Santa Clara County Health Equity Agenda

Qualitative Research Project Report

May 31st, 2023

Created by:

Dr. Vicky Gomez & Dr. Rachel Berkowitz

Department of Public Health and Recreation
College of Health and Human Sciences
San José State University

Prepared for the Health Equity Agenda Steering Committee

Acknowledgements

This project would not have been possible without the following individuals:

- The **Key Stakeholders** and **Community Conversation participants** who shared their time, expertise, and hope with us and with this effort in service of strengthening their communities.
- Our **undergraduate and graduate research assistants**, whose perspectives and dedication were essential to the completion of the project: Thea Marie Echevarria, Osiris Perez, Andrew Somera, Janie Thao, and Tran Tran
- Our colleagues from **Redstone Strategy Group** whose collaboration and thought partnership were invaluable: Jason Blau and Jessica Yan
- **Kris Cameron**, whose efforts to coordinate with and support us alongside the Steering Committee have been imperative.
- The **Health Equity Agenda Steering Committee member organizations** who gave us the opportunity to support this important work and whose commitment to doing right by the residents of Santa Clara County is deeply felt:
    - Santa Clara Family Health Plan
    - The Health Trust
    - Community Health Partnership
    - Black Leadership Kitchen Cabinet
    - Behavioral Health Contractors' Association
    - Working Partnerships, USA
    - County of Santa Clara, Public Health Department
- The **funders** of the important Health Equity Agenda work, including this qualitative project:
    - The Health Trust
    - Santa Clara Family Health Plan
    - County of Santa Clara
    - Assemblymember Ash Kalra

Executive Summary

Introduction

Motivated by observed inequities in COVID-19 outcomes throughout the pandemic, a Steering Committee made up government agencies, health plans and networks, and not-for-profits and community organizations, came together during the summer of 2021 to develop a Health Equity Agenda (HEA) for Santa Clara County. **Health inequities** are defined as unjust and preventable differences in health outcomes and the determinants of health.

From December 2021-April 2022, Redstone Strategy Group worked as a consultant for the Steering Committee to identify and prioritize existing metrics and potential interventions for the Health Equity Agenda. Redstone consultants conducted primary and secondary data collection and analysis and collaborated with the Steering Committee to develop a preliminary prioritization of inequities, metrics, and interventions/policy recommendations for a health equity index and the health equity agenda.

The HEA Qualitative Research Project began in January, 2022. We (Drs. Gomez and Berkowitz) joined the consultant team along with the Redstone Strategy Group to support the HEA Steering Committee's charge: to identify relevant Health Equity metrics and develop a Health Equity Agenda for Santa Clara County to be administered over the next 10 years.

The goal of the Qualitative Research Project is to understand what health inequities the residents of Santa Clara County prioritize and what solutions are needed in order to address these inequities. **The purpose of this report** is to present the findings from the Qualitative Research Project. The Steering Committee will use the information from this report along with their work with Redstone and their own expertise and professional endeavors to create the Health Equity Agenda, the identified Health Equity Metrics, and a strategy for implementing the Health Equity Agenda over the next 10 years.

While the primary audience for this report is the Steering Committee for the HEA, the report will be shared with interested participants and will be made public. **We hope that anyone accessing this report is able to use the findings to support ongoing efforts to address health inequities in Santa Clara County and beyond.**

Qualitative Project Methods

The Qualitative Research Project was guided by 2 questions:

> **Question 1**: What are the perspectives and priorities related to the Santa Clara County Health Equity Agenda, Menu of Metrics, and recommendations for next steps held by key stakeholders in Santa Clara County?
>
> **Question 2:** What are the experiences and priorities of Santa Clara County residents in relation to local health inequities and the Santa Clara County Health Equity Agenda?

We conducted semi-structured interviews with key stakeholders (organizational and community leaders) working with structurally marginalized communities and community conversations (focus groups) in English, Spanish, or Vietnamese with people who (a) live or stay in the County, (b) are older than 18, and (c) identify with a community that experiences structural marginalization along one or more axes of oppression.

We used a rapid codebook thematic analysis approach in order to analyze transcripts to develop themes and sub-themes related to patterns of priority health inequities, metrics, and solutions across the series of interviews and conversations.

Important limitations of this project to keep in mind are as follow:

(a) We can only speak to what was shared by those with whom we spoke. It is highly likely that important inequities and experiences from communities within the county may not be addressed based on this project's data.

(b) The themes and sub-themes that we present are based on analysis of patterns of perspectives and experiences across the dataset. While we strove to be as inclusive and thorough as possible, not all individual experiences or ideas that were shared by participants are able to be presented in this report.

Qualitative Project Participants

Between January 2022 and May 2023, we, with support from undergraduate and graduate research assistants, conducted and analyzed the transcripts from 15 semi-structured in-depth interviews with Key Stakeholders (N=16 stakeholders) throughout Santa Clara County and 24 community conversations with residents of Santa Clara County (N=258 individuals). Key Stakeholders hailed from a variety of community and governmental organizations working with diverse communities throughout the county. Across community conversation participants, a diversity of perspectives and marginalized identities were represented.

Findings: Inequities

Based on the patterns of responses we identified across the dataset as well as ongoing conversations with the Steering Committee regarding agenda priorities, we developed themes and subthemes within the following 4 domains:

- Inequities of healthcare
- Inequities of behavioral health
- Inequities of social determinants of health (SDOH) and addressing SDOH needs
- Inequities of homelessness

For each domain, we created a theme-and-sub-theme map to summarize the complexity of issues and causes related to that domain's inequities, followed by additional description and quotations across the themes and sub-themes. Table 1 presents an overview of the main themes for each domain.

Table 1: Overview of Main Themes for Each Inequities Domain

Domain	Themes
Inequities of healthcare	1. Complexity of health insurance is a barrier to accessing care, even more so for members of marginalized communities. 2. Gaps in availability of care for specific marginalized communities 3. Complexity of the healthcare system makes it difficult to navigate (without additional support), understand what is available, and ultimately access care 4. Cost of living in Santa Clara County affects access to, availability of, and affordability of care 5. Transportation is a barrier to access care 6. The system is not built for those who are not part of a dominant community to easily seek, access, or navigate it 7. Racism is fundamentally embedded within the healthcare system 8. Negative experiences with healthcare staff treatment of patients results in patients needing to self-advocate, advocate for others, and/or escalate issues to managers 9. Healthcare provider mistreatment of marginalized community members causes inequities in access to and quality of care 10. There is a lack of culturally sensitive care
Inequities of behavioral health	1. Individuals with public health insurance have difficulty access mental health care 2. There is a lack of culturally appropriate and empathetic mental health care which can address the specific realities of marginalized communities 3. There is insufficient information available about how to access mental health care 4. There are insufficient available, accessible, and affordable mental health services and substance abuse services, especially for marginalized community members 5. Stigma against mentally ill individuals and individuals experiencing substance abuse hinders access to care 6. Lack of or insufficient transportation creates barriers to accessing mental health services 7. Requirements to receive care and services can be prohibitive, particularly for the most vulnerable 8. The use of the carceral state to deal with mental health needs and substance abuse is unjust. 9. Mental health and substance abuse challenges are the result of inequities in SDOH 10. Complexity of the mental health care and substance abuse care systems makes it difficult to navigate and access

Domain	Themes
	services, particularly for those experiencing mental illness or substance abuse
Inequities of SDOH & addressing SDOH	1. Specific marginalized communities experience challenges and barriers to accessing and navigating the system of services to address SDOH needs 2. Complexity of the system for addressing SDOH needs makes it difficult to navigate (without additional support), understand what is available, and ultimately access services 3. The eligibility requirements to receive services to address SDOH needs are prohibitive (e.g. based on income, documentation status, disability status) 4. Not knowing what services are available to address SDOH needs, how to access those services, and how to navigate the system hinders use of services 5. Lack of or insufficient transportation creates barriers to accessing services to address SDOH 6. The cost of living and the cost of basic needs in Santa Clara County limits access to needed resources and leads to people having to choose between basic needs and other needs 7. Employment may be insufficient or inaccessible to afford the cost of living 8. Black or African Ancestry children are overrepresented in the child welfare system 9. There is a lack of empathetic, compassionate service providers 10. Mistreatment by providers of services to address SDOH needs hinder access to resources
Inequities of homelessness	1. Inequities of access to and experiences of healthcare (particular to unhoused individuals) 2. Inequities of access to and experiences of SDOH and addressing SDOH needs (particular to unhoused individuals) 3. Inequities of access to and experiences of mental health care and substance abuse care (particular to unhoused individuals) 4. Inequities of experiences of homelessness 5. Inequities within the shelter system

Findings: Solutions

Three proposed Redstone interventions were discussed amongst participants, and so we created theme-and-sub-theme maps and additional descriptive information and quotes related to participants' perspectives on the context, priorities, and needs for each of the three interventions. Table 2 presents an overview of the main themes for each intervention.

Table 2: Overview of main themes for 3 Redstone-prioritized interventions

Intervention	Theme
Culturally Centered Healthcare	1. Culturally appropriate, linguistically appropriate, and empathetic providers, staff & resources are needed in all healthcare settings.
P2P Support Workers	1. P2P must be trusted, passionate community members from cultural identity and/or linguistic groups they are engaging with 2. There is a need to ensure that P2P services are available across diverse organizations 3. New work should build on existing P2P programs within programs and setting which support access, resources, navigating services & systems, and providing direct services 4. There already exists support for expanding P2P programs & building systems connections across P2P programs 5. P2P workers must be well supported to safely & effectively do their jobs 6. Resources must actually be accessible and available for P2P efforts to be effective
Improving Data Infrastructure	1. Improve data infrastructure to allow for disaggregation of data to observe, understand, and address inequities 2. There should be consistent and publicly shared data collection inequities 3. Ensure that data and results from the HEA are publicly available and accessible 4. Engage with those experiencing inequities throughout data process 5. Ensure that HEA interventions are effectively evaluated

We next present needed and existing solutions discussed by participants and related to the Redstone-prioritized interventions for each inequity domain. Solutions for each inequity domain are organized along the following adapted BARHII framework [1] categories which have served as frames for reflecting on inequities, metrics, and solutions throughout the HEA development project:

- Social inequities
- Neighborhood and living conditions
- Access and behaviors
- Health outcomes

The presented solutions are not exhaustive for all possible solutions to address all the complex dimensions of the inequity domains. Rather, they represent what we learned from participants. The goal with organizing solutions in this fashion is to provide the Steering Committee with a jumping off point for solution ideas as well as grounding in existing solutions that participants noted and alignment with the Redstone-identified solutions.

Conclusion: Recommendations for Health Equity Agenda

Beyond reflection on specific inequities and solutions, participants also shared priorities and concerns related to the implementation of the Health Equity Agenda. The below seven recommendations for developing and implementing the HEA are grounded in the priorities and perspectives of participants as well as our reflections upon analyzing the rich information shared.

1. Review findings and revisit prioritized metrics and interventions.
2. Actively partner with community for all stages.
3. Build from existing assets.
4. Plan, implement, and assess across axes of oppression.
5. Use diverse modes of multilingual communication.
6. Investigate realities of specific healthcare settings.
7. Be transparent and accountable.