Advancing Community Health through Public Health Equity Positions

Theory of Change Brief

Overview

The scaling of health equity positions within California's local public health jurisdictions emerged over the past several years based on the growing recognition of structural health disparities and the urgent need to strengthen government capacity to address them. The COVID-19 pandemic exposed deep inequities in access, outcomes, and trust in public institutions-particularly among low-income communities, communities of color, immigrants, and rural populations. Supported by philanthropic and state-level investments, counties established roles such as Health Equity Officers, Coordinators, Managers and teams to serve as internal equity champions, community liaisons, and cross-sector conveners. These roles were designed to embed equity into internal operations, elevate community voice in planning and program design, and ensure that public health services and structures are more inclusive, culturally responsive, and accountable to those most impacted by inequities.

As part of a grantee-centered evaluation led by Bright Research Group and supported by the Blue Shield of California Foundation, a mixed-methods inquiry - including surveys, ripple effect mapping, focus groups, and key informant interviews - was conducted to better understand the contributions, strategies, and impacts of health equity positions within local health jurisdictions. A central goal of the evaluation was to generate insights that could inform the institutionalization and long-term impact of these roles. As the work of health equity positions and teams continues to evolve across local public health jurisdictions, a clear theory of change is beginning to emerge-one that illustrates how targeted investments in staffing, collaboration, data use, and institutional change can catalyze improvements in community health and advance enduring systems change.

This represents a point-in-time synthesis of emerging insights, given that health equity roles remain relatively new and are not yet fully institutionalized, and the structures that support them are still being built. Furthermore, the resources dedicated to health equity roles within local health jurisdictions vary greatly, with some counties employing entire teams and others employing half-time equity roles. This theory of change reflects a hypothesis in development-grounded in ripple effect mapping, focus groups, and interviews across multiple counties-that captures early signs of progress and the enabling conditions that make such progress possible. It envisions what could be achieved if these roles were sustained with the resources, authority, and longevity needed to embed equity at the center of public health governance.

It is also important to note that this work is unfolding in the midst of a shifting federal context-one in which equity is being both more explicitly named as a government function and more politically contested. Changing federal funding priorities, evolving mandates, and heightened scrutiny of equity-centered initiatives are reshaping the landscape in which local health departments must operate. As agencies adapt, this theory of change can serve as a practical and strategic tool: a shared framework for learning, for refining local and state strategies, and for stress-testing assumptions about how equity infrastructure can contribute to lasting population-level impact.

Strategies + Core Activities

Health equity positions engage in four interconnected domains of work. First, they lead community collaboration and trust-building. This includes convening cross-sector workgroups that align with CHA/CHIP priorities and elevate community-defined concerns. Health equity positions and teams create bidirectional learning environments through tools like podcasts, focus groups, and community listening sessions that foster inclusive dialogue and shared problem-solving. Their work is especially important in repairing trust between historically marginalized communities and public health institutions, requiring transparency, continuity, and culturally responsive engagement. These roles promote deeper community voice in public health planning, program design, and allocation of resources.

Second, health equity positions play a critical role in strengthening internal departmental capacity for equitable services and outcomes by influencing how decisions are made within public health departments. While the scope of influence varies depending on the type of role and its positioning within the department, these staff are positioned to influence agency direction by elevating community data, consulting on internal policies and practices, and building the internal will and capacity to act on equity commitments. Their contributions help guide decisions related to departmental priorities, resource allocation, and internal operations-often through advising leadership, facilitating equity workgroups, or embedding equity considerations into cross-departmental initiatives. In many counties, this influence has contributed to the establishment of equity-in-contracting review processes, revised hiring practices to ensure more inclusive representation, and department-wide initiatives focused on racial equity, cultural humility, and organizational learning. Acting as internal connectors, consultants, and advocates, equity staff challenge resistance, coach teams, and support alignment between everyday decisions and broader equity goals. Through these efforts, public health agencies are not only increasing their responsiveness to community needs but also deepening their commitment to using institutional power more responsibly and equitably.

Third, they use data and evidence to drive equity-aligned implementation of public health programming. Drawing from community-driven input and local health assessments, health equity positions help departments translate findings into responsive practices-such as extending clinic hours, deploying mobile services, adapting campaign messaging, or updating language access materials. Their role is to ensure that community needs and disparities data meaningfully inform decision-making at all levels, closing the gap between insight and action. This also includes ensuring that disaggregated data reaches leadership and shapes planning, communications, and service design.

Finally, while the internal capacity building work of health equity positions strengthens a department's ability to act on equity commitments through staff development, improved processes, and supportive practices, they also play a role in systems and policy change focused on embedding equity into the long-term structures that govern public health institutions. Health equity staff support this work by securing infrastructure that persists beyond individual leaders or funding cycles - for example, by developing promotoras integration frameworks, co-creating shared accountability structures with community partners, or helping to shift norms and expectations for meaningful public engagement. These deeper structural shifts support the scale, replication and sustainability of equity efforts, paving the way for more consistent, community-informed policy decisions across jurisdictions.

Outcomes

The cumulative result of these strategies unfolds across several layers of outcomes and at multiple levels. In the short term, public health departments see an increase in staff awareness and capacity; stronger relationships with community partners; more-inclusive outreach; and a greater willingness to adopt community-informed approaches. In the intermediate term, equity is increasingly embedded in daily operations; programs expand access to high-priority services; and public health departments allocate resources more equitably. Organizational cultures begin to shift toward accountability to communities, inclusion, and transparency.

Over the long term, these efforts translate into an improved scope of and pathways to services that are driven by community-driven needs; measurable improvements in health access and outcomes for historically marginalized groups; the institutionalization of equity-promoting practices; and the emergence of community-informed planning, decision-making and allocation of resources.

Inputs and Enabling Conditions that Drive Impact

The ability of health equity roles to achieve meaningful equity-centered impact depends on a set of core inputs and enabling conditions-foundational capacities that must be in place for the theory of change to unfold. These preconditions for success create the environment in which equity efforts can take root and grow. First, dedicated staffing is essential. These roles must be structurally supported and appropriately positioned to influence strategy, priorities, and practice. Structural support includes sustainable funding, formal authority, accountability mechanisms, and alignment with both internal systems and community priorities. Second, reliable and sustained funding-ideally embedded within local government budgets-is critical. Equity initiatives cannot rely solely on short-term or categorical grants. Ongoing investment ensures both the continuity of staffing and the implementation of longer-term, community-driven strategies. Third, access to a comprehensive data infrastructure is a critical input that enables informed, equity-focused decision-making. Public health departments need both quantitative data (e.g., community health indicators, social determinants metrics) and qualitative insights (e.g., community narratives, focus group findings, lived experience) to meaningfully understand and respond to disparities. Finally, strong and trusted community-serving infrastructure is vital. The presence of community-based organizations, coalitions, advisory bodies, and engaged local leaders creates the conditions for authentic partnership. Health equity positions are most effective when they can collaborate with these community partners to develop strategies, elevate priorities, and hold public systems accountable to the populations they serve.

When these prerequisites are in place-and backed by committed leadership and a political climate that values equity as a public good-public health departments are equipped to translate intention into impact and build toward enduring systems change.

Key Assumptions

This theory of change rests on several key assumptions about what makes equity-centered transformation possible within public health systems. One core assumption is that health equity positions will have access to and influence over decision-making. As previously noted, this influence in practice may vary depending on factors such as role title, placement within the organizational structure, or whether the work is carried out by an individual or a team. However, this inquiry found strong evidence that meaningful change can be driven through trusted relationships and strategic collaboration-even in the absence of formal authority-by building credibility, brokering connections, and elevating community-informed perspectives.

Additional assumptions include a long-term commitment by public health departments to investing in equity infrastructure-including sustained staffing, strong community partnerships, and systems for accountability. It is assumed that community engagement will not be transactional but instead reciprocal and rooted in shared power and the responsible use of power by influencers. Leadership is expected to champion equity, confront internal resistance, and realign departmental policies and practices accordingly.

It is also assumed that public health data systems will be designed to track progress on what matters most to communities and to guide continuous learning and improvement. Finally, the theory assumes that public health departments are willing and prepared to move upstream-to address the structural and social determinants of health, not only their downstream effects.

Health equity positions cannot do this work alone. They are catalysts for change within a broader ecosystem of committed partners, policies, and practices. When adequately supported and integrated, they serve as expanded capacity for public health systems to become more equitable, effective, trusted, and attuned to the communities they serve.

Public Health Equity Position
Theory of Change

CONTEXT

The COVID 19 pandemic and racial reckoning in 2020 shed light on structural disparities. California counties integrated health equity positions to strengthen public health systems and address long-standing inequities. Supported by state and philanthropic investments, these roles were established to embed equity in internal operations, amplify community voice, and foster more inclusive, responsive public health strategies.

STRATEGIES + ACTIVITIES	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
	↑ **trust and collaboration** between public health & CBOs	↑ **community participation** in planning, policy and design	↑ **responsible use of power** by government agencies
01 **Community Collaboration + Trust Building**	• Convene cross-sector workgroups • Facilitate bi-directional learning • Foster trust through authentic engagement • Incorporate community voice		
	↑ **staff awareness** of equity, inclusion, and cultural responsiveness	↑ **integration of equity** into policies, hiring, training, and operations	↑ **institutionalization of equity** across governance, workforce, and funding structures
02 **Strengthen Internal Capacity**	• Review and update policies • Deliver equity training and learning communities • Coach staff and align programs to equity goals • Embed equity leadership in decision-making		
	↑ **receptivity to community-driven data** in decision-making	↑ **application of disaggregated data** to guide programs and resources	↑ **health outcomes** and ↓ **disparities** among underserved populations
03 **Data-Informed Implementation**	• Use community data to guide priorities and funding • Apply feedback to adapt services • Elevate findings to leadership for action • Align outreach and implementation with data		
	↑ **early service adaptations** in response to community needs	↑ **in equitable access** to priority health services	↑ **improved service pathways** and ↑ **health equity** across race, geography, and income
04 **Systems Change in Service Access + Delivery**	• Integrate equity into plans, budgets, and mandates • Promote equitable policies for funding, hiring, and services • Institutionalize community engagement, CHWs, and language access • Strengthen lasting equity infrastructure beyond individual programs		

COMMUNITY-LEVEL IMPACTS

Improved Health Equity
Reduced disparities in care and outcomes

Stronger Community Capital
Investment in local leadership & partnerships

Restored Public Trust
Transparent, inclusive engagement

Responsive Systems
Better able to meet evolving needs and address root causes