulnerable populations for years, even if it hasn't always been labeled as equity, which helps staff recognize that these practices are already embedded in many programs."

"...stay grounded in why you're doing the work. Public health – especially equity-focused work – can be challenging and sometimes overwhelming but remembering that it's about real people and real lives keeps you centered."

"It's important not to get discouraged if you're a team of one, some counties have full teams dedicated to this work, so progress will naturally look different."

"Having a strong support system is essential in equity work, especially support from Public Health leadership, as it can significantly influence your progress. It's also helpful to connect with neighboring counties and others across the state to learn from work that has already been done and avoid starting from scratch. Building on existing efforts and shared experiences can guide your approach and strengthen your overall impact."

Overall Successes: Linking the California Equitable Recovery Initiative to Statewide Equity Planning

One of the most significant statewide successes influenced by the California Equitable Recovery Initiative (CERI) is the process to develop a State Health Equity Plan (SHEP) and its integration into California's broader State Health Assessment (SHA) and State Health Improvement Plan (SHIP) process. Together, these efforts mark a strategic shift toward a unified, equity-centered framework for statewide health improvement—moving from parallel planning efforts to a coordinated approach that places equity at the core.

The State Health Equity Plan

The SHEP planning process was launched in response to long standing health disparities and inequities, which were further exacerbated from the COVID-19 pandemic, and the urgent need to strengthen equity infrastructure across the public health system. This collaborative process engaged Local Health Jurisdictions (LHJs), community-based organizations, and other key partners to explore community health issues and equity infrastructure, identify promising and best practices, and develop a shared equity strategy and implementation plan as a part of the existing State Health Improvement Plan (SHIP).

This statewide equity planning helped to:

- Center health equity as a statewide priority.
- Elevate community-driven and programmatic best practices.
- Identify priority areas and shared strategies to address disproportionate outcomes.
- Strengthen equity infrastructure across the public health system.

From the outset, equity was the north star in the SHEP shared planning process—guiding partner engagement, prioritization, and strategy development.

Local Health Jurisdiction Contributions to the State Health Equity Plan

LHJs played a critical role in shaping the State Health Equity Plan. Through CERI-supported activities, LHJs strengthened their equity infrastructure, conducted organizational equity assessments, developed local Health Equity Plans, and deepened engagement with communities that have historically experienced the greatest barriers to health and opportunity. Their input helped shape statewide strategies that reflect local conditions and challenges. CERI created capacity, structure, and resources for local innovation, and those lessons directly informed statewide priorities and strategies.

The State Health Assessment / State Health Improvement Plan and the Shift in Direction

The SHA and SHIP provide a broader framework for statewide health planning and accountability. The SHA provides a comprehensive, data-driven overview of California's health status, highlighting trends and disparities in key health outcomes and contributing factors. The SHIP builds on the SHA, defining shared priorities, measurable objectives, and

shared strategies and actions to improve population health. Although the SHEP was always intended to be a part of the SHA/SHIP, maintaining separate processes and frameworks created complexity and limited clarity. A "plan within a plan" was not conducive to presenting a clear, cohesive vision for statewide health improvement.

California is now taking an important next step by fully integrating the SHEP into the SHA/SHIP. This shift maintains what matters most—equity remains the north star, and partner expertise and engagement continue to guide the work—while streamlining efforts into one coordinated structure. The priority areas identified through the SHEP shared-action planning process will carry forward as SHIP priorities, and the strategies and sample actions developed through SHEP will be a part of SHIP implementation. Rather than standing alongside the SHIP, equity is now woven directly into it.

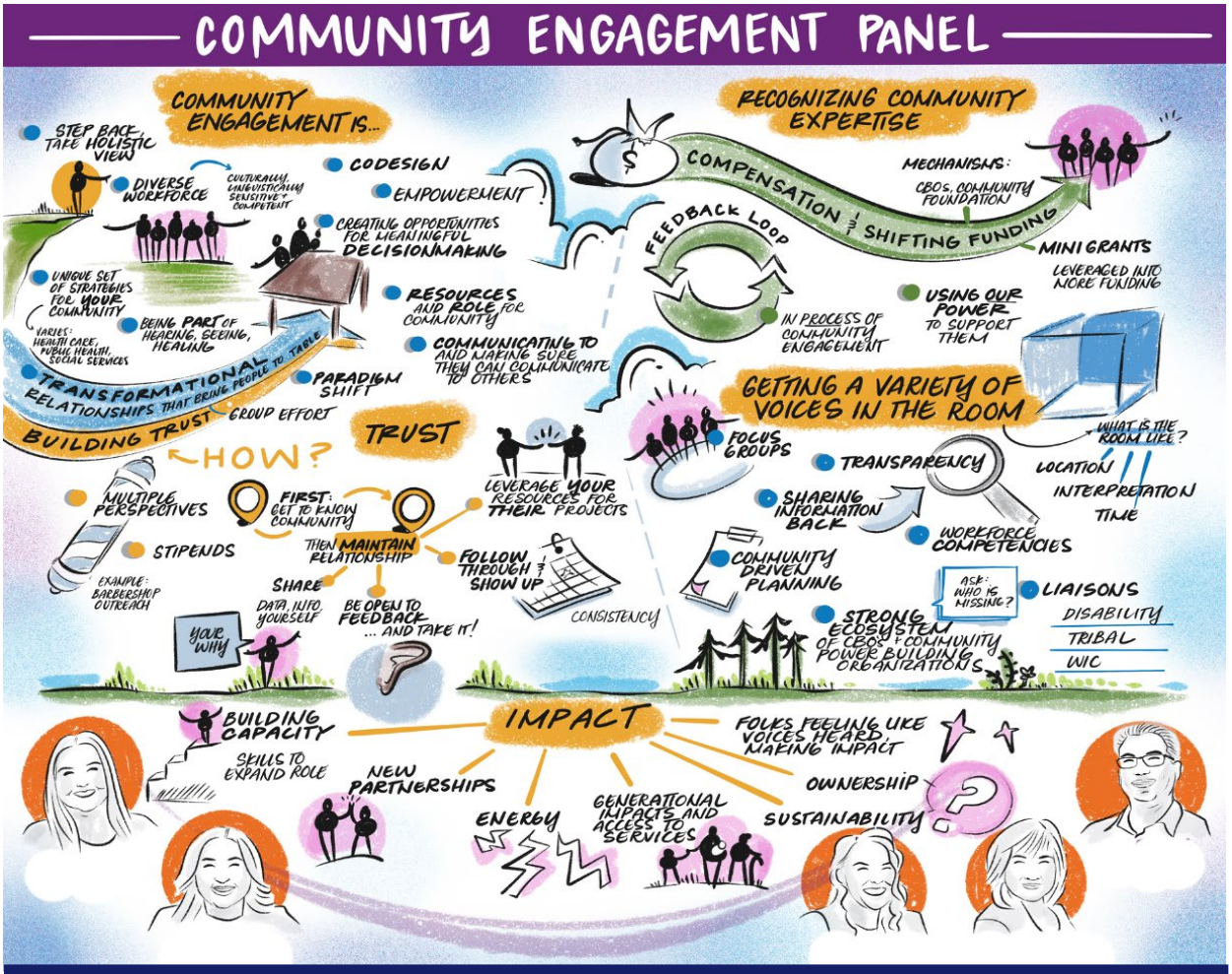
This integration reflects an evolving approach to equity work. Instead of treating equity as a parallel initiative, California is doubling down on equity as essential to community health improvement. Embedding the SHEP into the SHA/SHIP strengthens sustainability, maximizes limited resources, and ensures equity is infused into core public health activities—from assessment to strategy development to implementation and accountability.

Connection to the California Equitable Recovery Initiative's Overall Success

The SHEP represents a major statewide success supported by CERI because the initiative strengthened state and local equity infrastructure, generated actionable data and insights, and fostered a shared vision for advancing health equity across California. It helped elevate equity as a statewide public health priority and supported LHJs in operationalizing equity within their own systems. This effort directly shaped the development of SHEP and laid the groundwork for its successful integration into the SHIP. Through this evolution, CERI's impact extends beyond the grant period. It catalyzed a shift toward a more coordinated, equity-driven public health system—one that embeds equity into its core planning processes and advances a shared, sustainable vision for improving health outcomes for all Californians.

Considerations for Advancing Health Equity

To sustain and expand on the progress made throughout CERI, the California Department of Public Health offers the following considerations informed by CERI grant implementation experiences across participating LHJs. These considerations reflect common themes, promising approaches, and lessons learned throughout the initiative. They are intended to serve as a flexible, adaptable resource, recognizing that each jurisdiction operates within unique structures, capacities, and community contexts. Partners are encouraged to adapt and apply these insights in ways that best support their ongoing efforts to advance health equity.



Graphic recording of key insights from a community engagement panel at the 2023 California LHJ Equity Convening hosted by CDPH's Office of Health Equity. Image credit: Rio Holaday.

☑ Conduct Equity-Focused Organizational Assessments

- Use equity-focused assessment tools, such as those from CDPH and BARHII, to regularly review and identify gaps in policies, practices, and resource allocation to prioritize targeted improvements.
- Translate assessment findings into targeted improvements by revising procedures, updating workflows, and integrating equity checkpoints into routine decision-making, ensuring progress continues beyond individual staff champions or short-term grants.

☑ Establish and Support Dedicated Equity Leads

- Create a formal equity lead or champion role with a clear scope of responsibilities, ensuring this position is integrated into senior-level decision-making structures.
- Embed equity duties into position descriptions so responsibilities persist despite staff turnover or shifting priorities.
- Develop an internal escalation path so the equity lead can surface equity impacts early in policy, program, or budget decisions.
- Set up a cross-division equity workgroup led by the equity lead to coordinate activities, troubleshoot barriers, and maintain momentum.

☑ Invest in Workforce Development and Capacity Building

- Provide ongoing trainings (e.g. cultural humility, implicit bias, language access, equity principles) to strengthen staff knowledge and create a shared understanding across all programs.
- Develop applied skill-building sessions that use real LHJ scenarios (e.g. outreach planning, community engagement) so staff can practice integrating equity concepts into daily practice.
- Create internal learning spaces such as equity committees, talking circles, affinity groups, or short reflection huddles to encourage discussion, problem-solving, and continuous learning among staff.
- Strengthen workforce and diversity pipelines by partnering with colleges and universities to create internships, mentorship opportunities, and recruitment pathways for future public health practitioners.
- Integrate equity into onboarding so all new staff receive standardized training on cultural humility, language access, community engagement, and core equity principles from the start.

Strengthen Collaborative Partnerships

- Formalize partnerships with clear agreements (MOUs or shared work plans) to define roles, expectations, and shared responsibilities.
- Expand community engagement through culturally responsive outreach, partnering with trusted messengers such as Community Health Workers (CHWs) and Promotora's to build relationships and ensure community priorities guide services.

Implement Targeted, Race and Place-Based Interventions

- Use tools like the Healthy Places Index (HPI) and disaggregated local data to identify priority neighborhoods and populations, and direct resources such as mobile services, language access supports, and outreach teams, to the areas experiencing the greatest inequities.
- Work with trusted intermediaries when direct resident engagement is not always possible by partnering with CBOs, CHWs/Promotoras, Tribal leaders, or grassroots organizations who can help shape outreach, messaging, and service locations in culturally responsive ways.

Secure Sustainable Funding for Equity Infrastructure

- Blend and braid existing funding streams by identifying programs with overlapping goals and aligning staff time or activities so equity work can continue even when a single funding stream ends.
- Institutionalize core equity responsibilities into existing roles so critical equity functions do not disappear during funding gaps by integrating equity review steps into program planning, hiring practices, or community engagement workflows.

Conclusion

CERI demonstrates that building equity infrastructure requires enduring commitment, intentional partnerships, coordinated action, and consistent investment in community centered practice. Across the state, LHJs showed that when equity is embedded into workforce development, organizational policies, data practices, and shared decision-making, public health systems become more resilient and responsive to community needs.

Sustained investment in health equity infrastructure is essential to maintain and build on the progress made through this initiative. Stable funding enables health departments to retain staff, strengthen partnerships, set long-term goals, and track impact over time. Yet funding is not always predictable; public health budgets often shift in response to broader policy and fiscal changes, affecting the consistency of available resources. When funding levels fluctuate, health departments must adapt quickly—often with fewer resources—to continue meeting community needs.

While challenges remain, the lessons learned, shared practices, and Equity Infrastructure framework highlighted throughout this report provide a foundation for continued progress. The ongoing work of LHJs, state partners, and community organizations helps ensure that the strategies developed throughout CERI will extend beyond the grant period and support more equitable health outcomes statewide.

Graphic recording of equity wins from a regional roundtable panel at the 2023 California LHJ Equity Convening hosted by CDPHs Office of Health Equity. Image credit: Rio Holaday.

Appendices

Appendix A – Funding Allocation and LHJ Participation

This appendix provides an overview of how the California Department of Public Health (CDPH) allocated $32 million awarded in federal funding across LHJs, Community-Based Organizations (CBOs), and state operations. Table A1 summarizes the major funding categories, followed by a complete list of the 47 LHJs that received CERI funding from CDPH. For additional context on CERI's structure, statewide participation, and funding approach, please refer to the Overview section of this report.

Table A1. CERI Funding Allocation

Funding Category	Allocation
Local Health Jurisdictions	$20,000,000
Community-Based Organizations	$3,000,000
State Operations (CDPH)	$9,000,000
Total Amount Awarded: $32,000,000	

CERI Funded Local Health Jurisdictions

Rural North LHJs: Del Norte County, Glenn County, Humboldt County, Lake County, Lassen County, Mendocino County, Modoc County, Shasta County, Siskiyou County, Tehama County, Trinity County

Greater Sierra Sacramento LHJs: Alpine County, Butte County, Colusa County, El Dorado County, Nevada County, Placer County, Plumas County, Sutter County, Yolo County

Bay Area LHJs: City of Berkeley, Contra Costa County, Marin County, Monterey County, Napa County, San Mateo County, Santa Cruz County, Solano County, Sonoma County

Central California LHJs: Calaveras County, Kern County, Kings County, Madera County, Mariposa County, Merced County, San Benito County, San Joaquin County, Stanislaus County, Tulare County, Tuolumne County

Southern California LHJs: Imperial County, Inyo County, Mono County, Pasadena City, San Luis Obispo County, Santa Barbara County, Ventura County

Appendix B – Performance Measures Table

The table below summarizes statewide completed performance measures as reported in the final work plans from each LHJ during CERI. Only measures marked "Completed" were included. For context on how funding disruptions affected these outcomes, see the section "Unexpected Termination of Funding and Legal Challenges."

Table A2. Statewide Completed CERI Performance Measures

Performance Measure	Statewide Total
Dedicated health equity staff hired, or expand staff	70
Equity-focused organizational assessments conducted	59
Equity trainings provided	169
Local-level health equity plans	19
Community Health Improvement Plans (CHIPs)	25
Organizational policies updated to embed equity principles	15
Budgeting/contracting/resource allocation processes updated to embed equity	12
Investments in equity zones (or comparable place-based models)	6
Active partnership initiatives with Tribes	9
Local-level Health in All Policies (HiAP) Initiatives/cross-sector collaboratives	5
Community advisory committees/engagement venues	35
*Other LHJ-defined items	11
Grand total across all completed measures:	**435**

**e.g., public health pipeline programs, community-facing data dashboard, community specific vaccine outreach events etc.*

Appendix C – Storytelling Video Interviews with Local Health Jurisdictions

This appendix presents a collection of short video interviews with Equity Leads from five LHJs that received CERI funding. One LHJ was selected from each of the five regions represented among the 47 participating jurisdictions to ensure geographic diversity and a range of implementation approaches. The videos provide first-hand reflections on the unique activities carried out by each LHJ.

Modoc County Public Health

This story shows how public health staff partners with Community Health Workers / Promotoras to reach residents in geographically isolated communities. By uplifting their lived experience and leadership, community health workers are expanding access to services, giving back to their communities, and empowering themselves to make a difference.

Video: Supporting Rural Community Health Workers/Promotoras in Rural Communities

Nevada County Public Health

This story highlights how Nevada County staff provided mental health trainings in schools, strengthened support for families, and made essential health supplies easier to access through innovative county-wide vending machines.

Video: Expanding Behavioral Health Support for Students, Families and Communities

Monterey County Public Health

This story reflects a co-design approach with resident leaders that centered community voice in shaping a health conference. Grounded in lived experience, the process strengthened engagement and broadened its impact across the community.

Video: Centering Community Voices in Health Conference Planning

San Joaquin County Public Health

This story shows how local health department staff and community partners are using their Community Health Improvement Plan (CHIP) to make South Stockton a healthier place to live, including a park beautification initiative and new mural at Williams Brotherhood Park.

Video: Partnering with Community to Address Social Determinants of Health

Imperial County Public Health

This story highlights how a border region health department is using equity-focused planning and workforce development to move health equity from theory into everyday practice, strengthening both staff capacity and community relationships.

Video: Building an Equity-Focused Public Health Workforce

Appendix D – Organizational Assessment for Equity Infrastructure Final Report (2022–2025)

The final report for the Organizational Assessment for Equity Infrastructure provides a comprehensive analysis of the most strengths, gaps, and equity-related capacities across participating LHJs. Findings from this assessment informed statewide themes presented in this report, including workforce development, community engagement, and organizational readiness.

This report will be made available on the CDPH Office of Health Equity Webpage later this year.

Appendix E – Community-Based Organization Activities Supported by the California Equitable Recovery Initiative

CERI awarded three million dollars in competitive grants to ten CBOs across the state. These organizations, serving communities disproportionately impacted by the COVID-19 pandemic, led community-driven strategies to advance racial and health equity. They focused on organizing, peer learning, leadership development, and systems-change efforts rooted in local needs and lived experiences. Funded projects addressed various priorities, including equitable COVID-19 recovery, access to education and transportation, worker and caregiver empowerment, disability justice, long COVID impacts, civic engagement, and culturally responsive health information exchange.

Grantees centered community voices and power in urban, rural, and regional contexts to confront structural inequities affecting marginalized groups such as Black seniors, Spanish-speaking families with disabilities, low-income care workers, transit riders, youth, and immigrant residents. Collectively, the CERI CBO project strengthened community capacity, fostered cross-sector collaboration, and advanced scalable models for equitable recovery, resilience, and long-term health equity across California.

Appendix F – Division of Communicable Disease Control Analytics and Reporting Activities

With support from CERI funding, the Division of Communicable Disease Control (DCDC) within the California Department of Public Health advanced several analytic and reporting activities to better understand and address health disparities during and after the COVID-19 pandemic. To address existing COVID-19 data gaps, DCDC epidemiologists contributed significant in-kind support to conduct analyses examining the completeness

of key demographic and clinical variables in public health surveillance systems. Two manuscripts are currently being developed: one assessing the completeness of demographic and clinical data for latent tuberculosis infection (LTBI) and another evaluating similar data elements for COVID-19. These efforts help identify critical gaps in surveillance data and strengthen the evidence base needed to monitor disparities and guide more equitable public health responses.

CERI funding also supported analyses exploring the intersections of COVID-19 with other conditions and structural drivers of health inequities. DCDC epidemiologists drafted a manuscript applying an intersectionality framework and decomposition analyses to examine how selected social determinants of health contribute to disparities in tuberculosis deaths. The study focuses on differences between U.S. born Black and U.S. born White individuals with TB compared to non-U.S. born Asian individuals with TB, helping to illuminate the structural and social factors underlying inequitable outcomes. In addition, programmatic data quality efforts continued through the Emergency Department Screening Program (EDSP), where the STDCB RDA 3 completed the first round of quality assurance for seven emergency departments and is continuing to review additional and future data submissions to improve the reliability of Emergency Department based screening data.

These analytic and quality improvement activities contributed to several dissemination products that expand the evidence based on health disparities. The manuscript "*Sexually Transmitted Infection Disparities and Social Determinants of Health in California, 2013–2021*" was published online in the *American Journal of Public Health* on March 6, 2025, highlighting structural drivers of STI disparities across the state. In addition, the abstract *"Impacts of Race and Ethnicity Categorization: Unpacking the True Burden of Sexually Transmitted Infections in American Indian/Alaska Native Peoples, California, 2018–2023"* was accepted as a poster presentation at the 2025 Council of State and Territorial Epidemiologists (CSTE) Annual Conference. Work under the community engagement and linkage to care objective also culminated in the publication of the report "*The Integration of Health Equity into Policy to Reduce Disparities: Lessons from California During the COVID-19 Pandemic*," which documents how equity focused policies and partnerships informed California's pandemic response and strengthened pathways to care for communities most affected by COVID-19.

Appendix E - Glossary of Terms (Public Sources)

The definitions in this glossary are provided for general clarity and reference. They were adapted from publicly available external sources, which are cited directly beneath each term. Inclusion of these definitions does not imply endorsement from the California Department of Public Health of the external sources or their full content.

Accessibility

Design, construction, development, and maintenance of facilities, information and communication technology, programs, and services so that all people, including people with disabilities, can fully and independently use them.

Source: CDC-Glossary of Terms

Community-Based Organizations (CBOs)

A public or private nonprofit organization that operates within a local community for the greater common good. Examples include Federally Qualified Health Centers (FQHCs), community or school-based health centers (SHHCs) and service organizations. CBOs can bring established connections with local health departments (LHDs) and schools/districts.

Source: CDPH – Partnering With Community Based Organizations (CBOs) for SLVEs

Community Health Workers (CHWs)/Promotoras

Trusted frontline public health workers who provide culturally relevant health education, outreach, and connection to services within their own communities.

Source: CDC – Community Health Worker Resources

Collaborative Partnerships

Collaborative partnerships (people and organizations from multiple sectors working together in common purpose) are a prominent strategy for community health improvement.

Source: Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. Annu Rev Public Health. 2000;21:369-402. doi: 10.1146/annurev.publhealth.21.1.369. PMID: 10884958.

Community Health Assessment (CHA)

A state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection, and analysis.

Source: CDC – Community Planning for Health Assessment: CHA & CHIP

Community Health Improvement Plan (CHIP)

A long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years.
Source: CDC – Community Planning for Health Assessment: CHA & CHIP

Cultural Humility

A lifelong practice of self-reflection and learning that recognizes power imbalances and prioritizes institutional accountability in cross-cultural work.
Source: HHS OMH – CLAS Standards Framework

Cultural Responsiveness

The ability to understand and appropriately include and respond to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued (Hopf et al., 2021).
Source: ASHA - American Speech-Language-Hearing Association

Dedicated Equity Staff (Equity Leads / Health Equity Leads)

Health equity staff serve as internal experts and a resource for staff and peers within the department. They guide others to operationalize health equity in everyday health department work and develop resources and trainings on how and the department can integrate health equity in programs, policies, and plans. Health equity staff assess workforce and department cultural competency and identify training.
Source: ASTHO Report - Health Equity and Public Health Department Accreditation

Disaggregated Data

Data disaggregation refers to the separation of compiled information into smaller units to elucidate underlying trends and patterns. Compiled data may come from multiple sources and have multiple variables or "dimensions." To enhance understanding of a situation, the data is grouped by dimension, such as age, sex, geographic area, education, ethnicity, or other socioeconomic variables.
Source: The Network for Public Health Law - Disaggregation of Public Health Data by Race & Ethnicity

Diversity

Diversity refers to the presence of a wide range of individuals from different identities, including race, ethnicity, gender, sexual orientation, socioeconomic status, and more.
Source: ASTHO - Equity, Diversity, and Inclusion in Public Health: Creating a Healthier Society

Equity

Fair access to resources and opportunities by meeting people and communities where they are, recognizing historical and current disparities.
Source: California Health & Safety Code §131019.5

Equity Assessments (Organizational Equity Assessments)

A systematic, data-driven process used to review internal policies, procedures, and culture to identify and eliminate systemic inequities, discrimination, and barriers to inclusion. It evaluates the distribution of power and resources to ensure fair treatment across diverse staff, particularly for underrepresented groups.
Source: CDPH - Baseline Organizational Assessment for Equity Infrastructure

Equity Infrastructure

The set of processes, staff, and resources built and sustained in an organization to deliver services with an equity lens.
Source: CDPH - 2024 FAQs - Organizational Assessment for Equity Infrastructure

Health Equity

A fair and just opportunity for all people to achieve their highest level of health by removing preventable, unjust barriers.
Source: CDC – About Health Equity

Health Equity Roadmaps

A health equity roadmap is a structured, action-oriented framework designed to help healthcare organizations and systems dismantle structural barriers, reduce health disparities, and ensure equitable, high-quality care for all individuals. It serves as a guide for organizational transformation towards diversity, inclusion, and improved health outcomes for underserved populations.

Source: California Department of Health Care Services (DHCS) - Health Equity Roadmap Initiative

Health Inequities / Disparities

Preventable, unjust differences in health outcomes among groups that arise from structural factors and conditions.
Source: WHO – Health Inequities Factsheet

Health in All Policies (HiAP)

A cross-sector approach that integrates health, equity, and sustainability considerations into government decision-making.
Source: CDPH – Health in All Policies Program

Implicit Bias

Automatically activated, unconscious associations or evaluations that influence perception, judgment, and behavior toward people, groups, objects, or ideas, often without conscious awareness or intentional endorsement. Implicit bias is thought to be shaped by experience and learned associations between particular attributes, qualities, and categories (e.g. race, gender) that can influence perception and behavior without conscious awareness.

Source: APA Dictionary of Psychology

Inclusive Decision-Making

Include community members/residents and stakeholders in key decisions about program, policy planning, and evaluation activities.
Source: CDPH - Organizational Assessment for Equity Infrastructure

Interpretation Services

Live language services (spoken or signed) that enable individuals with limited English proficiency or communication disabilities to fully understand and participate in public health programs.
Source: HHS OMH – Language Access & CLAS Standards

Language Access

Language access means that people who do not speak English very well or at all, are able to use and benefit from a wide range of services.
Source: Georgetown University - National Center for Cultural Competence

Local Health Jurisdiction (LHJ)

A Local Health Jurisdiction (LHJ) in California is a local county, city, or city-county health department/district that provides public health services, oversight, and enforcement within a specific geographic area. These agencies work in collaboration with the California Department of Public Health (CDPH) to protect community health.
Source: Law Insider

Place-Based Approaches

The term "place-based approaches" describes a diverse range of activities that target a place or location, to build on local strengths or respond to a complex social problem.
Source: Victorian Government – Home Place-based approaches: A guide for the Victorian Public Service

Social Determinants of Health (SDOH)

The conditions in which people live, work, learn, and play that shape health risks and opportunities.
Source: WHO – Social Determinants of Health

State Health Assessment (SHA)

The State Health Assessment (SHA) provides a snapshot of health for the entire population, across a range of conditions and factors. Let's Get Healthy California – the SHA – leverages a broad range of information to identify key health issues and contributing factors, elevate trends and disparities, and identify assets and resources that can be mobilized to address these issues.

Source: State Health Assessment – California Department of Public Health

State Health Equity Plan (SHEP)

The SHEP was launched to develop a shared equity strategy and implementation plan, as a part of the State Health Improvement Plan. The Plan would outline shared population results and indicators (statewide equity goals) and a menu to strategies to align efforts, coordinate activities, and advance collective action across California. This work is now being integrated into the State Health Assessment (SHA) and State Health Improvement Plan (SHIP), rather than establishing a separate standalone plan. The integration of the SHEP into the broader SHA/SHIP aims to elevate equity as a shared public health priority and sustain long-term equity infrastructure.

Source: CDPH Office of Health Equity – State Health Equity Plan

State Health Improvement Plan (SHIP)

California's strategic plan for improving population health statewide. It sets long-term priorities, objectives, and cross-sector strategies informed by the State Health Assessment. SHIP focuses on improving health outcomes and addressing systemic factors affecting health.

Source: State Health Improvement Plan – California Department of Public Health

Workforce Development / Workforce Capacity

Training, support, learning spaces, and staffing investments that build a knowledgeable, diverse, and equity-oriented public health workforce.
Source: CDC – Public Health Workforce Resources