Benton County Health Department

Health Equity Assessment + Plan

Prepared by Rede Group

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Acknowledgements

This report was produced by Rede Group on behalf of the Benton County Health Department (BCHD). Rede Group and BCHD extend our sincerest gratitude to the community partners, BCHD staff, and BCHD leadership who took the time to share their insights and experiences as part of the assessment. Furthermore, this plan could not have been created without the vision and dedication demonstrated by the Health Equity Planning Workgroup, and we acknowledge and thank BCHD leadership and staff for their commitment to championing this plan and advancing health equity in Benton County.

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Letter from Director

Dear Colleagues,

I am excited to share the Health Equity Assessment and Plan for Benton County Health Department (BCHD). The work detailed in this report reflects an important milestone in Benton County Health Department's progress toward building our capacity to effectively address health inequities in the community.

BCHD is committed to advancing health equity and I believe this work is aligned with our organizational mission, vision, and values. In addition, a deeper understanding of and focus on health equity is called for in Oregon's Statewide Public Health Modernization Framework as well as National Public Health Accreditation standards and guiding principles.

In Benton County, we know that our community's health is significantly impacted by social, environmental, and economic conditions that require attention, resources, and skills to address. We must ensure we have the organizational characteristics as well as workforce competencies to lead this work in partnership with our community.

The intent of this assessment and plan is to help BCHD identify strengths, opportunities for improvement, and department-wide priorities for building health equity capacity. It also lays out a specific plan with key strategies for addressing BCHD's capacity gaps and opportunities for improvement and next steps for implementation.

I want to acknowledge and express my deep gratitude to members of the Health Equity Planning Workgroup, who dedicated many hours as well as their passion and expertise to lead the process to develop this Health Equity Plan. I believe that our staff are an invaluable resource in moving this plan forward and look forward to continued conversations and partnership.

There is significant work ahead and I remain excited and hopeful about where this work will take our health department and ultimately how it will help elevate and advance health equity in our community.

Sincerely,
April Holland
Interim Health Department Director

Introduction

Project Overview + Approach

The purpose of this project was to support Benton County Health Department (BCHD) in its commitment to building capacity for improving equity, diversity, and inclusion in the workplace and for addressing health inequities in the communities it serves. Between November 2022 and February 2023, BCHD underwent a comprehensive organizational assessment of its skills and capacities for addressing health inequities for the purpose of identifying strengths, gaps, and opportunities for improvement.

The framework and assessment tools were adapted from the Bay Area Regional Health Inequities Initiative (BARHII) organizational self-assessment toolkit. BARHII is based on a conceptual framework that illustrates the connection between social inequalities, health, and quality of life. BARHII articulates a set of organizational characteristics and workforce competencies that are essential for a local health department's capacity to address health inequities. BARHII assessments are used to:

- Establish a baseline measure of capacity, skills, and areas for improvement to support equity focused activities;
- Inventory a set of research-based organizational and individual traits that support effective equity focused work;
- Provide information to guide strategic planning writ large; and
- Serve as an ongoing set of tools to measure progress toward goals developed through the assessment process.

Upon completion of data analysis for the assessment, a Health Equity Planning Workgroup (planning workgroup) was convened from April - June 2023 to develop a health equity plan for BCHD. The planning workgroup was composed of BCHD staff representing all divisions as well as different positions in the organizational hierarchy. Over a series of facilitated weekly meetings the planning workgroup built its knowledge of and capacity for health equity planning, reviewed and interpreted assessment findings, identified health equity capacity gaps and strengths to build on, prioritized opportunities for action, and drafted a health equity plan with priority actions and goals. The plan will be presented to BCHD senior leadership for further development and implementation will be shepherded by the BCHD Health Equity Coordinator.

This assessment and plan are specific to the health department and its four divisions: Public Health, Healthy Communities, Behavioral Health, and Developmental Diversity. The assessment and plan do not include the community health centers.

BCHD contracted with the Rede Group to conduct the assessment and planning, and facilitate an initial health equity training series.

Demographics

Benton County is one of 36 counties in Oregon and is in the Willamette Valley. Corvallis is the county seat, and there are five cities and 11 unincorporated communities in Benton County. According to the U.S. Census, the total estimated population in 2021 was 96,017 people. Additional demographic information about Benton County is provided in Table 1.

Table 1. Benton County Resident Demographics

	Benton County	Oregon	Source
Male	50%	50%	U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates
Female	50%	50%	
0-19 years old	23%	23%	
20-59	54%	52%	
60-84	21%	23%	
85+	2%	2%	
White	88%	86%	
Black/African American	2%	3%	
American Indian/Alaska Native	2%	4%	
Asian	10%	7%	
Native Hawaiian/Pacific Islander	1%	1%	
Some other race	7%	12%	
Hispanic/Latino	8%	14%	
Adults with disability	14%	15%	
Veterans	16%	13%	

Note: Race categories are not exclusive of Hispanic/Latino ethnicity.

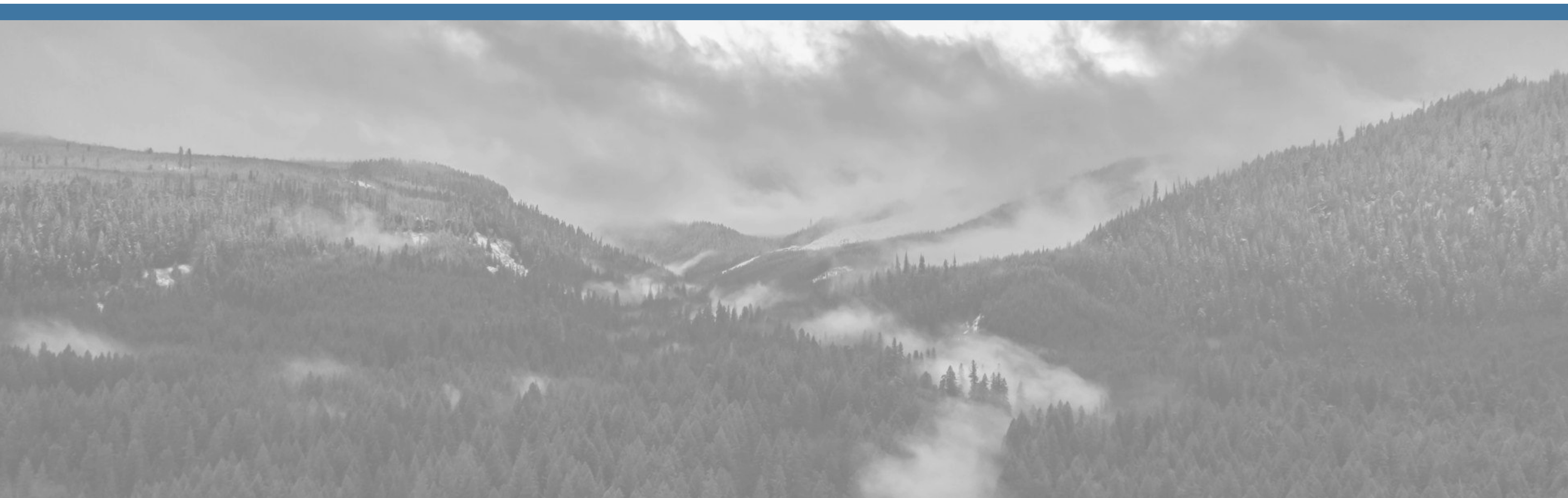
The 2021 - 2023 Benton County Affirmative Action Plan examined the number of staff employed by the county by race and sex. The number of staff by individual race/ethnicity categories were too small to report on and could contribute to identifying individual staff, but a combined staff of color category can provide an estimate of the demographic representativeness of BCHD staff (Table 2). According to this report, there were 106 total health department employees. Females are over-represented, and there is a higher percentage of staff of color employed at the health department compared to the general population of the county.

Table 2. Benton County Health Department Staff Demographics

Demographic category	Percentage of Benton County Health Department Staff	Source
Male*	25%	Benton County Affirmative Action Plan 2021 - 2023
Female*	75%	
White Staff	72%	
Staff of Color	28%	

Note: Although the plan only reported male/female sex, there are BCHD staff who identify outside the male/female binary

Health Equity Assessment



Methods + Analysis

Data Collection

Using tools adapted from the BARHII framework and toolkit, Rede conducted a survey with community partners, a survey with BCHD staff and managers, focus groups with BCHD staff, and interviews with BCHD managers (See Appendix A-E for data collection tools and materials). Figure 1 shows the response rate for each data collection method. Participants were recruited using community partner and staff lists provided by BCHD project leads. Survey data were collected using SurveyMonkey from 39 community partners and 93 employees of BCHD (staff and leadership). Interviews and focus groups were conducted virtually over Zoom with 15 management/supervisor interviews and 23 BCHD staff across four focus groups. Focus groups were broken into four affinity groups: Black, Indigenous, people of color (BIPOC); 2SLGBTQIA+; Women; and Men. We attempted to conduct two additional focus groups, one for staff with a disability and another for Spanish-speaking staff, but were unable to recruit enough participants.

Figure 1. Data collection methods and response rate by participant group

Participant groups	Survey	Interviews	Focus Groups
Community partners	39	n/a	n/a
BCHD managers/supervisors	15	15	n/a
BCHD staff (excluding managers/supervisors)	78	n/a	4 focus groups, 23 participants
Human Resources	n/a	1 informal interview	n/a

Data Analysis

Community Partner Survey and Staff Survey

Survey data was collected in SurveyMonkey and then exported to Google Sheets for analysis. Partial surveys with at least 50% of questions completed were included in each data set. The primary approach to analysis was descriptive, and subclass analysis was performed by role (staff or leadership), race/ethnicity, disability, and sexual orientation. Charts and other data visualizations were created to aid with data interpretation and highlight key findings.

Management Interviews and Staff Focus Groups

Transcription for interviews and focus groups was provided by Rev, a third-party transcription service. Transcripts were then uploaded into Dedoose and coded by multiple analysts once intercoder reliability was achieved. Coded excerpts were then analyzed for key themes and narratives, which were compiled into an internal, written preliminary analysis.

Meaning-Making and Sharing Key Findings

Once internal preliminary analyses were completed for community partner surveys, staff surveys, management interviews, and staff focus groups, the Rede project team held an internal "meaning-making" meeting. At this meeting, findings across data collection methods were shared, examined, and compared to search for themes across methods and participant groups. Key findings from this meeting were then organized into the organizational characteristics and workforce competencies of the BARHII framework.

The Rede and BCHD project team presented a high-level overview of these key findings to senior leadership to hear their reactions and reflections on what was shared by their partners and staff. We then brought an expanded version of the key findings, including all quantitative data and themes from qualitative data, to the planning workgroup meetings, where it was further analyzed over four weeks.

Limitations

Staff Survey

The staff survey was disseminated between November 29 - December 23, 2022. This can be a time of year when many people are out of the office due to the holidays, so timing may have impacted the response rate. The survey was disseminated to 170 staff, and 93 responses were included in analysis, for a response rate of 55%. Response rates varied depending on the BCHD division/area (between 44% and 83%), but the lower rates were from the divisions with a higher number of staff, so representation across division/area is satisfactory. Multiple strategies were utilized to increase participation, including sending multiple reminders, and having a drawing for all employees who completed the survey for one of three prize packages that included Benton County swag and a $20 gift card to a local coffee shop.

Partner Survey

The partner survey was disseminated between December 6 - 23, 2023. Like the staff survey, timing may have impacted the response rate for the partner survey. The survey was disseminated to 100 BCHD community partners, and 39 surveys were included in analysis, for a response rate of 39%. Multiple strategies were utilized to increase participation, including sending multiple reminders, translating the survey into Spanish, and offering a $25 gift card to a local coffee shop to anyone who completed the survey.

Subpopulation Analysis

An important part of an organizational health equity assessment is to understand how staff from different socio-demographic populations experience their work place and partnerships. Demographics were collected from staff survey and staff focus group participants in order to explore potential differences; however, with a relatively small population size to start with (170 staff), the number of staff identified from different socio-demographic groups was also small. Subpopulation analysis was conducted, but any findings related to these must be interpreted with caution due to

small sample sizes. For example, when looking at the experiences of employees of color vs. white employees, only 26% (n=24) of respondents identified as an employee of color, limiting the generalizability of the data.

Gallup Survey

A Gallup survey on staff engagement was disseminated to all Benton County employees, including BCHD staff, in late 2022, just prior to the health equity assessment staff survey. There may have been some confusion and/or survey fatigue when the staff survey was released that may have impacted participation.

Self-Selection Bias

Staff members were not required to participate in this assessment, although management encouraged participation and stated that staff could use work time to participate. The voluntary nature of this assessment may have introduced self-selection bias, as there may be differences in staff who volunteer to be involved in a health equity assessment in terms of motivation, positionality in the organization, and capacity to participate.

Health Equity Assessment Findings

Baseline assessment of current health equity capacity at BCHD

The BARHII toolkit and framework does not include a criteria for scoring an organization in how well they have integrated organizational characteristics and workforce competencies in how they operate (more details on the characteristics and competencies are included in the *Findings* section). In order to create a baseline that could be used to assess progress moving forward, findings from all data collection methods were applied to a criteria developed by the California Department of Public Health as part of an Organizational Assessment for Equity Infrastructure tool[1]. Because the criteria utilized was not

[1] Baseline Organizational Assessment for Equity Infrastructure
https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Assessment.pdf

created for BARHII, the fit is somewhat imperfect and the categorization somewhat subjective. However, it is a way to see where the opportunities are for improving how BCHD addresses health inequities and the conditions that impact health.

While the assessment did not find that any BCHD competencies currently fit into the Strong category, conversations with the planning workgroup and senior leadership indicate a deep commitment and clear vision for progressing into that category. Note that the blue text indicates Organizational Characteristics and gray text indicates Workforce Competencies.

Early		Established		Strong	
Not yet, or learning stage	Planned/intended but not started or in initial stages of implementation	Working towards this but not fully achieved	Fully achieved	In place with evidence of use (e.g., policies, procedures)	Practices are sustainable
	• Hiring to Address Inequities • Structure that Supports Community Partnerships • Support Staff to Address Inequities • Transparent and Inclusive Communication • Institutional Support for Innovation • Creative Use of Categorical Funding • Community Accessible Data and Planning • Streamlined Administrative Processes • Leadership • Community Organizing	• Institutional Commitment • Knowledge of Public Health Framework • Community Knowledge • Collaboration Skills • Problem Solving Ability • Cultural Competence & Humility	• Personal Attributes • Understand the Determinants of Health		

Health Equity Assessment Findings: Organizational Characteristics

The following organizational characteristics have been identified as strongly correlated with a local health department's ability to effectively address health inequities.

Institutional Commitment to Address Health Inequities

A health department that demonstrates an institutional commitment to address health inequities articulates this commitment in its mission and vision, has a strategic plan with goals and benchmarks for addressing inequities, and implements practices that reflect its stated commitment like inclusive decision-making and a focus on primary prevention.

In this assessment, we asked BCHD staff and managers to reflect on the agency's commitment to address health inequities. Almost all staff survey respondents (94%, n=85) felt that BCHD either already had or was moving towards a demonstrated commitment to addressing the conditions that impact health. Staff noted in focus groups that responding to recent health challenges, including the COVID-19 pandemic, had created more recognition of the impact of health inequities and a focus on communities that have been economically and socially marginalized. The hiring of bilingual and bicultural communications staff was one example lifted up by focus group participants of how BCHD had put its commitment into action and built its capacity to effectively serve communities impacted by health inequities.

> *"So our main mission is to look at those vulnerable and underserved populations and help reduce those inequalities. And throughout my work, I've always tried to look at their social determinants of health and how we can help connect people with resources and eliminate some of those barriers. And that is even more of a focus with COVID, and now as climate and health becomes a priority, is looking at those vulnerable and historically underserved populations on how we can help break down some of those barriers and improve the overall conditions." - Staff Focus Group Participant*

Managers and supervisors noted in management interviews that BCHD's mission, vision, and values reflected a commitment to addressing health inequities and also stated that BCHD at its core was committed to serving communities

that have been economically and socially marginalized. Most were not aware of whether or not BCHD's most recent strategic plan included specific goals or strategies for addressing health inequities.

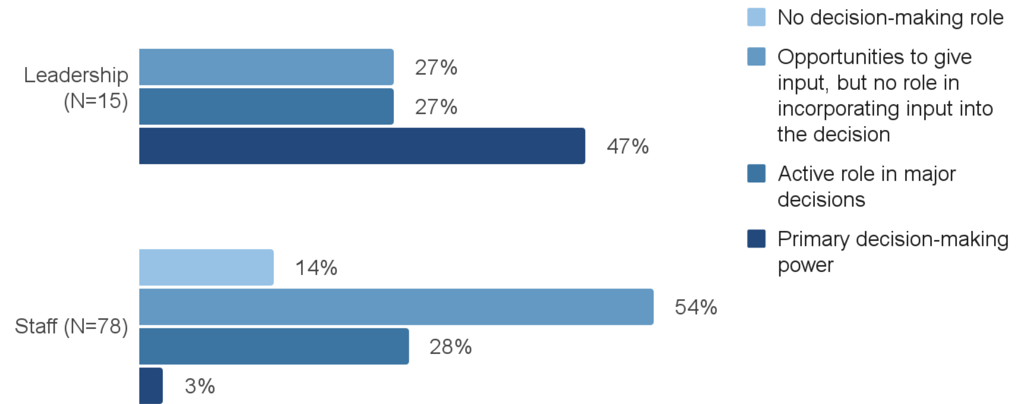
> *"We serve the underserved. That is specifically around addressing those inequities, and identifying those underserved populations and putting mechanisms and supports in place to serve them and make sure that there's no disparity in experience between those different groups." - Management Interviewee*

While most staff spoke about positive movement toward prioritizing work focused on addressing health inequities, many still noted barriers and room for improvement. Nearly half (43%, n=40) of staff survey respondents reported there was not enough of a focus at BCHD on health equity work. Focus group participants noted several systemic and institutional barriers that hinder capacity and energy directed toward addressing health inequities. Barriers mentioned included low wages, especially for direct service staff, high workloads that don't leave room for projects or learning that would enhance health equity capacity, and limited time and opportunity for collaboration across teams, across divisions, and with community partners.

> *"I have experienced just a lot of inconsistency in terms of collaboration and overlap, and willingness or welcomeness or a culture of feeling very guarded and distrustful of people from other departments that maybe you've never talked to. And a lot of these things, because we're looking at so much intersectionality, requires that kind of collaboration and shared knowledge. We cannot be siloed in this work. I've been really disappointed by how averse I feel like some departments can be versus others, or some sections versus others, to not wanting to have to collaborate." - Staff Focus Group Participant*

Staff survey respondents also noted that hierarchical decision-making impacted their ability to get involved in work focused on addressing health inequities. Staff in leadership roles at BCHD had much more decision-making power when it came to programs, units, divisions, and teams' efforts to address health inequities. While 74% (n=7) of survey respondents who were in leadership roles at BCHD felt they had an active role or were the primary decision-makers about efforts to address health inequities, only 31% (n=24) of all other staff reported that same level of decision-making power.

Figure 2: Role in making decisions that affect program, unit, division, or team's efforts to address health inequities, by role (Staff survey, N=93)



"I think a lot of times we're … meeting people in the community and people that I work with where they're at, when it comes to inequities, the fact that I do have to take it up the rung if there's an issue is really discouraging, in a way. I am very much encouraged to bring it to my supervisor's attention, very encouraged to bring it up if there is a company-wide policy that is an issue. That is what I'm very well-equipped to do and encouraged to do, but whether or not I can make policy change or take action on some of these things, I am not able to do that within my role." - Staff Focus Group Participant

Community partners also shared their perceptions of BCHD's commitment to and practices for addressing inequities. Most (79%, n=31) partner survey respondents agreed or strongly agreed that BCHD demonstrated an organizational commitment to health equity. However, many partners didn't know if or how BCHD put this commitment into action; for example, 23% (n=9) didn't know if BCHD advocated on behalf of the community, 26% (n=10) didn't know whether BCHD was responsive to community priorities, and 36% (n=14) didn't know if BCHD provided resources to community residents and partners to address health inequities.

Partners also identified room for improvement in terms of how BCHD supports community awareness, skills, and leadership; less than half of respondents (44%, n=17) agreed that BCHD built the leadership capacity of community members to address health inequities.

Hiring to Address Health Inequities

A health department that hires to address health inequities has the Human Resources (HR) capacity, policies, and practices to incorporate social justice principles, seek diversity, and reflect the populations served. Hiring must prioritize the skills and characteristics needed to effectively address health inequities in the community (see *Workforce Competencies*) and should result in diversity at all levels of the organization. HR policies and practices must also provide living wages, schedule flexibility, and continuing education.

Data on BCHD's hiring practices, staff diversity, and workforce capacity were collected through specific questions on the staff survey, in management interviews, and in staff focus groups. One important note about these findings is that HR is its own county department and most of the HR policies and practices explored in this assessment are outside the control and often influence of BCHD leadership.

Staff who participated in focus groups noted the importance of having a workforce that reflects the diversity of the county and community served.

> *"I think somebody who's part of a community can see what's going on differently than someone who's not part of that community. So having a coordinator like me... people tell me different things. They engage with the health system in a different way than they do with maybe somebody who's not part of that community." - Staff Focus Group Participant*

Many managers noted that BCHD has been trying to expand the recruitment pool and hire more diverse staff.

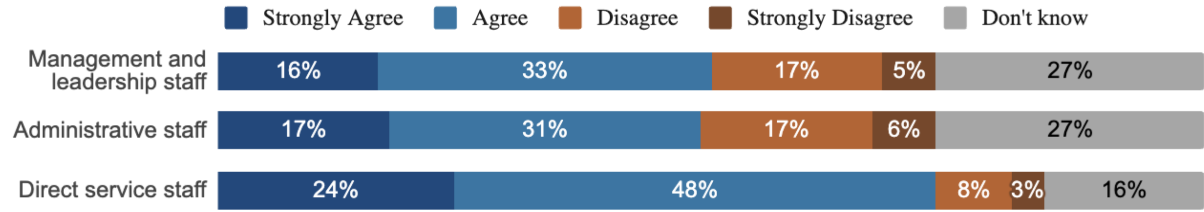
“We try to be unbiased in the way that we approach looking through applications and resumes. Then while we're interviewing, we're always looking for different types of diversity because we want to be reflective of the patient population we're serving. I think that we have been trying to hire more diverse candidates.” - Management Interviewee

A few focus group participants echoed this observation about BCHD being more conscious of hiring to address health inequities. However, the majority noted that efforts to hire staff who reflect the populations served and who have strong health equity skills have been minimal, and a few focus group participants shared about discrimination they’ve observed in hiring processes.

“I've seen definitely a shift in the amount of diversity in probably the last year and a half on our team. More people of color, more people with different gender identities. Just really just an increase in that, which I think has been really incredible. And then at the end of the day, it's still such a small percentage of people. And I know we can only make so many changes happen so fast and recruit in certain ways and it's such a big systemic issue, but it has been really nice to see an increase of diversity around here in some ways. There's still a lot of work to be done, like a lot, a lot of work to be done, but I have seen a nice shift. So it seems like something is working somewhere down the line, but I'd love to see that working three or four times harder at the much higher level.” - Staff Focus Group Participant

“Why are we not able to recruit, and why do we screen people out when there might be a chance that they are of a different background? We are discriminatory, 100%." - Staff Focus Group Participant

Staff survey respondents indicated that BCHD puts more effort into recruiting culturally diverse staff into direct service roles. Fewer than half of survey respondents agreed or strongly agreed that BCHD recruits culturally diverse staff into management, leadership, and administrative positions.



A top HR barrier noted by staff and managers included restrictions and inflexibility in setting minimum qualifications and screening candidates, noting that these processes overvalue education and undervalue experience as well as the personal attributes that are critical to effectively work to address health inequities. Focus group participants also identified low wages and limited flexibility in working locations and schedules as added barriers, noting that staff at lower levels of the agency hierarchy were more likely to experience these challenges.

> *"I think we do could do a better job of examining our minimum qualifications as well and valuing different kinds of experience, different kinds of education, different kinds of lived experience more than our county human resource model currently allows for." - Management Interviewee*

> *"I think if you look at our workforce, I mean, the low wage jobs are largely people of color and the high wage leadership positions are mostly white people, cisgendered white people even. And the structure itself perpetuates inequities." - Management Interviewee*

> *"Yeah, I've kind of begun to wonder about the job requirements when you look at what you're hired for and you have to have all these requirements plus a nice personality and easy to work with and collaborative. And then you're paying me $13 an hour, really?" - Staff Focus Group Participant*

Staff and managers also noted that the county requires management/supervisory experience in order for staff to be eligible for promotions, which is extremely difficult to acquire while working in a lower position at BCHD. This means staff often

have to leave the county for another job to gain the experience needed to then be eligible for a higher position at BCHD. While there are limited opportunities to gain supervisory experience (e.g., participating in county-sponsored leadership/management courses, serving in an underfill position for a short duration, working out of class), these opportunities were not equally accessible to staff. Barriers to promoting staff have resulted in less diversity among higher positions in the agency.

> *"There doesn't seem to be a lot of encouragement to move up in terms of positions for, I know lots of CSRs [client service representatives] who have moved into the health navigation position and then have had to quit to find a better paying opportunity because even if when they applied for other positions, they were consistently denied it... There doesn't seem to be a push to, 'oh yeah, we have the resource here. Hey, you, you and you who are really great at your job, who have trust in the community, who people come to you, how would you like to move up and be better trained to continue to work with us?' I don't really see that push." - Staff Focus Group Participant*

> *"And another thing, for example, we don't have a lot of diversity in our leadership team." - Management Interviewee*

Structure that Supports True Community Partnerships

A health department that is structured to authentically support community partnerships makes partners feel welcome and supported in health department processes (e.g. strategic planning) and implements strategies that build the capacity of partners to address health inequities.

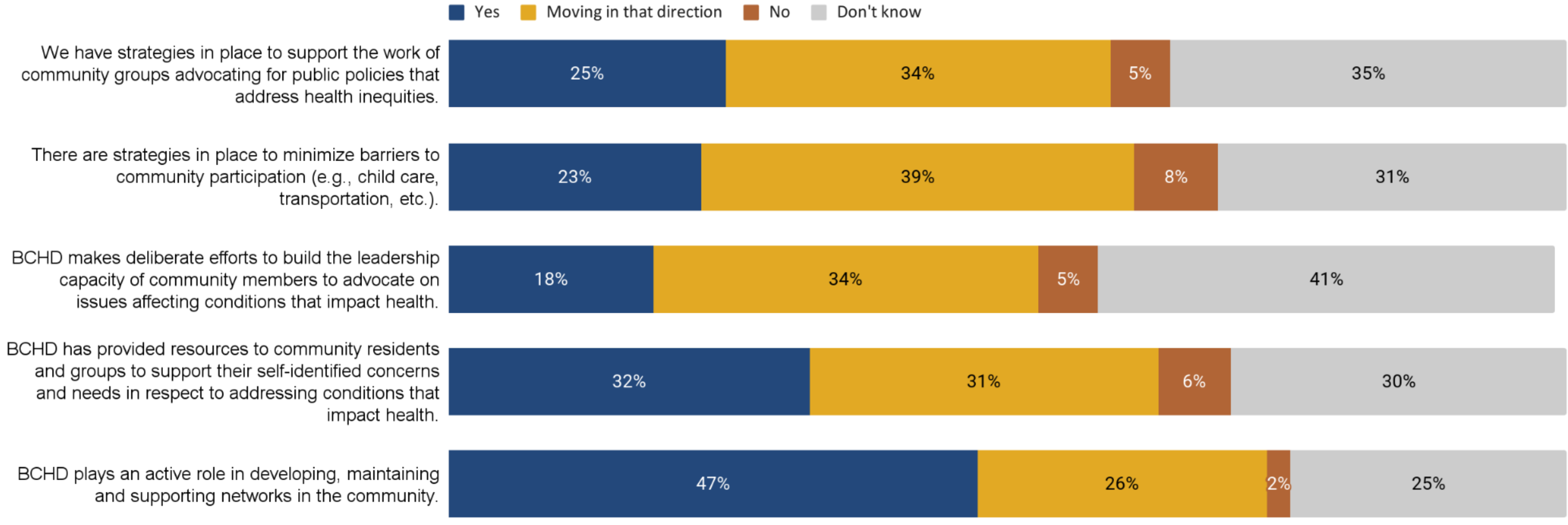
In this assessment, we asked BCHD staff, managers, and partners to reflect on BCHD's policies and practices concerning partnerships. Specifically, community partners were asked to reflect on their involvement in BCHD processes, thinking about their level of engagement and whether these processes have felt truly accessible to them. Staff and managers were also asked about their current and past work with community partners, and the success and challenges they've experienced while working to strengthen these connections.

During focus groups, we heard from BCHD staff that they understood and appreciated that community partnerships were essential to their health equity work, and many desired more opportunities to engage with partners.

“I think working with community groups, having voices be part of our decision-making is really key to what we do… And I think that we do a lot of work, months of work, really, strategizing ‘how do we best work with community partners? How do we really incorporate voices from the community?’ … overall I would say we do … a really good job of it. And that's not to say that there isn't a lot more that we could be doing, and I think we're just always trying to get better in that realm.” - Staff Focus Group Participant

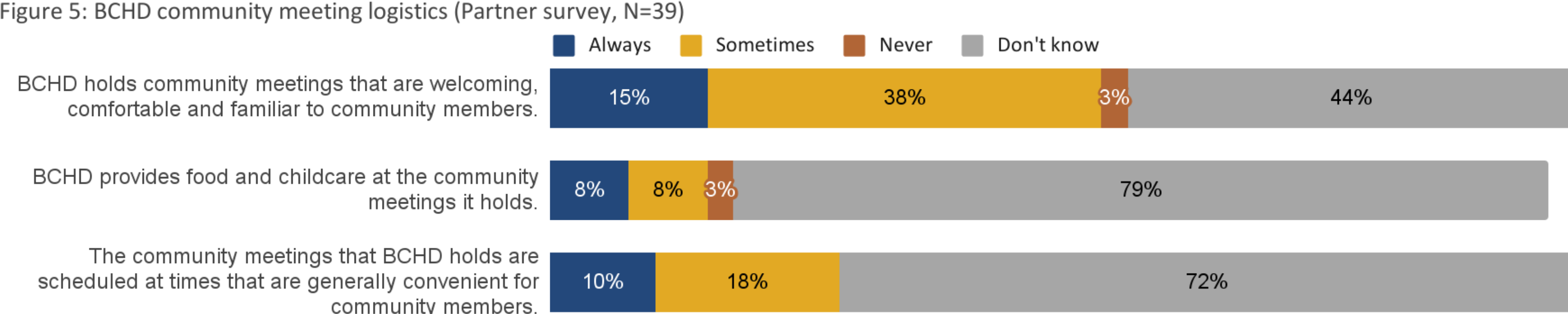
Both staff and managers noted that certain teams or divisions within BCHD tended to lead the work with partners (e.g. Healthy Communities), and others lacked information about BCHD’s partners and partnership practices and felt that developing and supporting community partnerships was not a part of their role. As shown in Figure 4, a majority of respondents (73%, n=68) agreed that BCHD played an active role in developing, maintaining, and supporting networks in the community (47%, n=44), or was moving in that direction (26%, n=24). Only 18% of respondents (n=17) said that BCHD made deliberate efforts to build the leadership capacity of community members, and 34% (n=32) said BCHD was moving in that direction. Approximately a third of respondents replied “Don’t know” to all five questions.

Figure 4: Strategies in place to support community efforts to address health inequities (Staff survey, N=93)



In the community partner survey, a majority of partners (85%, n=33) agreed that their work with BCHD addressed health equity and many reported collaborating with BCHD on a range of issues including food security, affordable housing, community safety and violence prevention, racial justice, and community economic development. Still, 79% (n=31) said they did not know if BCHD provided food and childcare at meetings, 72% (n=28) said they did not know if community meetings were scheduled at times that were convenient for community members, and 44% (n=17) did not know if BCHD held community meetings that were welcoming, comfortable, and familiar to community members (see Figure 5).

Figure 5: BCHD community meeting logistics (Partner survey, N=39)



> *"With certain departments, such as public health, partnerships have been great, very supportive. Ability to access staff for assistance with planning and resource distribution, also have played a key role in street outreach. Most recently funding has been important." - Partner Survey Respondent*

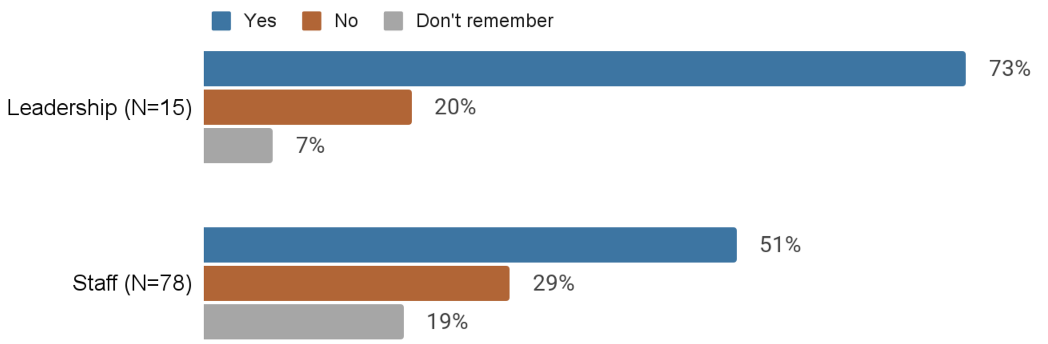
Overall, BCHD staff and managers agreed that more could be done to engage community partners, and there was a desire to explore supports including childcare for meetings and stipends for partners. In meetings, members of the planning workgroup highlighted a lack of department-wide policies and standards for working with community partners, which potentially created conflicting experiences for partners working with different departments/divisions.

Support Staff to Address Health Inequities

To effectively address health inequities, staff need continuous education and training, mentorship, supervision, and support from leadership.

In a survey of BCHD staff and leadership, about half (55%, n=51) of respondents reported that they had received training on the different ways BCHD can address the conditions that impact health. Nearly three-quarters (73%, n=11) of respondents in management and leadership positions have received this type of training, while about half (51%, n=40) of staff reported receiving this training.

Figure 6: Staff who have received training about the different ways BCHD can address the conditions that impact health (Staff survey, N=93)



In focus groups, BCHD staff said that the current required equity trainings were too high-level and not that helpful in building practical skills relevant to various roles, and other learning opportunities (such as conferences) were not accessible or effectively promoted to staff. In addition to these internal and external trainings, staff reported providing mentorship and coaching to each other. In the survey, 67% (n=16) of BCHD staff of color said that they had provided mentoring or coaching to other staff to support them in addressing health inequities either informally or as part of their job compared to 50% (n=29) of white employees (Figure 7). As shown in Figure 8, 56% (n=10) of BCHD staff who identified as lesbian, gay, bisexual/pansexual, or queer also said that they had provided this type of mentorship informally or as part of their job, compared to 53% (n=34) of heterosexual staff. It should be noted that most of this coaching (42% for employees of color, 50% for sexual minority staff) was provided informally, outside of required job duties.

Figure 7: Respondent has provided mentoring or coaching to other staff to support them in addressing health inequities, by race/ethnicity (Staff survey, N=83)

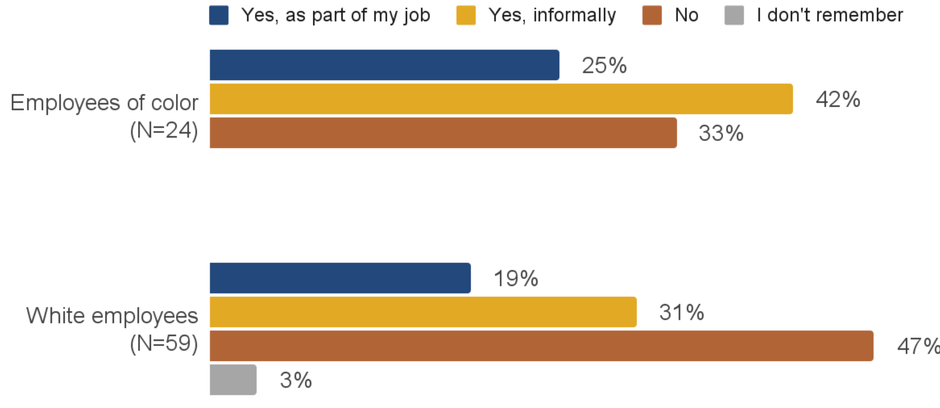
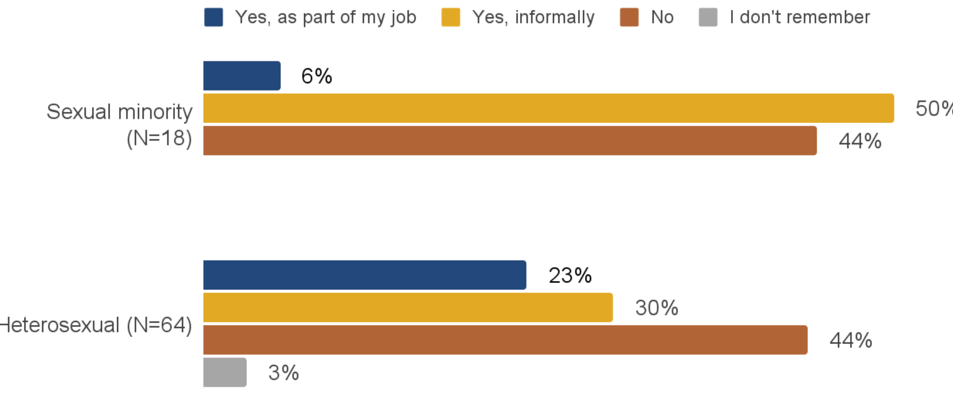


Figure 8: Respondent has provided mentoring or coaching to other staff to support them in addressing health inequities, by sexual orientation (Staff survey, N=82)



In focus groups, staff reported that they generally felt a lot of support from their managers to address health inequities in their work. As discussed in *Institutional Support for Innovation*, the majority of staff survey respondents (87%, n=81) reported that they had opportunities to talk with their supervisor(s) about the impact of their work addressing health inequities, and 78% (n=73) said their program, unit, division, and/or team engaged in group discussions about how their work addresses health inequities.

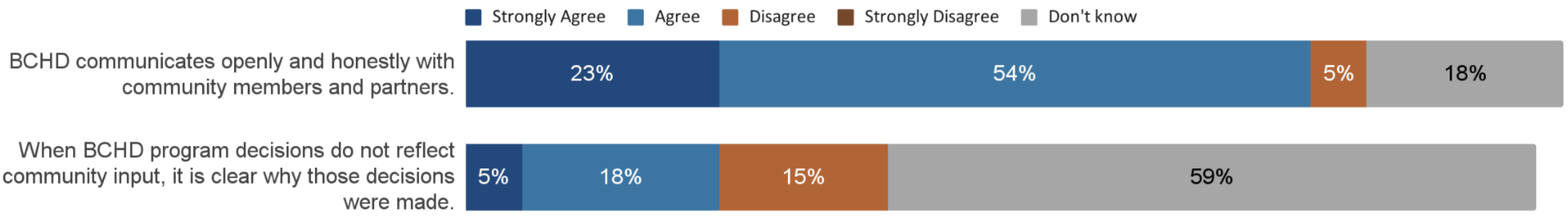
Lastly, some staff felt that health equity work gets deprioritized, especially for programs that are held to statutory and funding requirements that take higher priority. However, staff also noted that the addition of a full-time health equity coordinator position and the recruitment of more Spanish-speaking communications staff demonstrated a growing commitment to building health equity capacity.

Transparent and Inclusive Communication

This competency has four components: transparent communication, multi-directional communication, solicitation and use of community input, and sharing decision making with community partners. A local health department can be more effective in its work to address health inequities by engaging as many invested parties as possible in its efforts. This engagement helps to ensure that the needs and experiences of the groups and individuals that serve, and are served by, the department are met. Input from impacted communities supports departments in providing services that are reflective, effective, and beneficial for the communities it interacts with. Furthermore, open, consistent, and clear communication with interested parties showcases an organization's intentionality and transparency in engagement of their health equity efforts.

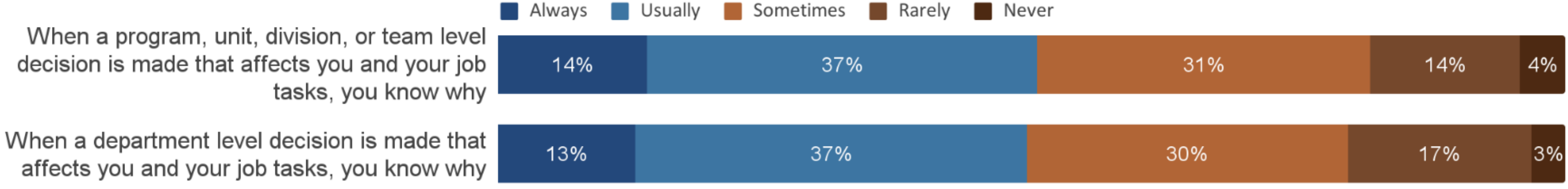
In this assessment, partners, staff, and management were asked how well BCHD performed in alignment with the spirit of transparent and inclusive communication. Partners reported that while they were not always clear on *why* BCHD program decisions were made (59%, n=23), they agreed that BCHD communicated openly and honestly with community members and partners *about* the decisions that were made (77%, n=30), especially in regards to social media (Figure 9).

“That's one of the areas I think that they do a pretty good job about, and that is social media, inviting stakeholders, more social media, reaching out to individuals who they think might want to or need to provide input.” - Management Interviewee



The majority of staff (57%, n=53) agreed or strongly agreed that part of their job was to bring the community's voice into the BCHD decision-making processes. It is notable that this organizational attribute aligns with the individual characteristics that support the advancement of health equity, according to BARHII (see *Personal Attributes* section). When asked about internal decision-making at the department, division, and team levels, only about half of staff reflected that they knew why decisions that impacted them and their job tasks were made (Figure 10). Staff also reported uncertainty about activities such as changes in program scope and implementation, shifts in department/division/team strategic focus, the addition or removal of tasks and duties, and other communication and decision-making.

Figure 10: Transparency in decision making (Staff survey, N=93)



Finally, during management interviews, many asserted their recognition that BCHD was still hierarchical in nature; reporting that most decisions and communications started from the senior management level with limited or superficial input from other parts of the organization. This perspective highlights the awareness of management and leadership of gaps and areas of improvement, and points to the potential for buy-in moving forward.

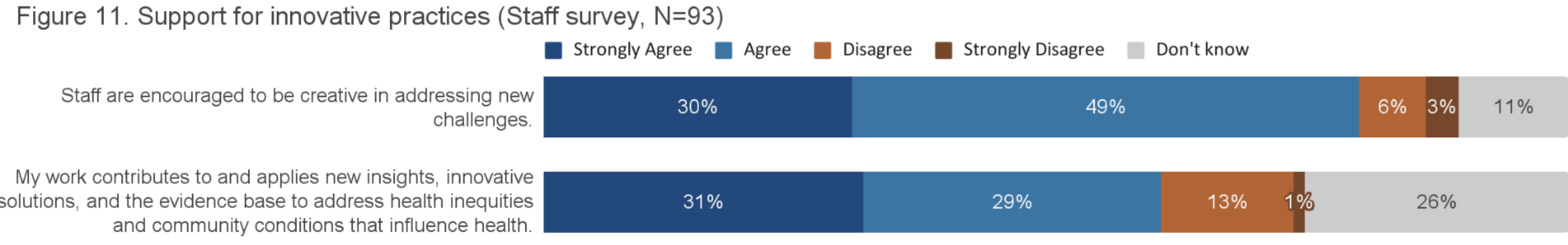
Institutional Support for Innovation

Institutional support for innovation is an important characteristic of health departments for addressing health inequities by providing the space for exploring new and creative ways to provide services and programming. Partners, staff, and managers were asked questions related to BCHDs support for innovation, including creating time for reflective thought and planning.

The majority of partner organizations who responded to the partner survey (70%, n=27) reported that BCHD did, or was working towards, adapting to community change and demonstrating creativity when working with non-health-focused community partners to address issues that are upstream drivers of health.

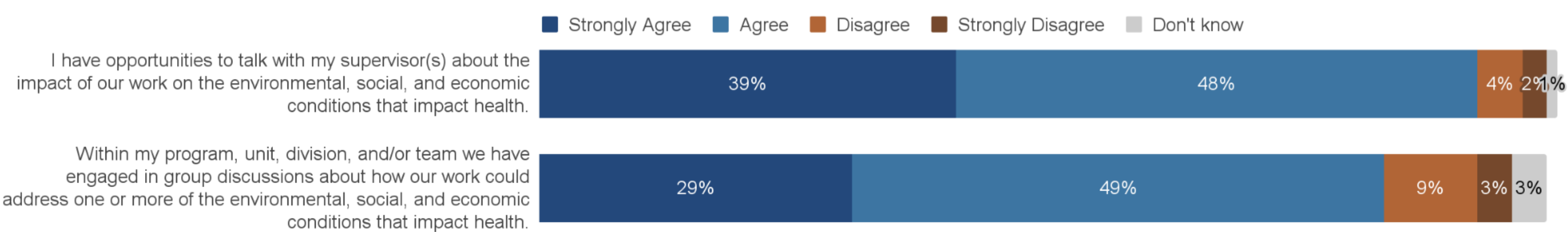
Overall, BCHD staff survey respondents agreed that they were encouraged to be creative in addressing new challenges (79%, n=74). Fewer respondents, but still over half (60%, n=56), agreed that their work contributed to and applied new insights, innovative solutions, and evidence base to address health inequities (Figure 11).

Figure 11. Support for innovative practices (Staff survey, N=93)



The staff survey also included questions related to opportunities to reflect with other staff and discuss how their work addresses the environmental, social, and economic conditions that impact health. As mentioned in *Support Staff to Address Health Inequities*, the majority of respondents agreed that they had opportunities to talk with their supervisor (87%, n=81) and their program/unit/division and/or team (78%, n=73).

Figure 12: Opportunities to discuss health equity (Staff survey, N=93)



During staff focus groups, participants were asked to reflect on how responsive leadership was when they brought forward new ideas and programs to address the root causes of health inequities. Most staff felt that they could bring ideas and suggestions to their managers. However, many staff also shared that they felt frustrated due to not seeing any changes based on their recommendations, and not receiving any communication back about the suggestions they provided.

> *"What I have experienced as an employee here is that every time I have brought something up and positioned it as an equity issue, I'm heard and my input is appreciated ... And then 90% of the time, either things are so slow to change or they don't change at all, that it just feels like I just brought it up. This is just a thing that I think might be unfair. If I don't have the immediate direct impact of being able to change it myself, it's really hard to see that there's movement in any sort of direction to alleviate it." - Staff Focus Group Participant*

During management interviews, participants were asked to share their thoughts on the culture of BCHD related to learning, growth, or change. The majority of management interviewees felt that there was a positive culture related to change. A few interviewees mentioned the use of the Idea Box, an innovative way to collect feedback from staff and the community on suggestions for change.

"We have a [county-wide] program called Idea Box, and that's where we can submit ideas for either process improvement or ideas to incentivize biking to work or whatever the idea is, and then you can publicly post that on our intranet and people can vote on whether or not that idea is pursued. I believe that there are incentives if your idea is selected." - Management Interviewee

Creative Use of Categorical Funds

Health departments need categorical funding and other funding sources that are creatively braided together to provide a continuum of resources that are stable, non siloed, and sustained over time. This kind of funding supports the innovative and collaborative work necessary to effectively address health inequities. In surveys, interviews, and focus groups, staff were asked about the availability and use of non-siloed funding.

Managers shared that BCHD has been able to acquire flexible funding to support work with community partners and clients, including carving out funding for "non-traditional supports" or setting aside "flex funding". Some managers mentioned practices like providing stipends for community members and partners to participate in BCHD-led efforts, providing food for meetings, and dedicating funding to support community coalitions, though these practices and resources seemed inconsistent across teams and divisions. Others mentioned challenges related to procurement, contracting, and other county budgeting procedures.

"We set aside money for what we call flex funding for this purpose [community engagement], because we are a government agency." - Management Interviewee

"We make sure we have carved out funds for non-traditional supports, although we run into problems with HR sometimes and our budget office around using it." - Management Interviewee

“Well, I think there are not sufficient mechanisms at the county level. We have fairly strict procurement and contracting procedures and financial policies and there's probably good reason for those to exist, but they are like a one-size-fits-all for county government set of policies. I think that the county and the health department would benefit if we could have some carve outs or exceptions to those in light of the missions that we have.” - Management Interviewee

Many (63%, n=59) staff survey respondents reported that BCHD was currently, or was moving in the direction of, providing resources to the community to support their concerns and needs for addressing the conditions that impact health.

Staff focus group participants spoke more about the challenges they faced, including their inability to purchase stipends for community partners, as well as an inability to pay for and secure child care for both community events and for direct client care.

“I don't know what we can do in terms of providing childcare during appointments, but can we hire somebody? Can that be a position? I mean, we're supposed to be about innovation in Oregon, right? Let's try something new and see how it works out, so that our female patients with children can actually be focused on their appointment during their appointment and not watching their kid and my other client. - Staff Focus Group Participant

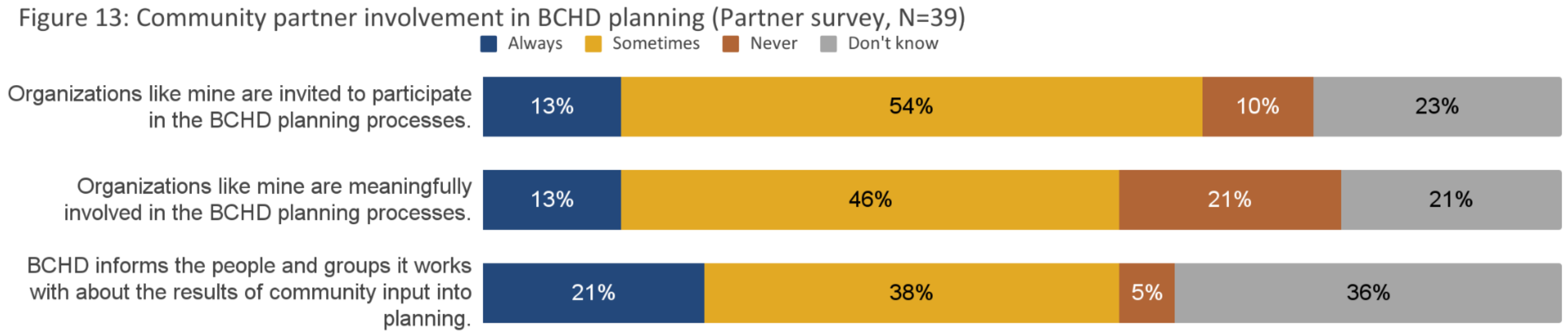
“How well-equipped am I and other staff to address health inequities? We are not. We're just not. We address health really well. Our health navigators are killing it. We do so well with health, but when we're talking about inequities, they're going to be about housing and transportation and livability and access and food. We are not equipped to address those health inequities. If we want to be equipped to address the inequities and not just the health, there have to be staff positions that include things like housing navigation, food navigation, job navigation. There has to be funding, flexible funding, to help pay for it, to help folks.” - Staff Focus Group Participant

Community Accessible Data and Planning

A health department’s approach to data collection and use as well as planning processes has a significant impact on their work to address health inequities. When data, needs assessments, and planning processes are accessible to community, partners and community members are more engaged in efforts to address inequities, leading to better outcomes.

Partner survey respondents shared their experiences and perceptions of how BCHD utilized data and engaged in assessment and planning processes. A majority (70%, n=27) of partner survey respondents said that BCHD was currently, or was moving in the direction of, sharing information and data in a way that was appropriate and accessible for the cultural, linguistic, and literacy needs of the community.

While many partners (67%, n=26) noted they were invited to participate in BCHD planning processes sometimes or always, 1 in 5 respondents (21%, n=8) said organizations like theirs were never meaningfully involved in BCHD planning, highlighting a gap between participation and intentional, meaningful involvement.



Partner survey respondents also identified that community leader participation in BCHD activities often declines throughout planning and decision-making processes. While 46% (n=18) of respondents identified that leaders from the community were invited to provide input in the beginning of a planning process, only 31% (n=12) observed that leaders were involved in decision-making for program planning and delivery. There was conflicting feedback provided by community partners when reflecting on their engagement with BCHD.

“They call us when they want something but I have not seen any invitation for input or collaboration.” - Partner Survey Respondent

“Leadership listens and is able to be influenced by our experiences and input.” - Partner Survey Respondent

Data from staff surveys and focus groups largely echo partner survey findings. A majority of staff survey respondents (74%, n=69) reported that BCHD collected and shared data in a manner that was appropriate for the cultural, linguistic, and literacy needs of the community.

Staff focus group participants and management interviewees noted success in gathering community input as part of assessment processes, though the extent of those efforts were dependent on division and team capacity and resources. There were also challenges with gathering input from communities that have been historically economically and socially marginalized who may not be as willing to engage with the county.

“So that means you're getting information from people who want to share it, and so that's a biased sample. I mean, we're glad to have that input, but if you're not including different entities in the community, maybe even try to reach some of the most marginalized in the community, then that community health improvement plan may not be representative of the entire county.” - Management Interviewee

Staff also recognized the opportunity for more community leadership and ownership of data and planning, and identified that effectively supporting community partners to lead work will require more skills and resources within BCHD for facilitating community partnership and community capacity-building.

“So I really think while we try to reach out and get opinions and comments from our community partners, I think we have a long ways to go. Being able to get that outreach and trying to be more inclusive of having them become partners in our planning and really getting that buy-in. And eventually it would be great to have our community partners be the main planners and development of these and that we are there to support them. At this point, we are doing the planning, we are doing the work and just sort of on the side involving our community groups to be able to get their input. I'd like to be able to raise it up to that next level where we start building the capabilities of our community partners so they can do a lot more of the work and we can support them.” - Staff Focus Group Participant

“We have a lot of issues of ‘how do we help foster that involvement and empower our community partners to actually take that next step up. Once we do get them involved, how do we keep that growing?’ And so I think we're really much at the bottom step and we're working on trying to get that engagement from our community partners, but I think once we get there, we need to keep building.” - Staff Focus Group Participant

Streamlined Administrative Processes

Findings related to the organizational characteristic of streamlined administrative processes overlap significantly with findings about BCHD's creative use of categorical funding (see *Creative Use of Categorical Funding* section).

The BARHII framework defines processes as “streamlined” when they are flexible and promote use. Reflecting on past experiences with BCHD’s administrative processes and policies, particularly in relation to engaging community members and partners, assessment participants and members of the planning workgroup highlighted a lack of specificity and consistency as a barrier to effective implementation. For example, staff focus group participants, management interviewees, and members of the planning workgroup all shared different experiences offering childcare and/or reimbursements for community meetings.

"And it's very difficult to really get the involvement from our community partners when they're struggling... I know some people have worked on trying to reimburse them for their time having gift cards or others to say, but to be able to have the voices heard, we need to figure out daycare, we need to figure out reimbursing..." - Staff Focus Group Participant

"We just have a lot of bureaucratic steps that we have had to overcome in the past, and many times it's just, we've been not allowed. We have not been allowed to provide for childcare, or yeah, so we've had to be creative. At one point in my time in Benton County, we were allowed to do gift cards, and then there were barriers regarding the IRS, which I completely understand. I'm not disagreeing - a $600 limit for a stipend, it becomes taxable income. I get that, but sometimes you just need to be able to be creative so we can make sure that we have inclusive and meaningful engagements." - Management Interviewee

In meetings with the planning workgroup, members found that their experiences using administrative processes at BCHD differed from others' on the workgroup, and concluded that administrative processes and policies need to be more specific so that all staff and leadership are accountable in the same ways. Additionally, planning workgroup members stressed that information and resources that already exist need to be more clearly communicated and accessible to all staff going forward.

Health Equity Assessment Findings: Workforce Competencies

Workforce competencies are the skills and abilities needed by local health department staff to effectively address health inequities.

Personal Attributes

Creators of the BARHII tool identified a set of individual characteristics that often show up in those who are most effective in their work to address health inequities. Along with the other skills and abilities outlined this section, health department staff should also be:

- life-long learners,

- self reflective,
- representative of the community they serve,
- passionate,
- creative and innovative,
- persevering, and an
- active listener.

In focus groups, staff added that, in their experience, collaboration, cultural responsiveness, lived experience, and a trauma-informed approach were important skills for addressing health inequities. Overall, staff reported they felt supported by their team and leadership to embrace and develop these attributes.

> *"And just in terms of feeling personally equipped ... I felt really supported in just that continual learning journey as somebody who identifies as ... fitting most of all kinds of pieces, dominant stereotypes. I don't know, it's just a constant for me, just understanding what the inequities are and then understanding other peoples' lived experience. And I think that as an organization, they've really supported my growth, I would say in that way." - Staff Focus Group Participant*

The vast majority of partners (92%, n=36) agreed or strongly agreed that BCHD staff they worked with demonstrate a commitment to health equity. BCHD staff also agreed that they had many of these characteristics and saw them in their colleagues, especially passion, commitment, humility, and lived experience. Almost all staff respondents (95%, n=88) agreed or strongly agreed that they have taken steps to enhance their own cultural humility, competence, and/or understanding (e.g., through trainings, self-reflection, personal relationships).

As shown in Table 2 in the Demographics section, the diversity of Benton County staff was somewhat reflective of the community served by BCHD. However, interviewees and focus group participants reflected that adjustments to recruitment, hiring, and promotion processes could improve this representation. Management interviewees also highlighted a desire to increase cultural humility among staff and leadership, leveraging flexibility within BCHD and the 'learner's mindset' that staff

bring to their work in order to continue to support staff in developing and nurturing these attributes that are so critical to addressing health inequities.

> *"I haven't had a workplace in my career previously that had as much support as I see here, as much latitude for leaders to give latitude to managers to provide opportunities for staff. I feel that development is as important as the accountability piece for work conducted. Without a balance of continuous learning and growth, you're not likely to see enough work or a different trajectory of the work being completed." - Management Interviewee*

Knowledge of Public Health Framework

Knowledge of the public health framework is another pillar of workforce competency. Competency in this area requires: preparation of program plans, understanding and use of data, applying a systems approach to everyday work, an understanding of public health core functions and services, conducting evaluations and assessments, and community organizing.

During staff focus groups, staff noted that they felt they were involved in community health assessments and developing community health improvement plans. More specifically, based on staff survey responses, 71% (n=66) agreed or strongly agreed that their work was a link for underserved populations to access services, and 60% (n=56) agreed or strongly agreed that their work played a role in evaluation of health services provided to particular populations (see Figure 14).

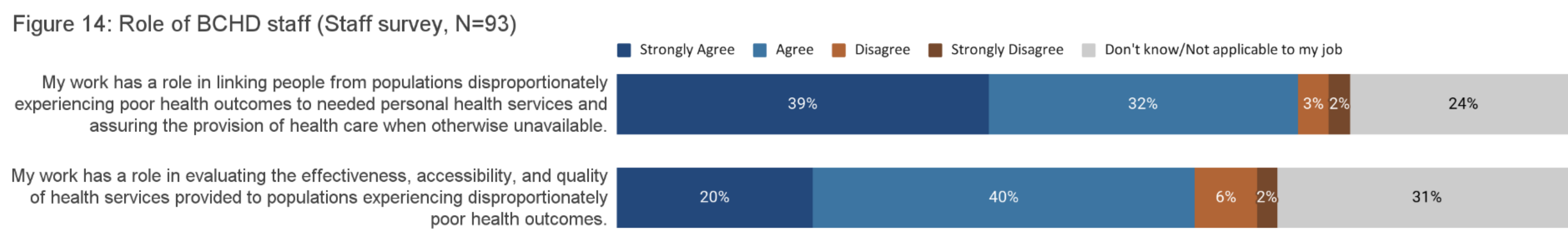
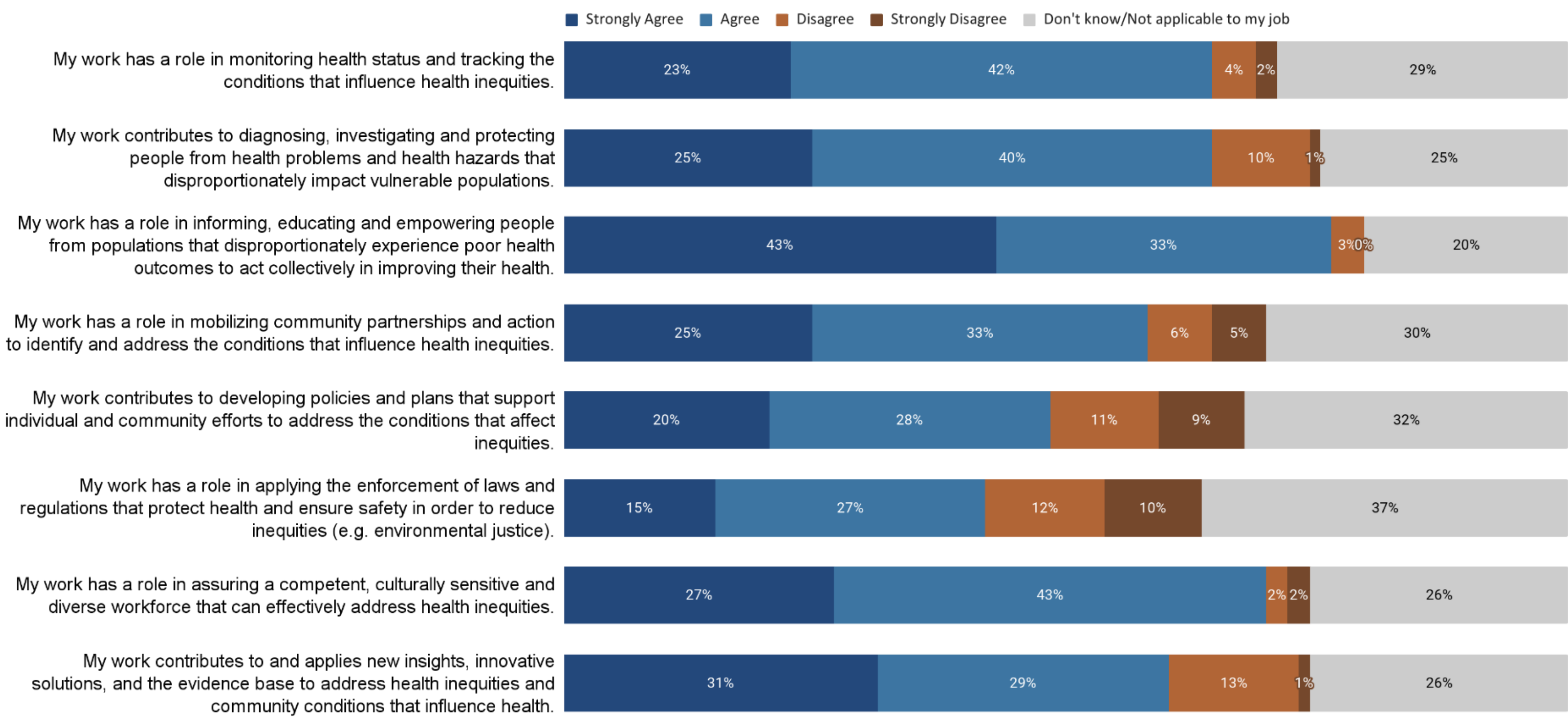


Figure 14: Role of BCHD staff (Staff survey, N=93)

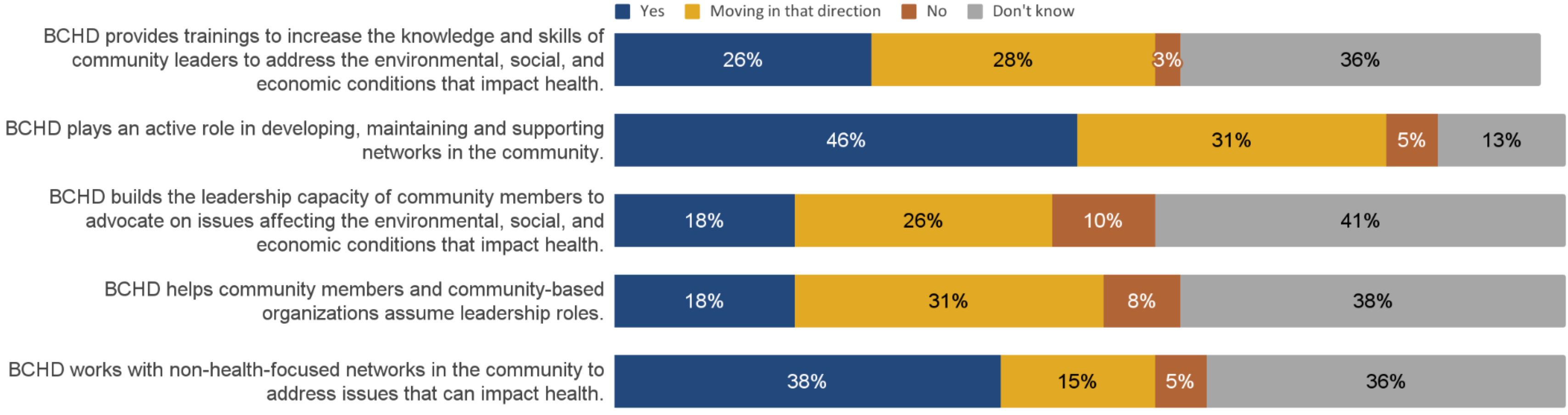
Additional core public health functions related to addressing health equity that are a part of the public health framework were also assessed in the staff survey (Figure 15). Depending on the public health function, between one fifth and one third of respondents reported that it was not applicable to their job to provide it or they did not know. The public health function with the highest percentage of survey respondents who agreed or strongly agreed it was part of their role was informing, educating, and empowering people to act collectively to improve their health (76%, n=71). The function with the fewest percentage of respondents who agreed or strongly agreed it was part of their role was applying the enforcement of laws and regulations that protect health (42%, n=39).

Figure 15: Core public health functions to address health inequities (Staff survey, N=93)



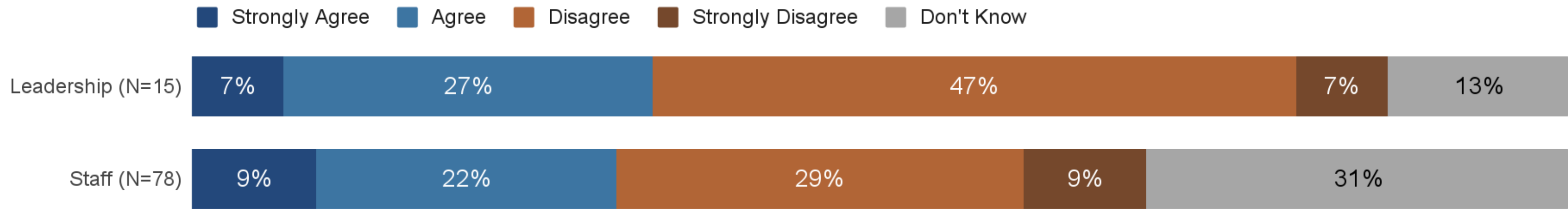
Community partner survey respondents were also asked to reflect on how well BCHD conducts core public health functions to address health inequities (Figure 16). The majority of partner survey respondents (77%, n=30) reported that BCHD was currently or was moving in the direction of playing an active role in developing, maintaining, and supporting networks in the community. The area reported for the most improvement for BCHD was to build the leadership capacity of community members to advocate on issues affecting health, with about half of respondents reporting that BCHD was currently or was moving in that direction (44%, n=17), and 10% (n=4) who said that BCHD was not doing this.

Figure 16: BCHDs role in building community capacity to address health inequities (Partner survey, N=39)



When asked on the staff survey about their ability to resolve conflict between the priorities of a community and the priorities of BCHD, less than 35% of both staff and leadership reported they were equipped to resolve said conflict. Over half of leadership respondents said that they disagreed or strongly disagreed that they knew how to resolve conflict (Figure 17).

Figure 17: Knowledge of how to resolve conflict when BCHD's priorities don't match the priorities of community (Staff survey, N=93)



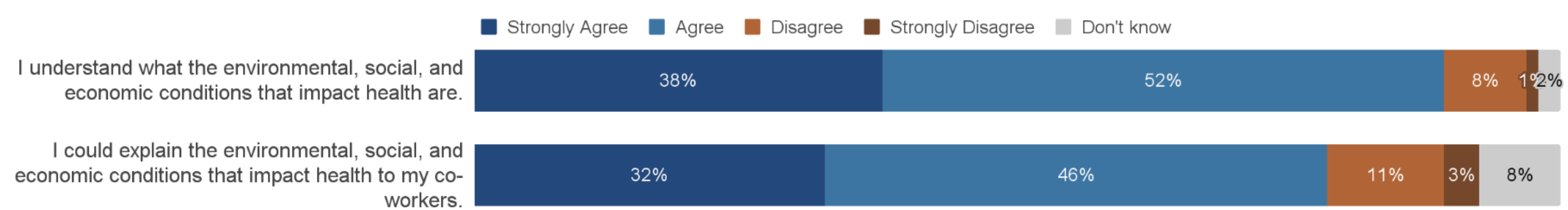
Understand the Social, Environmental, and Structural Determinants of Health

The workforce competency of understanding the social, environmental, and structural determinants of health is the first step to taking action to address those issues. This competency includes understanding and applying social justice principles, understanding the underlying causes of health inequities, and understanding the connections between race, class, gender, and health.

> *“I think that a lot of health inequities exist because voices were selectively excluded from a lot of processes that established both health and government policies that a lot of us are now working under. And I feel like it is incumbent upon us to make that extra effort to go back to make sure that that is being rectified by reaching out and including and addressing those health inequities. And it also feels like a lot of the populations that we're serving specifically are people who are also experiencing oftentimes generational health inequities, which even doubly so, I think, means that we need to be very aware of that.” - Staff Focus Group Participant*

The majority of staff survey respondents (89%, n=83) agreed or strongly agreed that they understood what the environmental, social, and economic conditions that impact health are, and many respondents also felt they could explain these drivers of health to their co-workers (78%, n=73).

Figure 18: BCHD staff knowledge of the conditions that impact health (Staff survey, N=93)



Focus group participants were unanimous that health equity was a central component of their work. The specific reasons they thought equity was important varied slightly, as some felt that addressing health inequities was the central role of government and public health, and others talked more about how the majority of people they serve were experiencing

health inequities, so it would simply be impossible not to consider. At the core of all of these responses was a clear drive and commitment to address health inequities among BCHD staff.

> *"Why should we concern ourselves with health inequities? How could we not? That's our job, to address people's health and the inequities in their health. And a lot of that is tied to those structural, systemic, historic inequities, usually based on race, the culture of poverty, gender, whole bunch of other things, disability, the intersection of all those together. I would flip that question and say how could we not make health inequities a concern of our department?" - Staff Focus Group Participant*

Staff survey respondents and community partner survey respondents were asked what the most important environmental, social, and economic conditions that impact health among the populations that BCHD serves were. Many of the same issues were identified by both staff and partners, as seen in Table 3. Housing was the top issue identified by both groups, and poverty and access to health care (including dental care, behavioral health care, etc.) were the second and third issues, although in opposite order for the two informant groups. Racism was the fourth issue reported by partner survey respondents, and was the fifth issue reported by staff survey respondents. Responses being similar between these two groups indicates that BCHD staff had an understanding of the social, environmental, and structural determinants of health that impacted the community.

Affordable Housing

Poverty

Access to health care

Table 3: Top 5 environmental, social, and economic conditions that impact health

Staff Survey Respondents (N=93)	Partner Survey Respondents (N=39)
1. Houselessness/affordable housing (63%, n=59)	**1.** Houselessness/affordable housing (31%, n=12)
2. Poverty (31%, n=29)	**2.** Access to health care (26%, n=10)
3. Access to health care (26%, n=24)	**3.** Poverty (21%, n=8)
4. Access to food (23%, n=21)	**4.** Racism (15%, n=6)
5. Jobs with livable wage (16%, n=15)	**5.** Limited providers (8%, n=3)
Racism/discrimination (16%, n=15)	Language access (8%, n=3)
Social support/community (16%, n=15)	

Another aspect of understanding the social, environmental, and structural determinants of health includes being able to talk with management and co-workers about those issues. As displayed in Figures 19 and 20, staff survey respondents felt that both management and staff they interacted with at BCHD were comfortable talking about many socio-demographic variables and the impacts of discrimination or oppression based on those socio-demographics.

Figure 19: Management at BCHD are comfortable talking about the following topics (Staff survey, N=93)

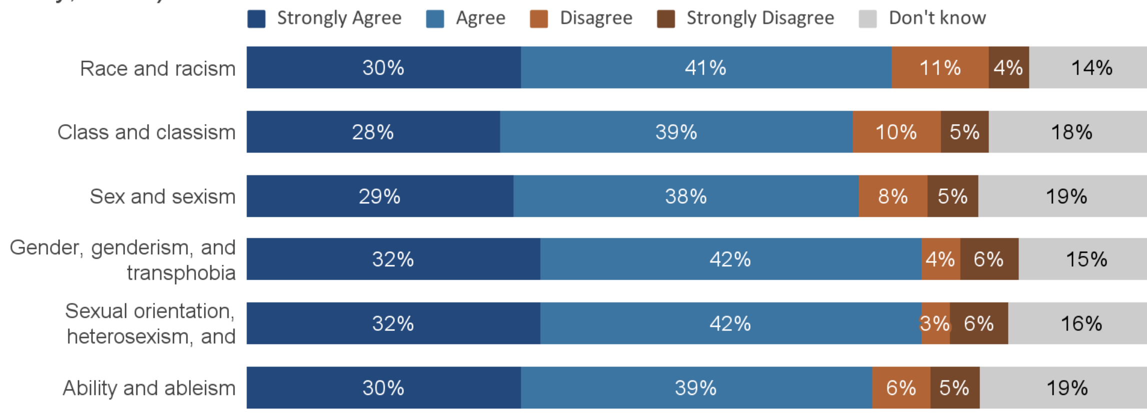
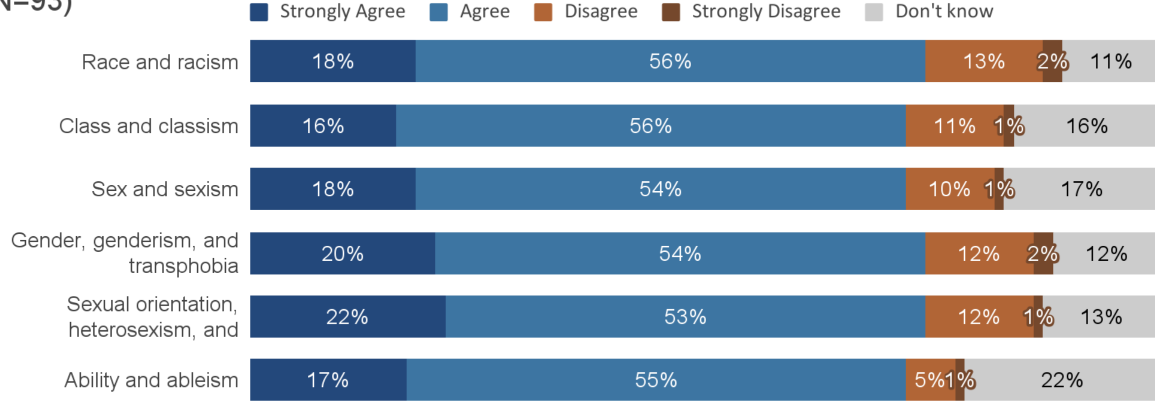


Figure 20: Staff at BCHD are comfortable talking about the following topics (Staff survey, N=93)



When examining staff survey responses on comfort with discussing socio-demographic topics based on role, race/ethnicity, and sexual orientation, there were some differences based on the topic being discussed. Respondents in leadership positions (80%, n=12) were more likely to respond in the affirmative that other management they interacted with were comfortable talking about sex and sexism when compared to all other staff respondents (65%, n=50), as well as being comfortable talking about sexual orientation, heterosexism, and homophobia (87%, n=13 of management compared to 72%, n=56 of all other staff). Although a higher percentage of employees of color agreed that management they interacted with were comfortable discussing race and racism compared to white employees (75%, n=18 vs. 68%, n=51), a higher percentage also disagreed (21%, n=5 vs. 14%, n=8). Staff who identified as a sexual minority were more likely than staff who identified as heterosexual to disagree that management they interacted with were comfortable discussing gender, genderism, and transphobia (28%, n=5 vs. 8%, n=5), as well as sexual orientation, heterosexism, and homophobia (22%, n=4 vs. 8%, n=5).

During focus groups, staff reported that conversations about different types of diversity, including racism, sexism, and ableism, took place at the team level and were less meaningful or even missing at the department level.

> *"I think on the team that I'm part of, I think they go really well.... There's a lot of humility and I think it's, again, a lot about the individuals themselves and that I think there's kind of a core group of folks that have been here for a long time and it's sort of a culture thing within our team. And I think people are able to call each other out and have real personal conversations about things. But I think to me, that's more about some of the specific individuals I guess on the team who I think are just kind of able to do that." - Staff Focus Group Participant*

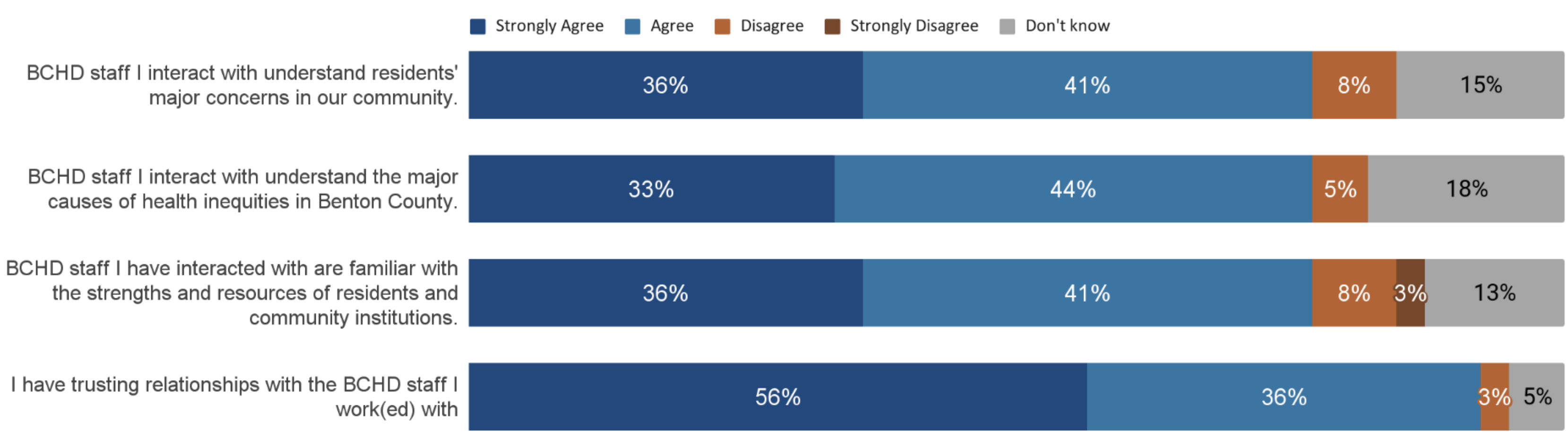
> *"My experience, it's very academic. We are a very white county, and so it's much more of the like, 'Oh yeah, in theory this is great, but fortunately we don't actually have to do it because most of us are white and we can just move on with the racism thing.' The more of the sexism seems to be less of an issue but this is the Health Department which has historically always had a decent representation of women historically, though not in a position of authority, but that has fortunately seemed to change. But a lot of the isms, it all feels very academic because we are relatively homogenous, especially once you get past the low-end manager types." - Staff Focus Group Participant*

Community Knowledge

Health department staff must be knowledgeable about community issues and resources, work well with diverse partners and community members, and build on the strengths and assets of the community to be effective at addressing health inequities.

In the partner survey, partners were asked to share how well the BCHD staff they worked with knew the community and effectively worked with the community. The majority of partners (77%, n=30) agreed or strongly agreed that the BCHD staff they interact with understood residents' major concerns, understood the major causes of health inequities in the county, and were familiar with community strengths and resources (Figure 21). Additionally, the majority of partners reported having trusting relationships with BCHD staff they work with (92%, n=36).

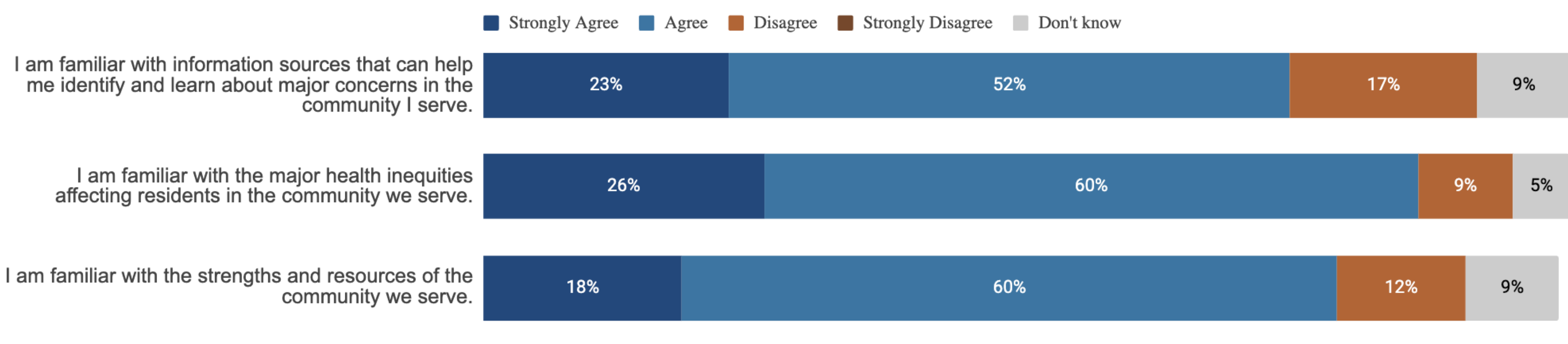
Figure 21: BCHD staff knowledge of health equity (Partner survey, N=39)



BCHD staff and managers were asked to reflect on their knowledge of the community in surveys, interviews, and focus groups (Figure 22). Staff survey responses largely mirror partner survey responses, the majority of staff survey respondents agreed or strongly agreed that they were able to learn about major community concerns (74%, n=69), were familiar with the

health inequities affecting the community served (86%, n=80), were familiar with community strengths and resources (78%, n=73), and were familiar with the demographic composition of the community (82%, n=76). Staff were more likely than partners to disagree with these statements, indicating a self-identified knowledge gap for the BCHD workforce that should be addressed.

Figure 22: BCHD staff knowledge of communities served (Staff survey, N=93)



In focus groups and management interviews staff demonstrated their knowledge of community issues, and specifically referenced underserved populations including the Mam-speaking community and the houseless population. Staff whose roles involved direct services and community partnerships were particularly well-versed in community issues, and many noted that they sat on committees and coalitions and/or were involved in projects in close collaboration with partners, deepening their knowledge.

“I know, speaking on behalf of my department, we have a lot of dedicated capacity for that [within department] and trying to build those bridges and maintain those partnerships in a way that's supportive and respectful. And showing up at community events, offering funding for providing childcare if that's something that feels like it's within our capacity or appropriate. And really trying to show up and listen and to do that work.” - Staff Focus Group Participant

“The examples that come to mind for me in my tenure have been for the formulation of a vaccine confidence [coalition] to address vaccine hesitancy among particularly people of color in our community and different cultures in our community and really pulling in leadership or respected leaders who could represent the concerns of a particular community or group and bring those forth so that our core public health team could answer their questions, provide information, respond to their concerns, provide resources and supports that those respected leaders could then take out to their communities to share in order to increase that vaccine confidence. ” - Management Interviewee

“I think our community groups do a lot in addressing health inequities, at least some of the community groups that I can think of right now ... I think in a lot of ways BCHD supports community groups in addressing the health inequities, and trusting our partner organizations to provide us with feedback from those with experience. So I think that community partners have to play a big role in addressing health inequities...” - Staff Focus Group Participant

Staff and managers also noted that the challenges faced by many communities in the county were systemic and required deep, upstream, transformative change. This is work that staff and managers want to be a part of, but focus group participants and interviewees noted there were still many barriers to addressing the upstream causes of health inequities. Some staff and managers also noted barriers to strong community relationships, including a lack of trust, that impacted the work BCHD was able to do.

“The resources to make change, that's hard, that's a struggle. If someone says, ‘We don't have anywhere to buy groceries within 20 miles,’ what do we do with that information? And how do we recruit a store? The proactive nature of changing things for those inequities is missing.” - Staff Focus Group Participant

“I think the community partnerships and relationships, particularly with our tribes, our communities of color, that's one thing that I think we can really improve upon...if we don't have those relationships built up before there's an issue, then a lot of times that relationship either gets worse or the condition that we're trying to help with gets exacerbated because you're not going in as a trusted source, you're going in as some type of punitive organization that's been suppressing people for centuries and you're just adding to that.” - Staff Focus Group Participant

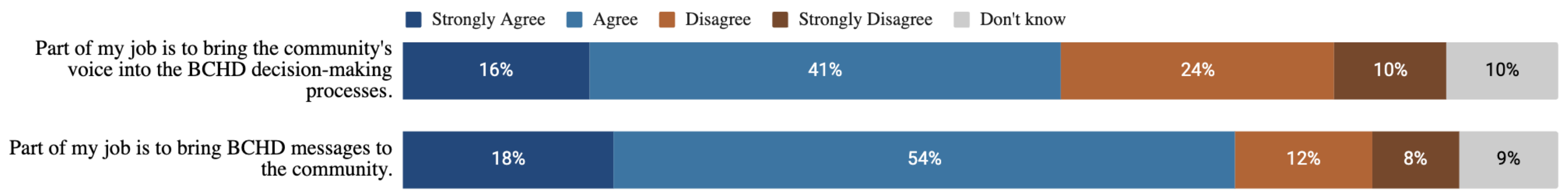
Leadership

Leadership skills are essential for health department staff to effectively address health inequities. Staff must work well within the agency and in the community, must understand and navigate diverse interest groups and power dynamics, and must engage and mobilize others.

BCHD staff were asked about their leadership skills and abilities in surveys, interviews, and focus groups. Many staff reported that they had taken on leadership roles within BCHD; and as previously noted in the *Support Staff to Address Health Inequities* section, more than half (53%, n=49) of staff survey respondents answered that they had provided mentoring or coaching to other staff, either informally (33%, n=31) or as part of their job (19%, n=18) to support them in addressing health inequities.

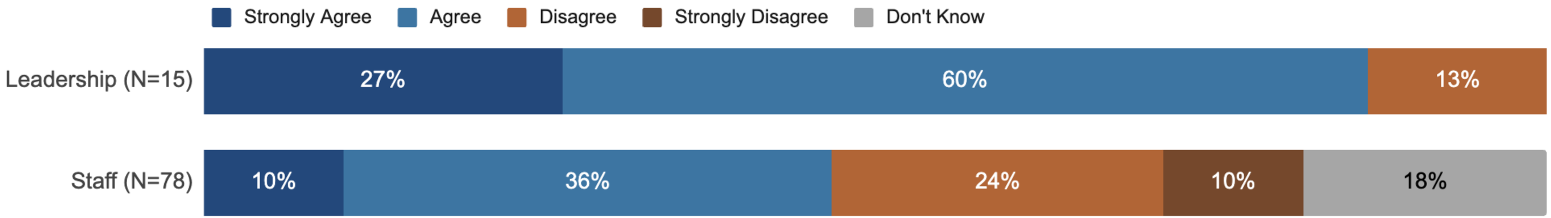
The majority of staff survey respondents also noted playing roles in bridging communication, understanding, and collaboration between BCHD and the community (Figure 23), with 57% (n=53) of respondents reported that they agreed or strongly agreed that part of their job was to bring the community’s voice into BCHD decision-making processes, and 72% (n=67%) agreed or strongly agreed that part of their job was to bring BCHD messages to the community.

Figure 23: BCHD staff role in supporting community voice (Staff survey, N=93)



About half (53%, n=49) of all staff survey respondents said they had influenced how BCHD provided resources to community residents and groups to address the conditions that impact health. Looking at survey responses by role, the percentage of respondents who reported that they agreed or strongly agreed that they influenced BCHD's provision of resources to the community was much higher for staff in leadership positions (87%, n=13) compared to all other staff survey respondents (46%, n=36).

Figure 24: I have influenced how BCHD has provided resources to community residents and groups to address the environmental, social, and economic conditions that impact health (Staff survey, N=93)



When asked about opportunities to assume leadership roles, almost 40% (n=33) of staff survey respondents disagreed or strongly disagreed that staff at all levels had the opportunity to become leaders in the work BCHD was doing to address health inequities. This finding arose as a theme in staff focus groups as well, with many focus group participants describing barriers to taking on leadership roles in BCHD's health equity work. Staff focus group participants also noted challenges

when they were in a leadership role in projects or initiatives aimed at addressing health inequities, including not having decision-making power, leadership support, or adequate resources.

> *“We have been short-staffed forever … And even if I go to trainings about how to reach out to the Hispanic community and make inroads to do some education in that area, there's no time, and the ability to even put thought into how to do this, how to use our resources to better communicate. And I'm feeling, in my position, I really feel a lack of, I hate to say it, leadership, I think because we have been short-staffed … I've been waiting a long time to address some of these issues and I don't think they're ever going to get addressed.” - Staff Focus Group Participant*

> *“I guess my feedback to that would be that I hear the terminology "health inequities" a lot. It's just a popular phrase that we hear. But I think that there could just be a lot more intentional, dedicated, prioritized work towards actually expanding and improving. I think that we hear it a lot, and I think that there's a lot of really good things that are said and good ideas, but the follow through sometimes is really what seems to be lacking. And I think that there's a lot of reasons for that: funding, capacity, all the hoops we have to jump through to be able to do anything in a government job. But it does get to a point where just saying "health inequities," and saying we know that they exist and we don't want them to, we've met max capacity for that being enough. We need to see some actual tangible movement from people much higher up than we are on making these things a reality now.” - Staff Focus Group Participant*

In focus groups and interviews BCHD staff and managers noted a trend in conventional, hierarchical leadership and decision-making at BCHD.

> *“Ultimately, the decision has to be made by someone. And we're not always able to make everyone happy or to meet the needs of everyone, but hearing those considerations and not making decisions in a vacuum is so important for the outcome of that decision. People in leadership don't know what's going on a lot of times and how decisions can impact programs and people in our community.” - Management Interviewee*

Management interviewees also noted a desire to learn and grow as leaders; some felt they have had support to grow their leadership skills whereas several others said they could use additional leadership training.

“And I find humbleness, it works great in my lack of knowledge and just ... I'm still learning, especially someone with pronouns that I may not be used to using, or I've known them different way, and now they're switching, it's like, "Just please remind me. I'm starting to learn. I'm trying. I'm really trying, but I need you your help to refine my skills.”” - Management Interviewee

Collaboration Skills

Successfully addressing health inequities with empathy cannot be done in a silo; it requires collaboration across divisions and/or organizations, meaningful representation of diverse perspectives and experiences, and trust. Those who collaborate well are often described as a “team player,” with good communication skills and a willingness to share power with others.

In focus groups and interviews, staff and management demonstrated their understanding of the importance of collaboration to be effective in their work. Internally, some staff felt that their team or division collaborated well, while others shared that they had experienced an inconsistent willingness to collaborate across divisions. Staff and managers both described BCHD as “siloed” and many manager interviewees reported a desire to “un-silo” the department to better support the overarching goals of the department, but also felt that they lacked the training or capacity to build alignment and collaboration across teams/divisions.

“Yes. That is something that I feel everyone should have. It's very helpful when it's not just you struggling, but when there's others helping you. And we work a lot with the health navigation team because they help a lot with community to access and to overcome those barriers to care. So we collaborate. We collaborate, but also in your own department, if you're having that support right there, it makes it easier... I feel supported and I feel I can pass that along to the community and they feel supported and I feel supported. So that's a good program” - Staff Focus Group Participant

“I have experienced just a lot of inconsistency in terms of collaboration and overlap, and willingness or welcomeness, or a culture of feeling very guarded and distrustful of people from other departments that maybe you've never talked to. And a lot of these things, because we're looking at so much intersectionality, requires that kind of collaboration and shared knowledge. We cannot be siloed in this work. I've been really disappointed by how averse I feel like some departments can be versus others, or some sections versus others, to not wanting to have to collaborate.” - Staff Focus Group Participant

This variation in collaborative experiences within BCHD was also reflected in staff survey responses (Figure 25). About two-thirds of respondents either agreed or strongly agreed that they knew how other divisions and programs were addressing health inequities (62%, n=58); they collaborated with other programs to address social determinants of health (61%, n=57); and that the collaboration between programs was supported by management (69%, n=64). Only 35% (n=33) of respondents agreed or strongly agreed that staff at all levels had opportunities to become leaders in BCHD’s health equity work, while 26% (n=24) disagreed and 14% (n=13) strongly disagreed. When reviewing responses to that question based on whether the respondent was in a leadership position or not, almost half of leadership respondents (47%, n=7) agreed or strongly agreed that staff at all levels have opportunities to become leaders in addressing health inequities, compared to a third of all other staff (33%, n=26) (Figure 26).

Figure 25: Internal collaboration to address health inequities (Staff survey, N=93)

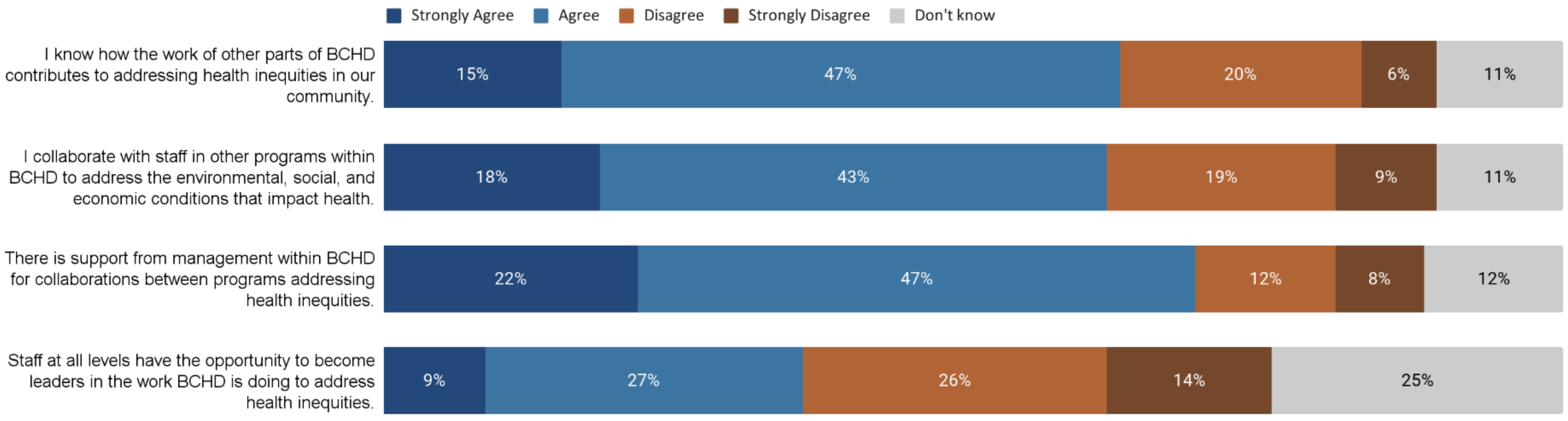
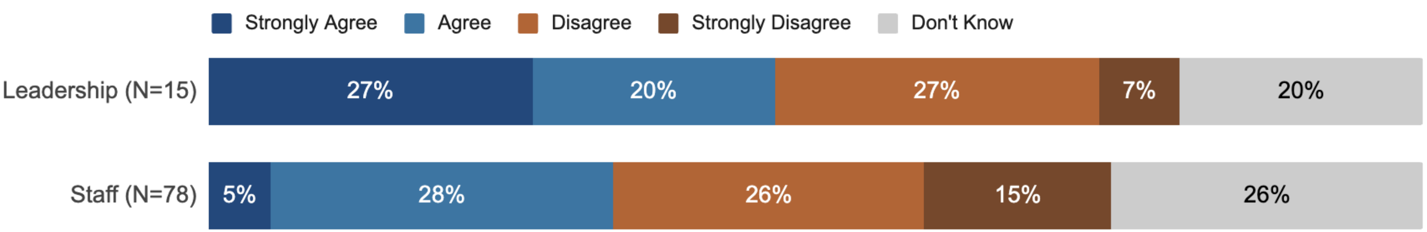


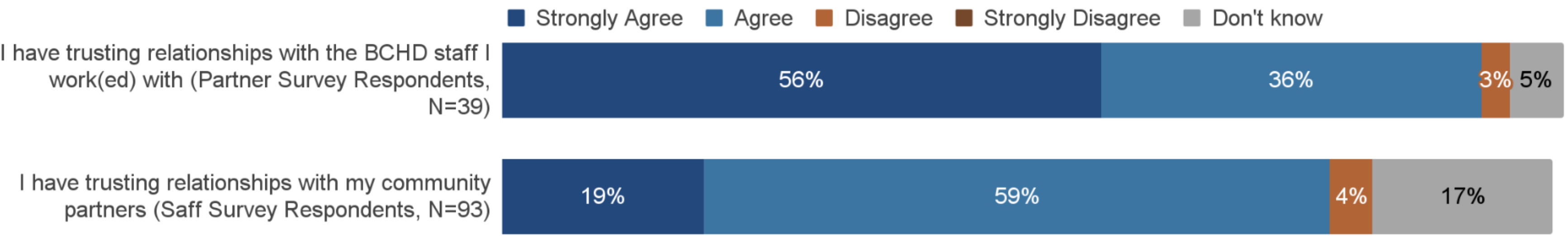
Figure 26: Staff at all levels have the opportunity to become leaders in the work BCHD is doing to address health inequities. (Staff survey, N=93)



Responses from the BCHD staff focus groups, staff survey, and community partner survey showed that, overall, BCHD had strong, trusting, and collaborative relationships with partners. Almost all community partner survey respondents (92%, n=36) said that they agreed or strongly agreed that they had trusting relationships with the BCHD staff they've worked with, while 78% (n=73) of BCHD staff agreed or strongly agreed that they had trusting relationships with their community partners (Figure 27). It is possible that agreement is lower among BCHD staff than community partners because BCHD staff were

concerned about overstating the quality of their partnerships, knowing there is room for improvement. However, survey respondents were not asked to provide context to their responses, so this cannot be confirmed without additional engagement with respondents.

Figure 27: Trust between BCHD partners and staff



> *"I'd say we are pretty well-connected with community partners, largely because of the work that the Healthy Communities team has done to stay connected and to make sure that we have accurate contacts that we … know who to reach out to if we need outside support for something or if we need to be the outside support for something... One of the collaborations I am most proud of participating in and helping to organize is dental nights at Garfield Elementary School for the indigenous Mam speaking population." - Staff Focus Group Participant*

As previously mentioned (see *Community Accessible Data and Planning*), when BCHD collaborated with community partners, these organizations were most often engaged to provide input in the beginning of the planning process (46%, n=18). Around one-third of respondents said they had also been engaged to review and give feedback on planning documents (28%, n=11), collect feedback from community members (31%, n=12), maintain active involvement through the planning process (26%, n=10), and/or participate in the decision-making of program planning and delivery (31%, n=12). According to these responses, community organizations and/or leaders were generally engaged at the same levels and in the same activities as other governmental/public agencies, as shown in Figure 28.

Figure 28: Role of partners in BCHD program planning and delivery (Partner survey, N=36)

	Role(s) of leaders from the community	Role(s) of other governmental/public agencies
Provide input in the beginning of the planning process	46%	41%
Review program planning documents and give feedback	28%	33%
Collect feedback from larger groups of community members and communicate the feedback to BCHD	31%	26%
Maintain active involvement throughout the planning process as appropriate	26%	33%
Participate in the decision-making of program planning and delivery	31%	28%

BCHD staff and partners both expressed high levels of collaboration with community partners in the initial stages of a project or process (e.g. providing input), with a steady decline towards the end of a project or process (e.g. final decision-making). Although three-quarters (n=30) of partner survey respondents reported that they received open and honest communication from BCHD, only one-quarter (n=9) reported that when BCHD program decisions did not reflect community input, they knew why those decisions were made. This feedback suggests that BCHD has room for improvement when it comes to "closing the loop" on communication and collaboration with partners (see also *Transparent and Inclusive Communication*).

Community Organizing

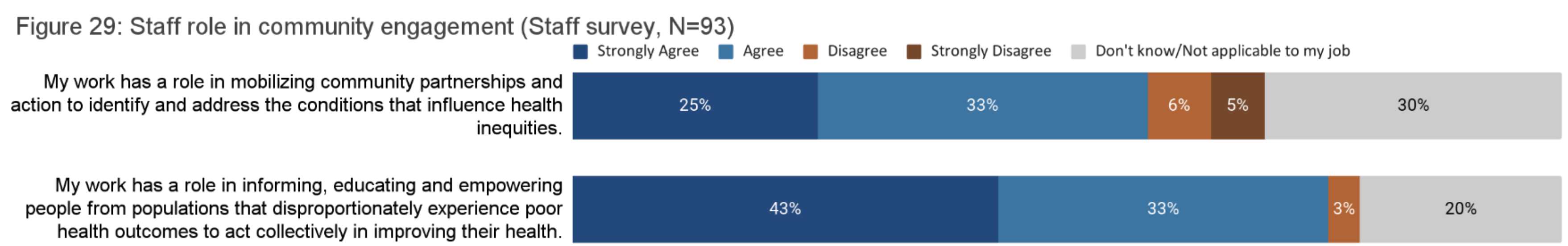
The findings in this section overlap with the *Collaboration Skills* section.

Excellent community organizing skills go beyond the important and continual task of building trust and developing community networks by inspiring deeper levels of community involvement and ownership. Adept community organizers start by seeking out community input and feedback, and then carry this involvement forward to support community members and organizations in leadership roles. Findings from this assessment suggest that BCHD staff and leadership were proficient in developing relationships and communicating with their community partners, and had room to grow in supporting community members and partners as leaders in their health equity work.

A majority of BCHD staff survey respondents (76%, n=71) agreed or strongly agreed that their work had a role in informing, educating, and empowering people who disproportionately experience poor health outcomes, and 58% (n=54) of respondents agreed or strongly agreed that their work had a role in mobilizing community partnerships to identify and address conditions that influence health inequities (Figure 29).

However, in focus groups, staff discussed barriers to meaningfully and consistently involving community in their work, including limited capacity of partner organizations and past mistrust between community members and BCHD. Manager interviewees also reported that relationships with community were generally positive, but recognized that bureaucracy inherent in the department impacted those relationships. Staff and managers alike reflected on their desire to cultivate more community leadership and ownership of initiatives that BCHD was involved in, such as the development of a community health improvement plan.

Figure 29: Staff role in community engagement (Staff survey, N=93)

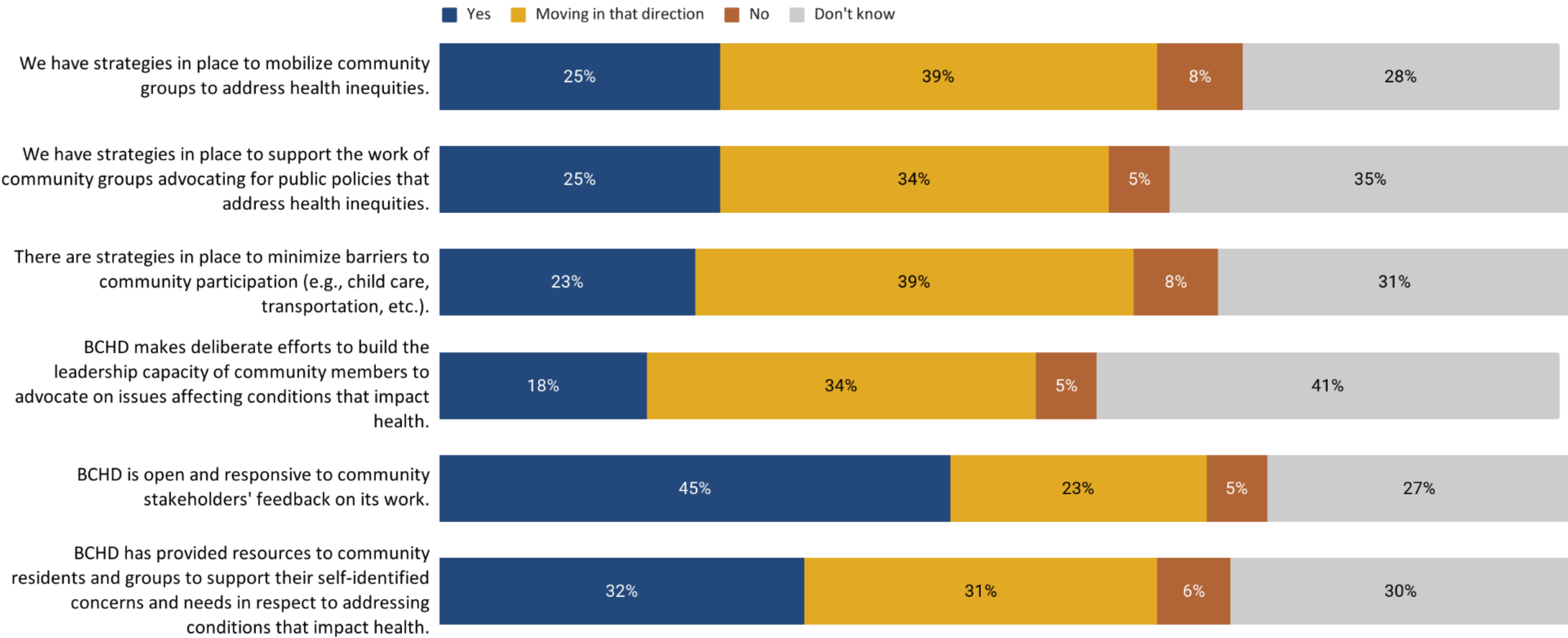


Looking ahead, BCHD staff and managers reported that they would like to see more engagement with community that was focused on building capacity for community partners and members to be involved in more leadership roles, rather than advisory roles.

> *"So I really think while we try to reach out and get opinions and comments from our community partners, I think we have a long way to go. Being able to get that outreach and trying to be more inclusive of having them become partners in our planning and really getting that buy-in. And eventually it would be great to have our community partners be the main planners and development of these and that we are there to support them. At this point, we are doing the planning, we are doing the work and just sort of on the side involving our community groups to be able to get their input. I'd like to be able to raise it up to that next level where we start building the capabilities of our community partners so they can do a lot more of the work and we can support them instead of us doing the work and just sort of superficially [engaging them]... " - Staff Focus Group Participant*

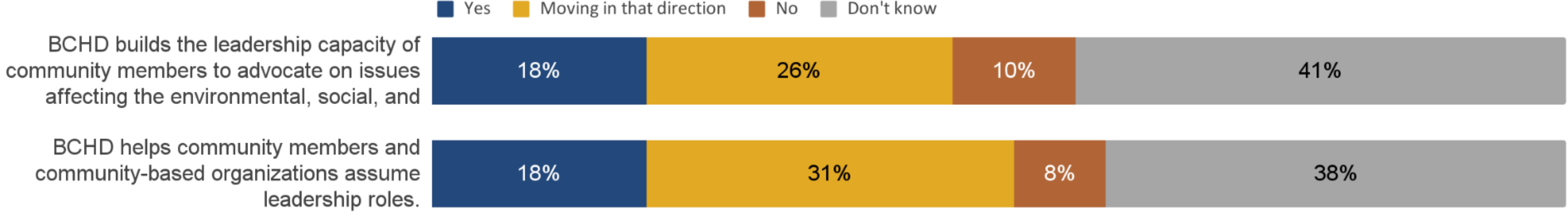
These findings were reflected in the BCHD staff survey as well. When asked about various strategies that BCHD had in place to support community efforts to address health inequities, 45% (n=42) of respondents said that BCHD was open and responsive to community stakeholders' feedback on its work, and 23% (n=21) said that BCHD was moving in that direction. Conversely, only 18% (n=17) of respondents said that BCHD made deliberate efforts to build the leadership capacity of community members to address health inequities, and 34% (n=32) said that BCHD was moving in that direction (Figure 30).

Figure 30: Strategies in place to support community efforts to address health inequities (Staff survey, N=93)



Community partner survey respondents confirmed these findings from staff and managers, as 44% agreed that BCHD currently built the leadership capacity of community members to address health inequities or was moving in that direction. Similarly, 49% agreed that BCHD helped community members and community-based organizations assume leadership roles or was moving in that direction (Figure 31).

Figure 31: BCHD support for community leadership capacity (Partner survey, N=39)



As shown in Figure 32, partner survey respondents reported that BCHD had been successful, or was moving in the direction of, developing and supporting networks in the community (77%, n=30); creating and distributing materials that met the cultural, linguistic, and literacy needs of the community (72%, n=28); and collected and shared data in culturally, linguistically, and developmentally appropriate ways (69%, n=27). However, as previously discussed and elevated in focus groups, interviews, and the staff survey, there was room to improve and expand strategies to build community's capacity for leadership in addressing health inequities. In the partner survey, 49% (n=19) of respondents said that BCHD was currently, or was moving in the direction of, helping community members and organizations assume leadership roles. Additionally, 44% (n=17) of respondents said that BCHD was currently, or was moving in the direction of, building the leadership capacity of community members to advocate on issues that affect environmental, social, and economic determinants of health.

Figure 32: BCHD community support (Partner survey, N=39)

	Yes	Moving in that direction	No	Don't know
BCHD creates and distributes oral and written materials that are appropriate for the cultural, linguistic, and literacy needs of the community.	46%	26%		21%
BCHD collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community.	41%	28%	3%	21%
BCHD provides trainings to increase the knowledge and skills of community leaders to address the environmental, social, and economic conditions that impact health.	26%	28%	3%	36%
BCHD plays an active role in developing, maintaining and supporting networks in the community.	46%	31%	5%	13%
BCHD builds the leadership capacity of community members to advocate on issues affecting the environmental, social, and economic conditions that impact health.	18%	26%	10%	41%
BCHD helps community members and community-based organizations assume leadership roles.	18%	31%	8%	38%

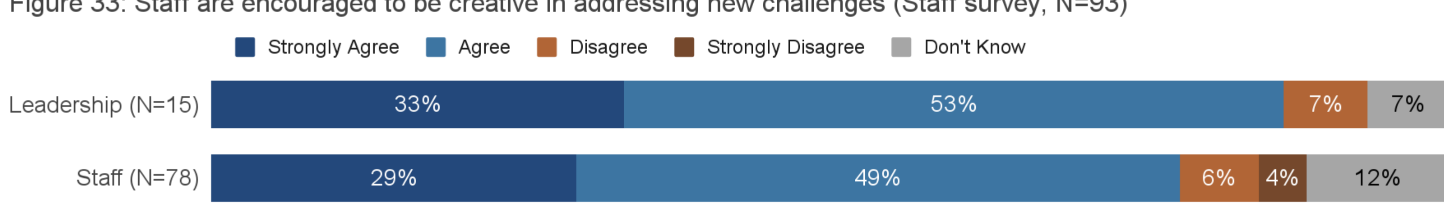
"What we have not done historically is do more of a community led assessment, right, where we're sitting down with our community members to say, what is it that's going on, and what are just in general ... the issues that you're seeing? That has been wrapped up into different community health improvement planning processes, but it's not something routine that we do that I think we should be doing." - Management Interviewee

Problem Solving Ability

Problem solving ability is the use of negotiation and conflict resolution skills, willingness to take risks, and learning from failures. This competency describes the flexibility for individuals within BCHD to respond to the needs of both internal and external customers. The ability to learn from and course correct failures is a valuable skill in working towards health equity, as it is an iterative practice of assessing setbacks, adjusting goals and priorities, and discovering innovative ways to deal

with roadblocks. The findings in this section overlap with all of the other competencies, as problem solving is integral to the implementation of the other areas.

Feedback from both staff and leadership reflected that a good number of respondents felt that problem solving was evident at BCHD. According to the non-leadership staff survey respondents, 78% agreed or strongly agreed that they were encouraged to be creative in addressing new challenges, and 86% of leadership answered similarly.

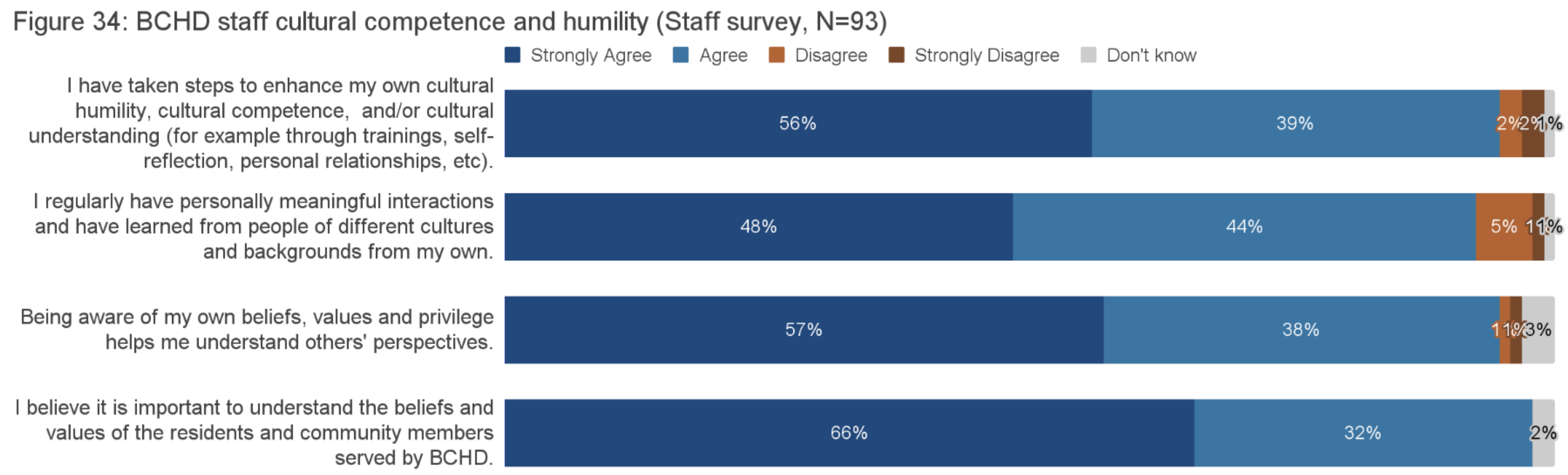


Cultural Competence and Humility

The workforce competency of cultural competence and humility includes cultural respect and humility, appreciation that diverse perspectives and roles are necessary to promote public health, effective cross cultural communication, and interpreting data for diverse audiences. BCHD managers, staff, and partners were asked questions to gain an understanding of this competency.

Almost all staff survey respondents had taken steps to enhance their own cultural humility, cultural competence, and/or cultural understanding (95%); had regular, personally meaningful interactions with people of different cultures and backgrounds (92%); were aware of their own beliefs, values, and privilege and how they helped them understand others' perspectives (95%); and believed that it is important to understand the beliefs and values of community members served by BCHD (98%).

Figure 34: BCHD staff cultural competence and humility (Staff survey, N=93)



In order to have diverse perspectives to promote public health, a diverse workforce is critical. According to management interviewees, BCHD has dedicated itself to recruiting staff from diverse backgrounds as a part of its commitment to addressing health equity. For example, when recruiting for some positions, bilingual and bicultural applicants were listed as preferences. Some interviewees did reflect that BCHD could do a better job of having more representation of the people they serve in terms of race, ethnicity, age, gender, social, and economic conditions.

> *"And so we want a variety in genders, a variety in races, a variety in ages too, because we want to be able to serve patients in a way that they want to be served. It's helpful to have someone that you feel familiar with serving you instead of just always one race, one age, one gender." - Management Interviewee*

An area that management interviewees identified as a challenge regarding the recruitment of diverse staff was the relatively strict minimum qualifications, which resulted in a lack of flexibility and inclusiveness, as well as an over-emphasis on formal degrees while overlooking the value of lived experience.

“I think we could do a better job of examining our minimum qualifications as well and valuing different kinds of experience, different kinds of education, different kinds of lived experience more than our county human resource model currently allows for.” - Management Interviewee

Effective cross-cultural communication is an important component of cultural competence. Both BCHD staff and community partners were asked if they thought that BCHD creates and distributes oral and written materials that meet the needs of the community. Results are fairly similar for both informant groups, although two staff respondents disagreed that BCHD did this.

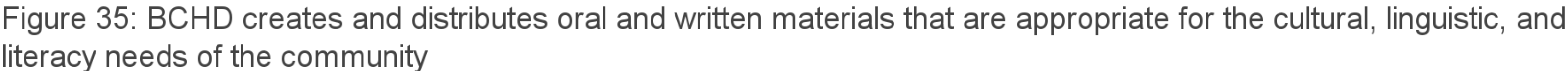
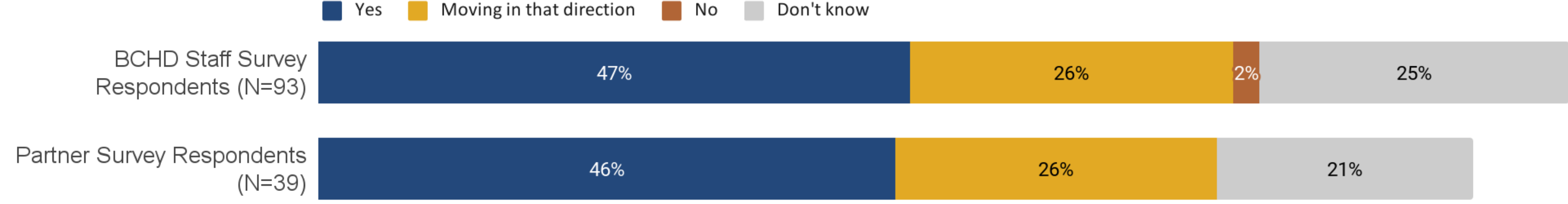
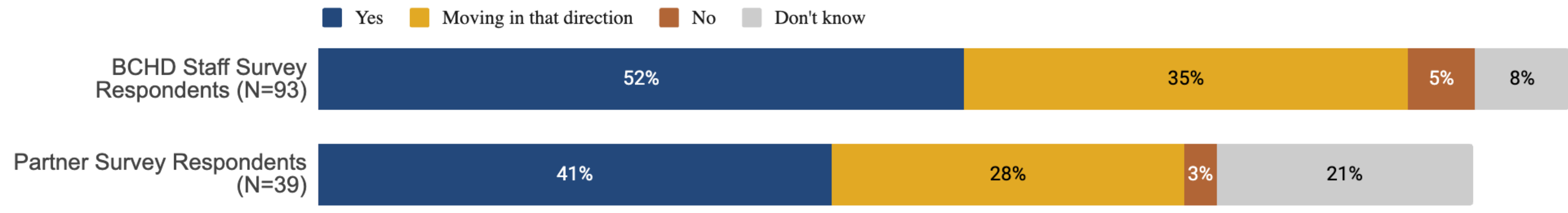


Figure 35: BCHD creates and distributes oral and written materials that are appropriate for the cultural, linguistic, and literacy needs of the community



Providing data in a manner that was appropriate for diverse audiences is another aspect of cultural competence. Like oral and written materials, both BCHD staff and community partners were asked if they thought that BCHD collects and shares data that meet the needs of the community. A higher percentage of staff survey respondents (87%, n=81) thought that BCHD did this or was working towards doing this compared to community partner survey respondents (73%, n=27). Five staff survey respondents and one partner survey respondent reported that BCHD did not collect and share data in a manner appropriate for the needs of the community.

Figure 36: BCHD collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community



Health Equity Plan

Health Equity Plan

Introduction

In the following sections we transition to sharing BCHD's methods and approach for developing a Health Equity Plan informed by assessment findings. We also summarize the plan's priorities, key strategies, and recommendations for implementation.

Building organizational and workforce capacity for addressing health inequities requires an intentional approach and sustained commitment. The priorities and key strategies in this Health Equity Plan will be implemented over the next five years (2023 - 2028) and will support BCHD to leverage existing strengths and address health equity capacity gaps.

Methods + Approach

Building on the assessment, the development of this plan was grounded in the BARHII framework for assessing and building local health departments' capacity for addressing health inequities. Our specific approach to developing this plan involved convening a Health Equity Planning Workgroup composed of BCHD staff to lead the process, bringing their diverse perspectives and expertise. BCHD senior leadership recognized the importance and value of a staff-led process and provided their buy-in for this approach and their commitment to implementing the plan developed by the workgroup.

Convening a Health Equity Planning Workgroup

The Health Equity Planning Workgroup was charged with the urgent task of providing leadership to develop a comprehensive health equity plan for BCHD focused on building capacity and competencies for eliminating health inequities. Workgroup responsibilities included:

- Co-develop the planning process and establishing community agreements for collaborative work;
- Review and interpret health equity assessment findings to identify BCHD strengths, gaps, and opportunities for improvement; and
- Develop a health equity plan with priorities and key strategies for improving health equity capacity at BCHD.

BCHD Project Leads led an intentional recruitment process to ensure the workgroup included a diverse group of staff representing different BCHD divisions and teams as well as different roles within the agency hierarchy.

Workgroup Members:

- Jasper Smith, Developmental Diversity
- Alicia Griggs, Developmental Diversity
- Cade Deloach, Behavioral Health
- Sam Bailey, Health Administration
- Kailee Olson, Health Administration
- Julie Arena, Health Administration
- Amanda Garcia, Public Health
- Javier Navarro, Public Health
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- Eric Wolke, Human Resources

*Indicates a workgroup member who did not remain active throughout the entire process

The planning workgroup was staffed by BCHD's contracted partners, the Rede Group. Workgroup meetings were co-designed and facilitated by Rede Group.

Workgroup Process

The planning workgroup convened weekly from April 14 - June 2, 2023. Over the course of seven meetings the facilitation team guided the workgroup through a purposeful and collaborative process that included foundational work to build relationships, establish workgroup processes, identify desired outcomes, and develop the health equity plan.

Planning activities included:

1. Review the purpose of a health equity assessment and health equity plan
2. Review and interpreted findings from BCHD's comprehensive health equity assessment
3. Synthesize health equity capacity gaps, impacts, and strengths to build on
4. Identify priorities and key strategies for improving health equity capacity
5. Discuss operational considerations such as resource needs, timeline, progress monitoring, and roles and responsibilities
6. Review a draft health equity plan for presentation to senior leadership for further development and implementation

Vision

While this assessment captures a moment in time, the plan is meant to shape the future of BCHD's health equity work. This transition from capturing BCHD's "baseline" health equity capacity to articulating shared hopes and goals requires a long-term view. Working toward long-term goals can feel cyclical or seasonal, starting with inspiration and the decision to assess, which leads to a recognition of the distance between where we are and where we want to be. As the next steps to shorten that distance are identified, the process uncovers strengths, resources, and barriers. Sometimes this work can feel de-motivating, but returning to a shared vision helps tether long-term goals to key strategies and can breathe life and energy back into the process.

As this plan was being written, the health equity planning workgroup envisioned:

- Staff and leadership who demonstrate enthusiasm and commitment to these focus areas and key strategies.
- Leadership championing this plan and seeking necessary supports, buy-in, and resources to ensure that staff have what they need to advance health equity in their work.
- Services and processes that are welcoming and accessible to all, and more consistency in our engagement with the community – ensuring that there are "no wrong doors".

- A sense of energy, pride, and excitement about a strong plan that we know is going to help us address health inequities, and a shared understanding of our collective responsibility to continually improve the culture, operations, and policies at BCHD.

Aligned with this vision, the workgroup developed a set of overarching values that they brought to the planning process and kept in mind when refining the priorities and key strategies in this plan. These values are:

Prioritizing + supporting groups experiencing disadvantage

Positively impact staff, partners, clients, and community members that have been socially marginalized by poverty, racism, gender discrimination, ableism, and other forms of systemic oppression.

Increasing accessibility of programs + services

Make programs and services more accessible, safe, inclusive, and easy to navigate, especially for community members who are emerging English speakers, are LGBTQIA2S+, and/or experience disabilities.

Improving the "culture of equity" at BCHD

Improve mindsets, practices, and policies around feedback, shared leadership, transparent communication, and accountability. Ensures mechanisms for monitoring progress toward achieving equity goals internally and externally.

Moving forward, it will be critical to continue the momentum built as a group and honor the power and collective wisdom of BCHD staff. This plan only marks the beginning of the hard work ahead. The hope of the planning

workgroup is that the vision and values articulated in this plan become so institutionalized in BCHD that the work moves forward despite any individual differences or structural changes – that doing the work equitably is the *only* way it is done. Health equity should not be viewed as an additional requirement on top of existing work, when in actuality, it *is the work*.

Health Equity in Practice: Focus areas, key strategies, and recommendations for implementation

After completing the health equity assessment, Rede coordinated with the client team to convene and facilitate six health equity planning workgroup meetings to review findings and inform the creation of this health equity plan. After having broad, reflective conversations about the findings, we organized themes from these conversations into four categories:

- What is BCHD lacking?
- What is this impacting?
- What are strengths that BCHD can leverage?
- What are some opportunities for action?

Answers to the questions were refined in later workgroup meetings, and were eventually sorted into high-level focus areas with key strategies. The six focus areas are shown in Figure 37.

Figure 37: Health Equity Planning Focus Areas

Members of the planning workgroup were also asked to complete a survey to provide recommendations on the timeframe, contributors, resources needed, desired results, and any other comments they wanted to share about these key strategies. In addition to the survey, we dedicated a full workgroup meeting to also discussing these implementation considerations. Notes from this meeting and the survey responses have been summarized under each key strategy as goals and recommendations for implementation. The key strategies are situated under the focus areas that they are most relevant to, but many of them can be applied to multiple focus areas.

1. Improve training and professional development

As the planning workgroup reviewed the findings from the health equity assessment, it became clear that BCHD staff and managers could increase their capacity and effectiveness related to health equity by engaging in tailored training and professional development activities. Ideally, these trainings and activities would be selected based on the specific work done by the employee and their current healthy equity knowledge and skills (see Appendix F). The end-goal is a robust,

modern, evolving package of quality and accessible trainings that directly improve BCHD's health equity capacity and skill set. As trainings are developed it is important that staff at all levels, particularly those working in direct service/client service roles, have dedicated time to spend on professional development.

Key Strategies

<table>
<tr><td colspan="2">Develop standards/requirements for health equity trainings</td><td>Timeframe: one year or biennium</td></tr>
<tr><td>Goal</td><td colspan="2">Recommendations for implementation</td></tr>
<tr><td>A robust, modern, evolving package of quality and accessible trainings that directly improve BCHD's health equity capacity and skill set. More follow-up and accountability for staff to apply learnings.</td><td colspan="2">Engage: Human Resources, Department Directors, Health Equity Coordinator, Health Dept. Director, Onboarding Coordinator, EDI Coordinator, and staff with lived experience.

• Include staff that have been economically and socially marginalized in approval processes for training programs/facilitators.
• Build upon guidance and recommendations from other agencies as appropriate.
• Utilize the county's learning management system.
• Review Appendix F.</td></tr>
<tr><td colspan="2">Require more trainings on equity and cultural competence/humility</td><td>Timeframe: one year or biennium</td></tr>
<tr><td>Goal</td><td colspan="2">Recommendations for implementation</td></tr>
<tr><td>BCHD staff have the ability to grow beyond "health equity 101", developing a passion and interest for lifelong learning in this area that in turn shapes the culture of BCHD to be one that prioritizes diversity and equity in practice. Trainings are</td><td colspan="2">Engage: Employers Partnership for Diversity, Health Equity Coordinator, Health Dept. Director, Onboarding Coordinator, EDI Coordinator, Human Resources, Equity Committee, and staff with lived experience/appropriate identities.

• Trainings should be meaningful and clearly connected to the specific work of the employee – quality over quantity.
• Accompany additional trainings with follow-up and/or other measures of</td></tr>
</table>

meaningful <u>*and*</u> *advance cultural competency each year.*	accountability – ensuring that skills and learnings are being applied to the work. • Consider mandatory training on appropriate community partnership and engagement for all managers. • Prioritize, review, and update BCHD trainings with the support of Human Resources. • Explore training through the Employers Partnership for Diversity.

Implement trainings for SOGI and REAL-D data collection and reporting	**Timeframe:** one year
Goal	**Recommendations for implementation**
Staff develop proficiency in collecting, reporting, and using REAL-D and SOGI data to inform programs and services.	Engage: Quality Improvement and Data Services Manager, Epidemiologist, Clinical Director & Managers, Health Senior Leadership, Quality Improvement Coordinator

Provide more small group learning and sharing opportunities	**Timeframe:** one year
Goal	**Recommendations for implementation**
Deeper learning and engagement with health equity concepts. Peer support and collaboration for staff and managers.	Engage: Health Equity Coordinator, Health Dept. Director, EDI Coordinator • Research and build upon best practices for group training and sharing (see Appendix F). • Carve out designated time for these activities – prioritize learning and sharing opportunities when looking at workload. • Explore providing affinity groups and spaces so that staff from diverse groups can learn from and support one another.

<table>
<tr><th colspan="2">Provide more training, support, and coaching for managers to build equity and leadership skills</th><th>Timeframe: one year and as new managers are onboarded</th></tr>
<tr><td>Goal</td><td colspan="2">Recommendations for implementation</td></tr>
<tr><td>Demonstrated commitment to equity at the highest levels of the organization. Managers and senior leadership have tools and resources to build equity and leadership skills among staff, and there are fewer miscommunications, misunderstandings, and discrimination incidences among staff.</td><td colspan="2">Engage: Human Resources, County Leadership, Health Senior Leadership

• Secure buy-in from County Leadership and Human Resources.
• Research and build upon best practices for training (see Appendix F).
• Build out a “New Manager Orientation” that includes best practices for distributive leadership, providing and receiving feedback, and supporting skill-building.
• Designate time for these activities – prioritize training when looking at workload.</td></tr>
</table>

2. Improve Human Resources policies and practices

Assessment findings related to workforce competencies revealed the importance of hiring, retaining, and promoting staff with strong health equity skills. Throughout their reflections the planning workgroup discussed the need to improve Human Resources (HR) policies and practices to ensure BCHD is hiring and supporting staff who have lived experience, health equity knowledge and skills, as well as personal attributes such as humility and curiosity. Improving HR policies and practices should be a collaborative process built on trust and shared understanding between BCHD leadership, staff, and Benton County HR. Having an HR representative on the planning workgroup was one opportunity to strengthen relationships and understanding, and the success of the activities outlined below will be dependent on this ongoing partnership. The end goal is greater collaboration and transparency between HR and BCHD staff and the BCHD workforce.

Key Strategies

Implement best practices for hiring and retaining staff with lived experience (e.g., State of California andOregon State University revised minimum qualifications to consider experience alongside education)	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Hiring processes identify and value the skills and expertise of individuals with lived experience and, over time, BCHD staff are more representative of communities being served.	Engage: County Leadership, Human Resources, subject matter experts, Health Equity Coordinator, EDI Coordinator, hiring managers, staff with lived experience • First conduct a review of current job qualifications. • Work with subject matter experts and review best practice models to develop guidelines or criteria for assessing and valuing lived experience in hiring. • Revise job qualifications accordingly. • May require time, funding, and additional HR capacity.

Prioritize health equity skills and qualities like humility and collaboration in hiring	**Timeframe:** TBD
Goal	**Recommendations for implementation**
BCHD's workforce is committed to health equity and has the skills necessary to be a health equity leader.	Engage: County Leadership, Human Resources, subject matter experts, Health Equity Coordinator, EDI Coordinator, hiring managers, staff with lived experience • Identify the specific health equity skills and qualities desired (e.g., ability to collaborate within teams, across divisions, and with community partners). • Develop and implement assessment tools, interview questions, rating scales, etc. to evaluate identified skills and qualities. • Ensure training for hiring managers and others involved in hiring processes. • May require additional funding and capacity.

Include team members and supervisees on hiring panels	**Timeframe:** TBD

Goal	Recommendations for implementation
BCHD hiring processes include diverse perspectives and are transparent.	Engage: County Leadership, Human Resources, subject matter experts, Health Equity Coordinator, EDI Coordinator, hiring managers, staff with lived experience • Develop and implement training for all participants on hiring panels (e.g., reducing/mitigating unconscious bias in hiring and employees relations law best practices). • Build in adequate time into hiring timelines to include more staff in the process.

Add a Human Resources "navigator" position or navigation capacity to ensure more accessible and collaborative hiring processes for candidates and hiring managers	**Timeframe:** TBD

Goal	Recommendations for implementation
Hiring processes are transparent, inclusive, and accessible to navigate for candidates as well as for hiring managers.	Engage: County Leadership, Human Resources, subject matter experts, Health Equity Coordinator, EDI Coordinator, hiring managers, staff with lived experience, staff who were hired recently • Identify current gaps in transparency, inclusivity, and accessibility through consultation with staff. • Explore conducting equity audits of hiring processes. • Develop standardized procedures and policies and provide needed training and support for process improvements. • Explore using/adapting best practice models such as the OSU search advocate program (https://searchadvocate.oregonstate.edu/) and acknowledging staff who work as search advocates with stipends or leadership experience "credit".

Revise management experience requirements for promotions (e.g., include experience with project management, budgeting, policy development, etc.)	**Timeframe:** TBD

Goal	Recommendations for implementation
All BCHD staff have opportunities for professional advancement within BCHD; BCHD management and leadership has strong health equity skills and is reflective of the community.	Engage: County Leadership, Human Resources, subject matter experts, Health Equity Coordinator, EDI Coordinator, hiring managers, staff with lived experience, staff who were hired recently • Research equitable best practices and use findings from this assessment and BCHD mission, vision, and values to develop BCHD desired leadership skills and qualities. • Review current management experience requirements to assess whether they align with the desired leadership skills and qualities. • Work with subject matter experts to identify best practices to revise requirements. • Ensure candidates have clear guidance to understand the experience requirements/qualifications.

Provide training/information to all divisions and teams about current HR practices and options including hiring options (e.g., underfill positions)	**Timeframe:** TBD

Goal	Recommendations for implementation
Ensure consistency and awareness of HR practices across the organization.	Engage: County Leadership, Human Resources, Health Equity Coordinator, EDI Coordinator, Health Senior Leadership, all staff • Develop clear, consistent, accessible, and regularly updated training materials and resources and ensure all staff have access to them (e.g., store on the BEE on the Human Resources page).

3. Support staff

The support of staff arose as a key focus area for the workgroup, recognizing that staff are the catalyst for this work in praxis. With support from management through updated policies and procedures, individuals and teams are better equipped to execute health equity focused programs and can better serve Benton County residents. Unsupported, staff are more likely to experience burnout and the department to experience turnover of negatively impacted staff. Workgroup members reported equitable pathways for leadership/advancement, compensation for staff with valuable expertise, opportunities for training and experience within BCHD, and ongoing support as key actions in supporting the staff.

Key Strategies

Review health equity assessment subpopulation analysis (e.g., comparing the experiences of staff at different levels of the agency hierarchy, or comparing experiences of staff of color to those of white staff) to identify trends, needs, and strengths of staff who lack support and opportunities for leadership/advancement	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Utilize data to inform programs and policies that ensure all staff are supported.	Engage: Health Equity Coordinator, EDI Coordinator, County Leadership, Health Senior Leadership, staff with lived experience • Regularly review subpopulation data to ensure that the demographics of leadership are reflective of the entire staff population. • Provide a family life/childcare support option to support staff.
Ensure staff have equitable access to existing resources for training and professional development	**Timeframe:** TBD

Goal	Recommendations for implementation
Ensure that every individual who desires to obtain advanced training or advance professionally has an equitable chance of doing so within BCHD.	Engage: Health Equity Coordinator, EDI Coordinator, Health Senior Leadership, staff with lived experience, Onboarding Coordinator, Administrative Specialists, Human Resources • Research best practices for the types and availability of training that will support Staff's ability and experience.

Compensate staff who provide specific expertise and apply it beyond their job duties (e.g., providing staff training)	**Timeframe:** TBD

Goal	Recommendations for implementation
Ensure that staff that exceed and surpass their job expectations are fairly compensated.	Engage: County Leadership, Human Resources, Health Equity Coordinator, EDI Coordinator, Health Senior Leadership, staff with lived experience • Create and make readily available a process for staff to self-nominate themselves for opportunities to utilize specific expertise.

Provide more opportunities for staff to gain leadership/ management experience without leaving BCHD (e.g., limited duration roles to manage a project or small team)	**Timeframe:** TBD

Goal	Recommendations for implementation
Creation of an environment where BCHD can retain staff. Where current staff have visible opportunities and access to leadership/management experience internally.	Engage: County Leadership, Human Resources, Health Equity Coordinator, EDI Coordinator, Health Senior Leadership, and staff with lived experience • Ensure that opportunities are extended equitably, as well as being mindful that staff that have been economically and socially marginalized tend to be the ones overloaded and under compensated.

	• Recognition of experience of staff who serve in peer support roles (referenced below).

Provide peer support for new staff to help them navigate BCHD	**Timeframe:** TBD

Goal	Recommendations for implementation
New staff have a network of trained, highly knowledgeable peers to support with acclimation into BCHD.	Engage: Health Equity Coordinator, EDI Coordinator, Health Senior Leadership, staff with lived experience, Onboarding Coordinator, Administrative Specialists, Managers • Ensure individuals who are selected as peers reflect the diversity of staff across multiple identity categories. • Peers are trained in general human resources practices, made aware of happenings in other departments, and are a visible part of onboarding; peers have annual training and evaluations. • New employees check in with their assigned peer once a month for the first 3 - 6 months.

4. Support community partnerships and engagement

Community partnerships are critical to public health services that are nimble, equitable, and responsive to community needs, strengths, and desires. Findings from the health equity assessment and conversations with the health equity planning workgroup highlighted the need for more consistency in community engagement. Creating and adapting policies that standardize the operational aspects of community engagement (e.g. stipends) as well as the experiential aspects (e.g. trauma-informed methods) and are accessible to all staff, will support deeper, more sustainable partner relationships.

Key Strategies

Ensure BCHD teams and programs have equitable access to resources (e.g.,	**Timeframe:** TBD

stipends) for community engagement	

Goal	Recommendations for implementation
Staff have the support and resources they need to effectively and equitably partner with community, and partners experience this engagement as consistent across BCHD teams.	Engage: Health Senior Leadership, County Leadership, Equity Coordinator, County Finance • Research and develop a community partner and community member compensation policy that is communicated across BCHD. • Identify additional resources for community partnership and community engagement that are available or needed (e.g., funds for child care, transportation support, food, etc.).

Create policies for standard partnership and engagement practices (e.g., stipends, child care, accessibility, etc.)	**Timeframe:** TBD

Goal	Recommendations for implementation
Staff have the support and resources they need to effectively and equitably partner with community, and partners experience this engagement as consistent across BCHD teams.	Engage: Health Senior Leadership, County Leadership, Health Equity Coordinator, County Finance • In addition to procedural policies (e.g. accessibility standards), consider concretizing community engagement practices, emphasizing trauma-informed methods. • Expanding the types of engagement BCHD seeks from community partners and members. At the moment, partners are often engaged to provide input, but are not as involved in decision-making. • Staff may need additional training to learn about and implement best practices for community engagement. • As policies are being developed (across key strategies), access should be a primary consideration; policies should always be easy for staff to find, and should be made public as appropriate.

Analyze Community Health Assessment and Community Health Improvement Plan data to identify opportunities for deepening community partnerships to address health inequities (e.g., are there gaps in partners working on specific issues identified as a top community need?)	**Timeframe:** TBD
Goal	**Recommendations for implementation**
BCHD leverages deep and trusting partnerships to be responsive to community needs and desires.	Engage: Healthy Communities Division, Health Equity Coordinator, Health Senior Leadership, and staff with lived experience

5. Improve BCHD programs and client services

The planning workgroup spoke at length about how improving BCHD's internal health equity capacity must result in tangible benefits to the community. Some workgroup members expressed worry that all of BCHD's energy and focus would be put on strategies to improve internal systems and structures which, while necessary to impact long-term change in how BCHD works in the community and serves clients, may divert attention and resources from community health improvement strategies in the short-term. The strategies outlined here span BCHD divisions and teams and reflect an end goal of ensuring that BCHD treats all community members with respect, honors their humanity, and ensures they have access to the care and resources they need.

Key Strategies

Improve the accessibility of BCHD spaces (signage, accessible restrooms, etc.)	**Timeframe:** TBD
Goal	**Recommendations for implementation**
BCHD clients and community	Engage: Benton County Facilities/Public Works, Health Senior Leadership, Health

<table>
<tr><td>members feel welcome and are able to fully access all BCHD spaces.</td><td>Communications Coordinator, EDI Coordinator, Administrative Specialists, staff with lived experience
Consult Americans with Disabilities Act recommendations requirements/guidelines and identify additional accessibility best practices.
Gather input from staff on what is currently working and not working as far as accessibility of BCHD spaces.
Resource needs include funding and contractors for building improvements.</td></tr>
<tr><td>Improve language access for BCHD programs and services</td><td>Timeframe: TBD</td></tr>
<tr><td>Goal</td><td>Recommendations for implementation</td></tr>
<tr><td>All BCHD clients and community members can access BCHD services in their primary languages.</td><td>Engage: Health Equity Coordinator, EDI Coordinator, Public Information Officer, Health Communications Coordinator, staff who speak languages other than English
Assess current language capacity and capacity gaps, including staff language skills and utilization and effectiveness of language service agencies and any other language access tools being used.
Create and implement a plan for addressing gaps.
Explore opportunities for staff to learn basic terminology of a new language or improve their language skills in languages beyond English. This could also include best practices for culturally competent communication (e.g., deaf cultural competence training).</td></tr>
<tr><td>Assess all BCHD forms for gender inclusivity, accurate translations, clear and simple language, etc., and make needed revisions</td><td>Timeframe: As soon as possible</td></tr>
<tr><td>Goal</td><td>Recommendations for implementation</td></tr>
<tr><td>All BCHD clients and community members feel seen, respected, and</td><td>Engage: Health Equity Coordinator, Administrative Specialists, Compliance Manager(s), staff with lived experience</td></tr>
</table>

included.	• Resource needs include funding and capacity. • May require hiring an external consultant who is a subject matter expert and can work alongside BCHD staff. • Ensure communication about and consistent implementation of revised forms.
Analyze CHA and CHIP data to identify other needed equity improvements	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Leverage data that BCHD has already collected from community members and community partners to inform health equity strategies.	Engage: Health Equity Coordinator, Healthy Communities Division, Health Senior Leadership • Review community-identified health needs and priorities to identify areas of alignment and areas of difference with BCHD plans and priorities. • Where differences exist, consider adjusting/adapting BCHD plans to align more closely with community-identified needs. • Explore opportunities to directly resource communities to address their identified health needs.
Implement SOGI and REAL-D data collection and reporting; build in a plan for reviewing this data to identify needed equity improvements	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Accurate data on BCHD clients and community members is collected and used to drive quality improvement.	Engage: Health Senior Leadership, Health Equity Coordinator, IT/data systems, Community Health Center • Dependent on first implementing training on SOGI and REAL-D data collection and reporting (see above). • Resource needs include funding and potentially added IT/data systems capacity.

	Review best practices for reviewing SOGI and REAL-D data and data-driven quality improvement.

Explore alternative and best practice models for public health practice and service delivery (e.g., entitlement model, peer model)	**Timeframe:** TBD
Goal	**Recommendations for implementation**
BCHD implements best practice and leading-edge models for delivering programs and services.	Engage: BCHD divisions and teams, Quality Improvement Coordinator, Health Equity Coordinator • Identify and replicate best practices from BCHD divisions and teams (e.g., build on plans and strategies from Developmental Diversity and Behavioral Health). • Research other best practice models and consult with subject matter experts on implementation and needed shifts in organizational culture (e.g., abundance vs. scarcity mindsets).

6. Increase transparency and accountability

Workgroup participants shared thoughts about transparency and accountability that were also reflected in the staff surveys and focus groups. Transparency and accountability were elevated as top needs for ensuring that BCHD has internal mechanisms in place for feedback and quality improvement in support of its equity work, both internally and in the community. Planning workgroup members identified the importance of establishing regular reviews of existing policies to ensure all policies are current and equitable. This extends to financial policies within BCHD like programmatic discretionary funds, budget allowances, etc. Ideally a collaboration of individuals from across BCHD would provide oversight for policies, procedures, and systems within the department in order to support equity and a culture of transparency. This would require dedicated time and capacity for staff across the department. Inclusion of an equity-focused performance management

process and manager-specific training would support the desire for accountability in management practices as well as clarity and consistency in career opportunities for staff.

Key Strategies

Establish a health policy oversight committee with an explicit role/objective to implement policies, procedures, and systems that support equity	**Timeframe:** one year
Goal	**Recommendations for implementation**
BCHD utilizes best practices for management, documentation, and review of all its policies.	Engage: Health Department Administrative Specialist, Health Senior Leadership, BCHD Compliance Manager, Health Equity Coordinator, staff with lived experience • Review existing policies with a health equity and trauma-informed lens, including BCHD, Human Resources, and financial policies. • Research best practices and leading industry technology in order to implement software that will aid in policy document management and tracking of policy review timelines and related activities. • Create a documented process for qualifications, onboarding, separation from the county, and conduct of staff on the Health Oversight Committee. • Create a committee comprised of diverse staff to oversee the maintenance and execution of the software selection and implementation process, as well as providing ongoing guidance for current and future policies.

Develop an advisory body (e.g., health equity leadership group) made up of staff in direct service and other varying roles who can advise senior leadership	**Timeframe:** one year
Goal	**Recommendations for implementation**
Transparency and accountability mechanisms are established and maintained due to staff having an active role in providing oversight	Engage: Health Equity Coordinator, Health Senior Leadership, Quality Improvement Coordinator, Health Department Administrative Specialist, EDI Coordinator, staff with lived experience

within the organization.	- Create a documented process for qualifications, onboarding, separation from the county, and conduct of staff on the advisory board. - Ensure the advisory board is composed of diverse staff from across BCHD, actively recruit staff from all departments and of all backgrounds. - Research other best practice models and consult with subject matter experts on implementation and needed shifts in organizational culture.
Implement forums for managers and leaders to listen to staff feedback on equity improvements with accountability for action	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Staff have an established system available to provide feedback and ask questions of BCHD leaders, specifically surrounding equity improvements.	Engage: EDI Coordinator, Health Equity Coordinator, Health Senior Leadership and Managers, Quality Improvement Coordinator, Health Department Administrative Specialist, staff with lived experience - Provide staff with dedicated forums to be held regularly and efficiently. - Ensure staff have support in providing feedback about their direct managers to their manager's manager. - Research other best practice models and consult with subject matter experts on implementation and needed shifts in organizational culture.
Increase transparency in decision-making, including opportunities for questions and feedback	**Timeframe:** TBD
Goal	**Recommendations for implementation**
BCHD has a culture of transparency where staff are encouraged to ask questions about decisions and are provided an avenue to give feedback on decisions made by leadership.	Engage: Health Senior Leadership, Communications Coordinator, Health Equity Coordinator, staff with lived experience Provide staff with dedicated time and process for questions and feedback to be provided.

	• Ensure staff have support in providing feedback about BCHD decisions; create an open and transparent atmosphere. • Ensure consistent communication between direct supervisors and staff/teams via team meetings and 1:1 meetings to ensure effective, timely, and transparent communication about decisions.
Include equity goals and skills into performance evaluation and management processes for all staff	**Timeframe:** TBD
Goal	**Recommendations for implementation**
Performance evaluation and management processes are clear and include best practices for evaluating equity skills and leadership and tying it to reviews and evaluations.	Engage: Human Resources, County Leadership, EDI Coordinator, Health Seniors Leadership, staff with lived experience • Ensure equity goals and skills are part of performance reviews for all positions. • Maintain Human Resource records to provide documentation of progress of goals and skills.

Sustained commitment and accountability: guidance for evaluation and monitoring

Beyond this health equity assessment and plan, BCHD senior leadership, managers, and staff will work together to refine the key strategies and actions that will improve health equity in Benton County. While BCHD is tasked with developing specific metrics to evaluate and update this plan as needed, this section provides some high-level guidance on monitoring and evaluation.

Ground actions in data

This health equity plan was created based on findings from a health equity assessment. Collecting data allows us to examine the origins and nature of inequities that we know exist, and supports the development of shared understanding.

The goals and recommendations for implementation included with the key strategies in this plan can provide a helpful starting place to develop more formal evaluation metrics. See also Appendix G for an action plan template that can be used as a tool to operationalize the key strategies and recommendations in this plan.

Connect back to the vision

As aforementioned, this plan contains both short-term and long-term goals. Moving from the “early” level to the “established” and “strong” levels of these organizational characteristics and workforce competencies will be a heavy lift, requiring commitment, sustained support, tenacity, and vision. Instituting a regular practice of reviewing, adapting, and connecting actions to the vision in this plan provides opportunities to re-energize staff and leadership in this work.

Continue assessing, reflecting, and planning

Over six weeks, the health equity planning workgroup met for 90 minutes at a time to delve deep into the assessment findings, develop recommendations, and discuss potential opportunities and barriers. This dedicated time for diverse staff members to come together and do some focused thinking on BCHD's health equity work was central to the creation of this plan. As BCHD shifts from assessment to implementation, it is recommended that a health equity workgroup is engaged to ensure that the work continues to move forward in a way that is informed by diverse experiences and perspectives of BCHD staff. Further, establishing mechanisms for ongoing communication with and feedback from all BCHD staff will be vital to building long-term buy-in and shared understanding of this work and the desired outcomes.

Appendix

A. Staff Survey
B. Partner Survey
C. Staff Focus Group Guide
D. Management Interview Guide
E. Glossary of Key Terms
F. Equity Training Resources
G. BARHII Action Plan Template