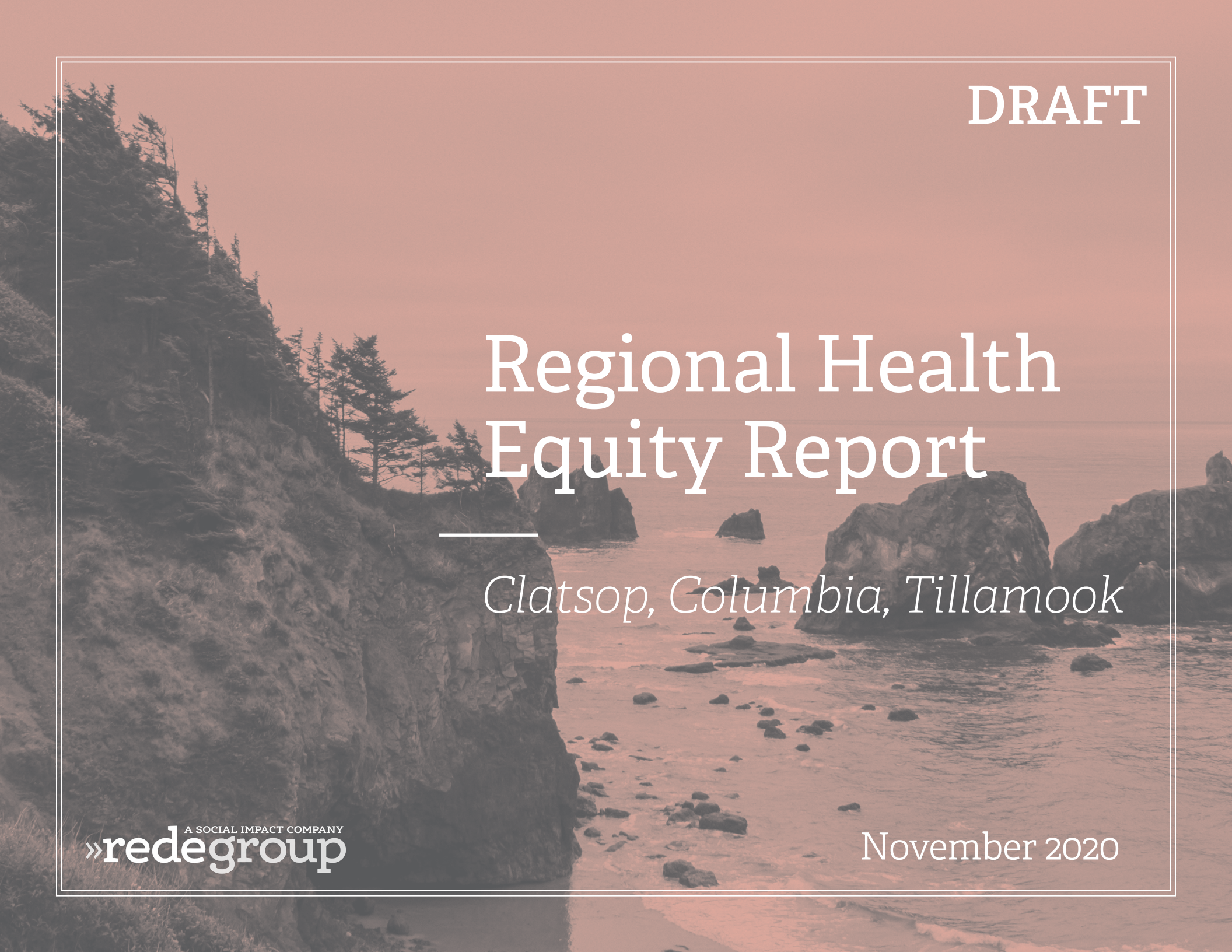


DRAFT

Regional Health Equity Report

Clatsop, Columbia, Tillamook

A SOCIAL IMPACT COMPANY
»redegroup

November 2020

acknowledgments

We want to acknowledge the many people who contributed to the development of this Regional Health Equity Report, including staff and leadership within Clatsop, Columbia, and Tillamook County Health Departments and County Commissioners who provided their input through surveys and interviews.

Rede Group project team:

Beck Wright, MPH
Alex Muvua
Jill Hutson, MA
Erin Charpentier, MFA
Noelle Hill, MPH
Elisabeth Castillo
Ashley Coskey
Sarah Hallaj, RD, MPH

Under the direction of:

Michael McNickle, PhD, MPA, REHS
Public Health Director, Clatsop County Department of Public Health

Ellen Heinitz, ND
Community Health Project Manager, Clatsop County Health Department of Public Health

Michael Paul, JD, MPH
Public Health Director, Columbia County

Marlene Putman, JD
Local Health Administrator, Tillamook County Health & Human Services Department

Cover photo: Cannon Beach, Oregon. Photo by: Sarandy Westfall

contents

contents

Figures + Tables:

DRAFT

introduction, methods, analysis, & limitations

introduction

Background

Clatsop, Columbia, and Tillamook Counties are working together to evaluate health equity in Oregon's Northern Coastal Region and plan how to mitigate disparities.

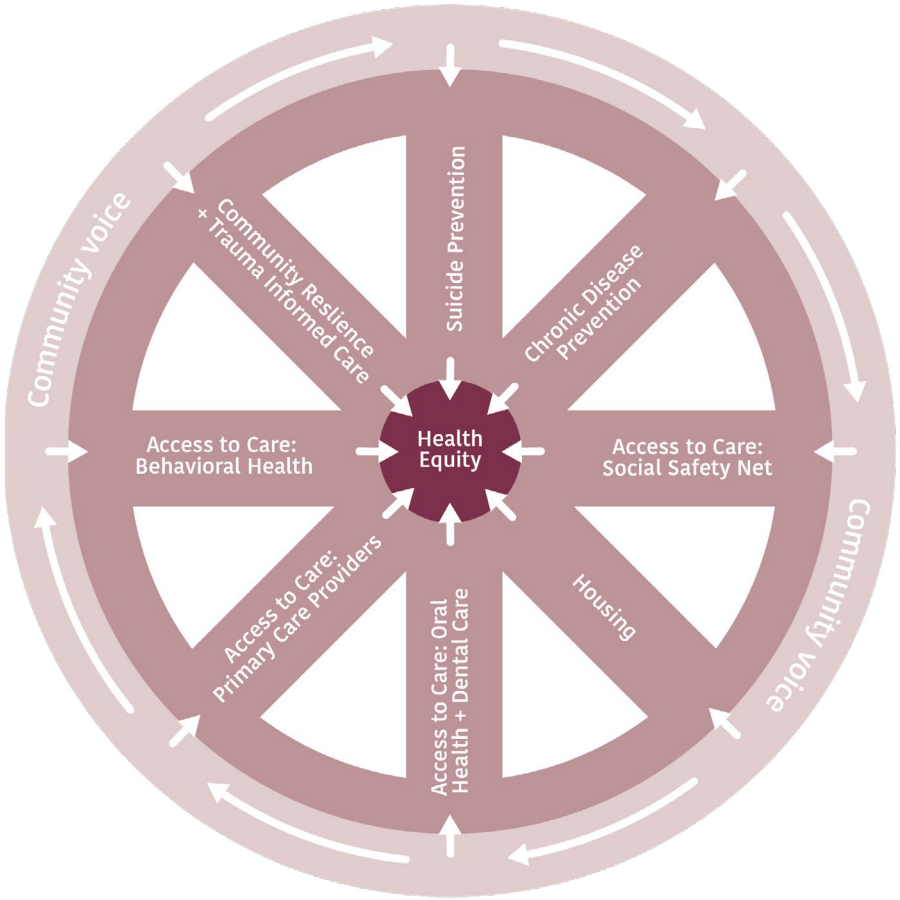
> "HEALTH EQUITY MEANS THAT EVERYONE HAS A FAIR AND JUST OPPORTUNITY TO BE AS HEALTHY AS POSSIBLE. FOR THE PURPOSES OF MEASUREMENT, HEALTH EQUITY MEANS REDUCING AND ULTIMATELY ELIMINATING DISPARITIES IN HEALTH AND ITS DETERMINANTS THAT ADVERSELY AFFECT EXCLUDED OR MARGINALIZED GROUPS" (RWJ, 2017).

Although health equity work has been on-going and evolving in the region for many years, this particular body of work-- to formally asses health equity and plan for improvements-- was initiated in 2019 as a part of the region's Public Health Modernization[1] regional partnership for communicable disease control. As the lead agency for the regional collaborative, Clatsop County hired The Rede Group (Rede) to support assessment and planning.

Purpose

The purpose of the report is to describe the distribution of social determinants of health, health behaviors, and health factors within the region of Clatsop, Columbia, and Tillamook Counties, how the three public health departments currently work to addresses health equity, and to develop a regional health equity plan for recommendations.

Figure 1: Health equity wheel



notes:

1. Public Health Modernization is a broad scale, statewide initiative to update and upgrade Oregon's public health system with a focus on delivering foundational public health services to everyone in the state.

Regional health equity assessment

This report draws on multiple data sources to describe, using statistical measure, the health status of the communities within the region:

- American Community Survey (ACS)
- Behavioral Risk Factor Surveillance System (BRFSS) Oregon County-level Reports
- Oregon Health Insurance Survey (OHIS)
- County Health Rankings (CHR)
- Oregon Healthy Teens Survey (OHT)
- Oregon State Population Health Indicators County Tables
- Oregon Vital Statistics Annual Reports
- US Census Bureau
- Oregon Health Authority COVID-19 Data

A limitation for the Regional Health Equity Assessment is a lack of existing equity data. Due to the small population sizes of Clatsop, Columbia, and Tillamook Counties, there is little available data that examines the intersections of race, gender, sexual orientation, disabilities, veteran status, poverty, etc. and health indicators. The lack of data cannot be interpreted to mean that there are no inequities between groups in the region.

Because Latinx is an ethnicity, not a race, not all data sources report on it in the same way. In some cases, Latinx is pulled out of data for race, and other times it is not. For any race data presented in this report, it will be indicated if it includes people who have Latinx ethnicity or not.

Another limitation of this assessment is the timing of the 2019 novel coronavirus (COVID-19) pandemic. The spread of the coronavirus in Oregon and the United States has significantly impacted all Americans, including key stakeholders in this evaluation, such as governmental public health and County Commissioners. The need for counties within this region to prioritize work on the COVID-19 response, as well as the Governor-imposed stay at home order, impacted the assessment data collection and limited the contracted project team's ability to schedule and conduct interviews and collect survey responses. It is also noteworthy that all communication for the assessment, including project team meetings and stakeholder engagement, occurred virtually due to COVID-19.

Clatsop County COVID-19 Case Study

Semi-structured interviews (see Appendix A for interview questions) were conducted by Consejo Hispano staff with ten community members who were diagnosed with COVID-19 to identify common themes and important narratives. Consejo Hispano is a community based organization that supports the equitable integration of Latinx residents in Oregon and Washington. They offer programs and services that focus on education, health, financial empowerment and advocacy & civic engagement. Because they are a trusted source of support, they were a natural partner for collecting data on the experiences of Latinx community members.

Interviews were also conducted by Rede with key public health staff involved in managing the outbreak, as well as with county leadership to provide contextual information about the circumstances of the outbreak.

Interview data was coded to identify themes and important narratives to inform the case study (see page 33).

BARHII toolkit

The Bay Area Health Inequities Initiative (BARHII) Organizational Self-assessment for Addressing Health Inequities toolkit (see Appendix B) was selected by the regional collaborative as it is an evidence-based toolkit that serves to identify the internal local health department capacity, skills, and areas for improvement to support health equity focused activities. Developed by a collaboration of health departments in the San Francisco Bay area, the BARHII toolkit provides resources tailored to local health departments and uses public health language, which made it more relevant than other assessment options. This toolkit was a health equity tool recommended by the Oregon Health Authority Modernization Team.

The BARHII toolkit offers multiple self-assessment instruments: an internal staff survey, collaborating partner survey, staff focus group, management interviews, and internal document review and discussion. The regional collaborative and the contracted research team used a modified version of the internal staff survey and management interview guide for this assessment.

LHD internal health equity capacity assessment: staff survey

Rede collaborated with Clatsop County Public Health Administrator and Community Health Project Manager to modify the BARHII staff survey to meet the needs of the regional collaborative. The adapted survey tool consisted of 41 multiple choice questions and three open ended questions for a total of 44 (see Appendix C). Survey questions were entered into SurveyMonkey[2] and also formatted into a pen and paper version.

The Clatsop County Community Health Project Manager administered the survey in person and through a SurveyMonkey link to the health department staff in all three counties. Paper surveys collected from staff were entered into SurveyMonkey by the Clatsop County Community Health Project Manager.

The survey was administered for an extended period of four months (March-June 2020) in order to collect as many responses as possible during COVID-19. The survey received 28 responses.

Rede tabulated all data to perform basic analysis and develop tables and charts displaying responses. Open-ended responses were transferred to Dedoose qualitative analysis software[3] for content analysis. Data were analyzed in aggregate for the region to preserve anonymity due to the small number of staff working in individual counties.

LHD internal health equity capacity assessment: leadership interviews

Working directly with the Clatsop County Community Health Project Manager, Rede identified a list of seven interviewees consisting of Local Public Health Department directors and managers, and County Commissioners with a knowledge of health inequities and disparities in the community they serve. Interviews were scheduled by Rede with six interviewees. Rede conducted four structured interviews with health department managers and two interviews with County Commissioners, using an adapted BARHII interview guide (see Appendix D). Interviews were conducted by telephone and were performed by a professional interviewer from Rede. Interviews took place from March-May 2020 and were recorded and transcribed to aid in accuracy of reporting.

notes:

2. SurveyMonkey Inc.San Mateo, California, USA. www.surveymonkey.com
3. Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

methods, analysis, & limitations

Rede conducted a multi-phase content analysis of the transcripts, in which each was coded by an analyst based on emerging themes using Dedoose qualitative analysis software and reviewed by a second analyst to ensure accuracy. Data across all interviews were analyzed to identify key themes and potentially important narratives.

Stakeholder engagement

To be added at a later date.

Health Equity Planning

Rede facilitated two meetings in November 2020 with key stakeholders including County Public Health Directors from the three counties and additional key staff to review and gather feedabck on the draft regional health equity assessment and develop the regional health equity plan.

Terminology + Acronyms

Latinx: Latinx is a term used to describe people who are of or relate to Latin American/ hispanic origin or descent. It is a gender-neutral or nonbinary alternative to Latino or Latina.

The following acronyms occur throughout this report:

AI/AN	American Indian/Alaska Native
BARHII	Bay Area Regional Health Inequities Initiative
CBO	Community based organization
ESE	Environmental, social, and economic
HI	Health inequities
LHD	Local health department
NL	Not Latinx
NH/PI	Native Hawaiian/Pacific Islander

DRAFT

regional health equity assessment

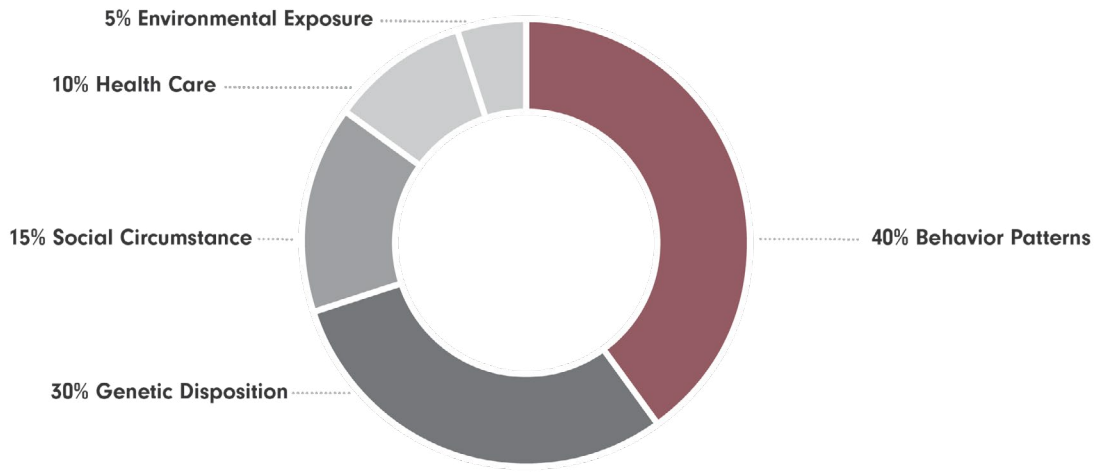
Social determinants of health

The conditions in which people are born, live, learn, work, and play affect a wide range of health outcomes. Factors such as poverty, housing, access to healthy food, education, and inequitable access based on structural racism or classism are powerful predictors of health. Understanding these factors, called the social determinants of health, is critical to understanding a community's overall health.

The social determinants of health play a complex role in health outcomes and there is not consensus on how to precisely measure their overall impact on health. As seen in Figure 2, behavior patterns are the leading contributor to premature death. Behavior patterns are modifiable, and thus, an important place to focus efforts to improve health.

As the Health Impact Pyramid in Figure 3 exemplifies, improving the social determinants of health in a community will have the biggest impact on population health.

Figure 2: Proportional Contribution to Premature Death[4]



notes:

4. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93

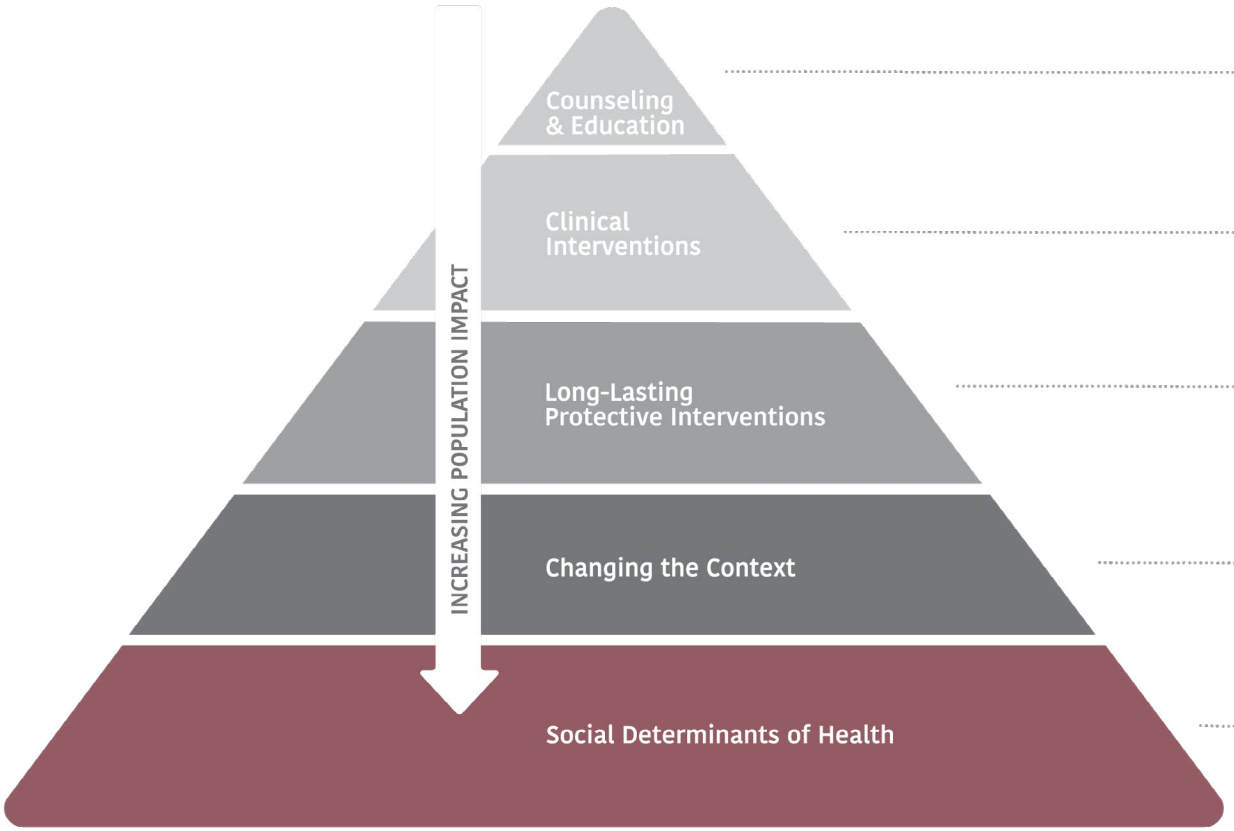
Table 1: Social Determinants of Health[5]

ECONOMIC STABILITY	NEIGHBORHOOD AND PHYSICAL ENVIRONMENT	EDUCATION	FOOD	COMMUNITY AND SOCIAL CONTEXT	HEALTH CARE SYSTEM
• employment • income • expenses • debt • medical bills • support	• housing • transportation • safety • parks • playgrounds • walkability • zip code/ geography	• literacy • language • early childhood education • vocational training • higher education	• hunger • access to healthy options	• social integration • support systems • community engagement • discrimination • stress	• health coverage • provider availability • provider linguistic/cultural competency • quality of care
HEALTH OUTCOMES: **MORTALITY, MORBIDITY, LIFE EXPECTANCY, HEALTH CARE EXPENDITURES, HEALTH STATUS, FUNCTIONAL LIMITATION**					

notes:

5. Henry J. Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, May 2018. Retrived from: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Figure 3: Health impact pyramid[6]



One-on-one counseling or educational programs such as encouraging people to eat healthy & be physically active.

Ongoing clinical interventions such as treatment for high blood pressure, high cholesterol, & diabetes.

One-time or periodic interventions such as immunizations and regular health screenings.

Population-level interventions such as the Indoor Clean Air Act, healthy food vending policies, and tobacco tax increases.

Interventions such as early childhood education, public transportation, home improvement loans and grants, water fluoridation, & healthy food availability.

notes:

6. Frieden T. R. (2010). A framework for public health action: the health impact pyramid. Am J Public Health. 2010 April; 100(4): 590–595.

Community health data

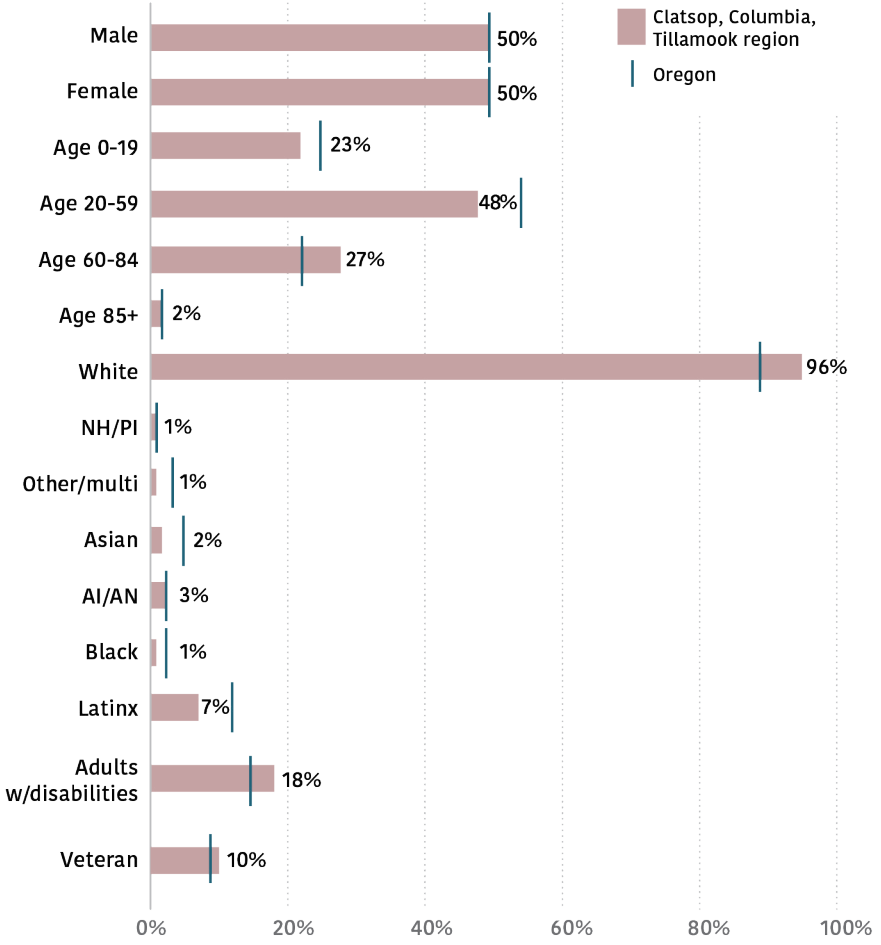
The community health data presented in this section were gathered from the 2019 Regional Health Assessment[7] and updated where available. Additional secondary data were incorporated as identified by the research team and regional collaborative.

DEMOGRAPHICS

Figure 3 shows the demographic makeup of the region. This region has a higher percentage of people ages 60-84, White people, and adults with disabilities when compared to Oregon state as a whole. The region has a lower percentage of younger people, ages 0-59, and people of color (with the exception of American Indian/ Alaska Natives) when compared to the state.

Figures 5, 6, and 7 provide basic demographics and a snapshot of select indicators for the social determinants of health in each county, including poverty, food insecurity, housing, health insurance, education, childhood experiences and disability. For each of these indicators, the Oregon averages are shown in the blue line for comparison. Further in the report, some of the same indicators are displayed in bar charts for the region (and for each county if regional data were not possible).

Figure 4: Population by gender, age, race, ethnicity, disability, and veteran status

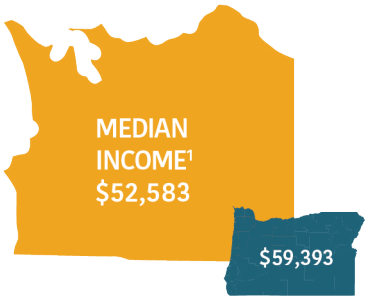


source: US Census Bureau, ACS Demographic And Housing Estimates. 2018

notes:

7. Regional Health Assessment & Regional Improvement Plan 2019

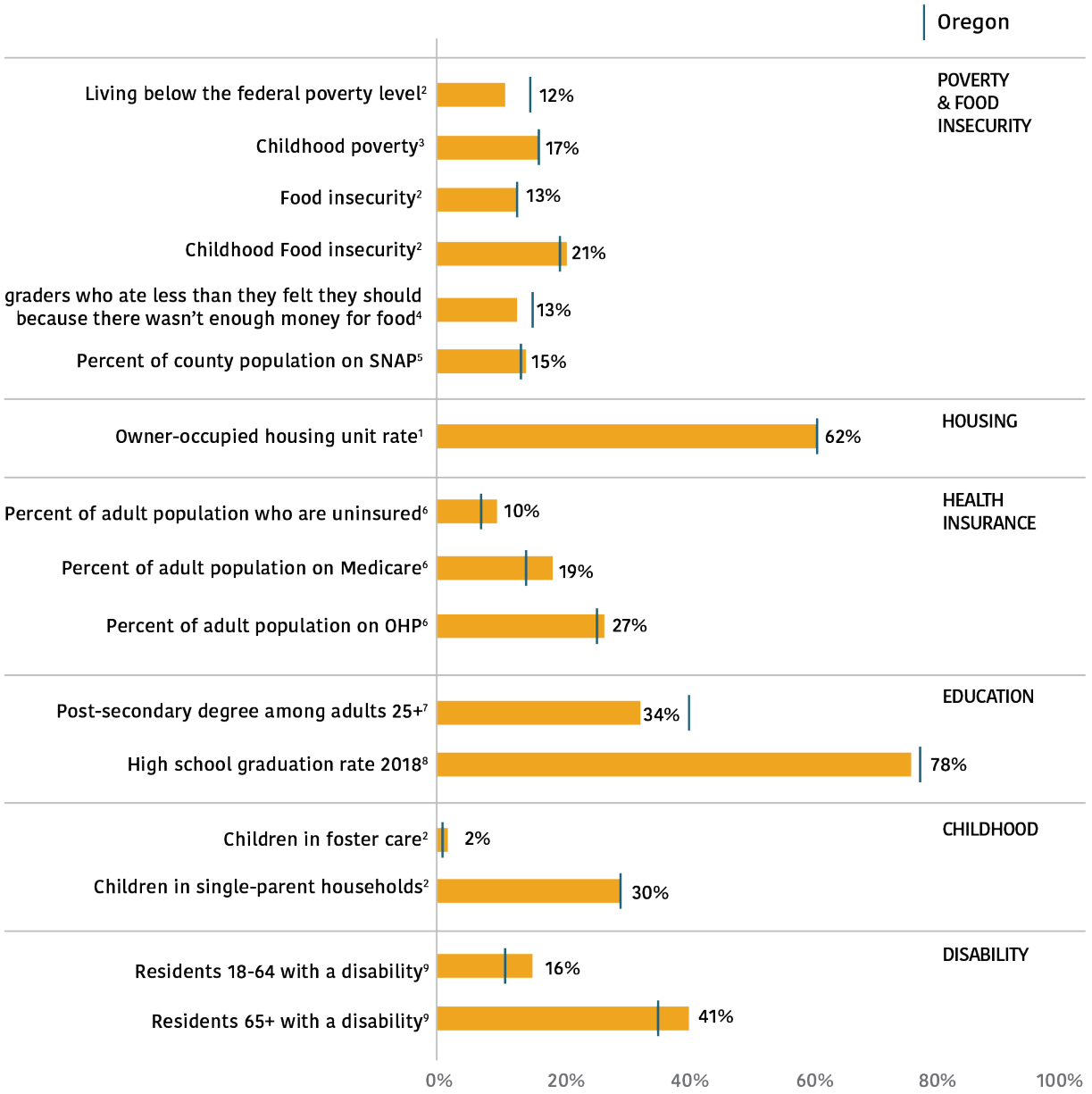
Figure 5: Clatsop County overview



Clatsop
White.....96%
Black.....1%
AI/AN.....3%
Asian.....2%
Other.....2%
Latinx.....9%

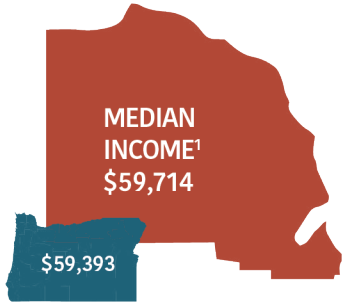
Population.....38,562

Race categories are not exclusive of Latinx ethnicity



Sources:
1. U.S. Census Bureau (2014-18)
2. OHA Population living below federal poverty level by county, Oregon, 2013-2017 and food insecurity by county, Oregon 2016
3. 2019 Children First for Oregon County Data Sheets
4. Oregon Healthy Teens Survey 2019
5. SNAP County Table by FIPS Jan2019-Dec2019
6. OHA, Oregon Health Insurance Survey 2017
7. Post-secondary degree among adults ≥ 25 years by county, Oregon, 2013–2017
8. OHA, Four-year high school graduation rate by county, Oregon, 2017–2018
9. American Community Survey, 2014-2018 5 year estimates

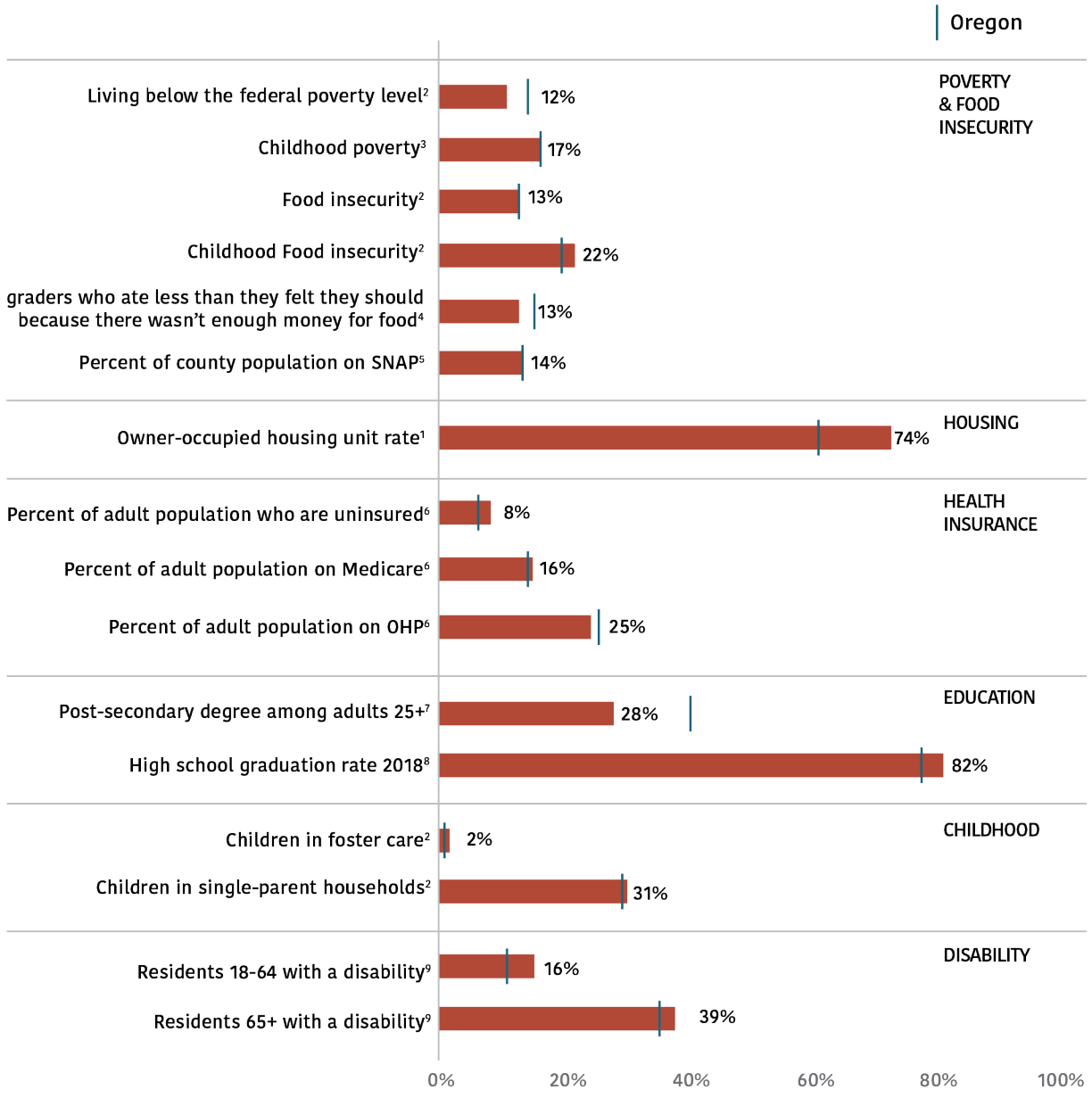
Figure 6: Columbia County overview



Columbia
White.....97%
Black.....1%
AI/AN.....3%
Asian.....2%
Other.....1%
Latinx.....5%

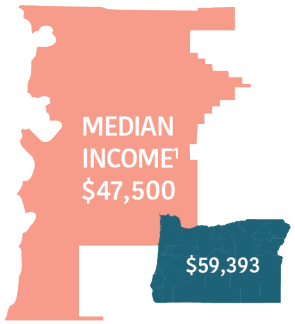
Population.....50,851

Race categories are not exclusive of Latinx ethnicity



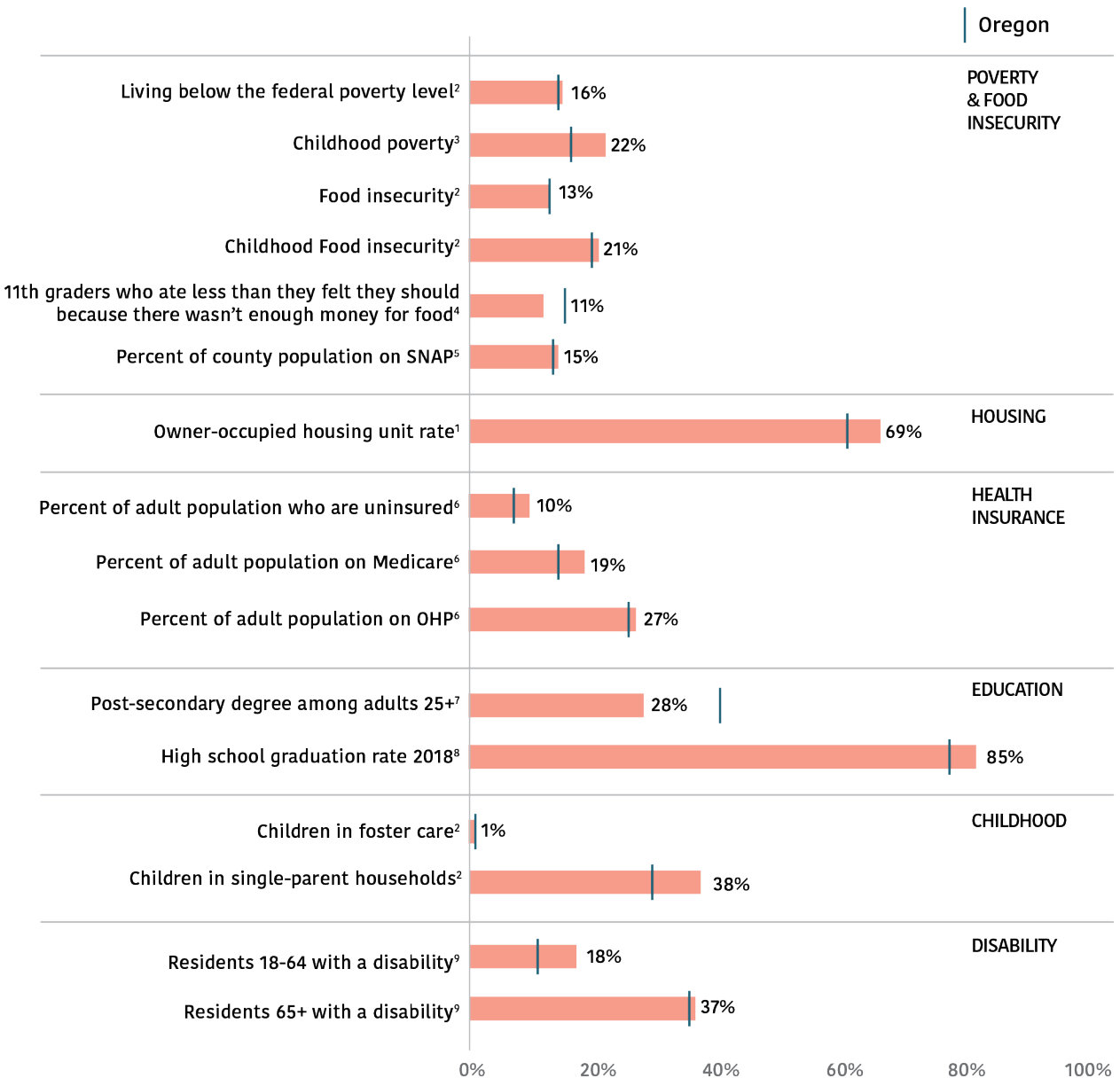
Sources:
1. U.S. Census Bureau (2014-18)
2. OHA Population living below federal poverty level by county, Oregon, 2013-2017 and food insecurity by county, Oregon 2016
3. 2019 Children First for Oregon County Data Sheets
4. Oregon Healthy Teens Survey 2019
5. SNAP County Table by FIPS Jan2019-Dec2019
6. OHA, Oregon Health Insurance Survey 2017
7. Post-secondary degree among adults ≥ 25 years by county, Oregon, 2013–2017
8. OHA, Four-year high school graduation rate by county, Oregon, 2017–2018
9. American Community Survey, 2014-2018 5 year estimates

Figure 7: Tillamook County overview



Tillamook
White.....96%
Black.....1%
AI/AN.....3%
Asian.....2%
Other.....2%
Latinx.....10%

Population.....26,076



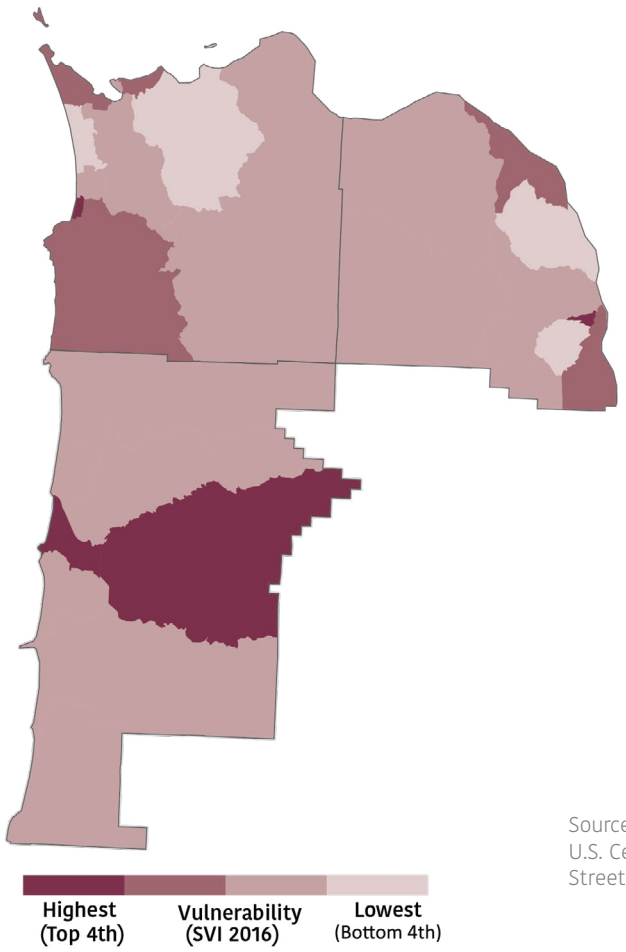
Race categories are not exclusive of Latinx ethnicity

Sources:
1. U.S. Census Bureau (2014-18)
2. OHA Population living below federal poverty level by county, Oregon, 2013-2017 and food insecurity by county, Oregon 2016
3. 2019 Children First for Oregon County Data Sheets
4. Oregon Healthy Teens Survey 2019
5. SNAP County Table by FIPS Jan2019-Dec2019
6. OHA, Oregon Health Insurance Survey 2017
7. Post-secondary degree among adults ≥ 25 years by county, Oregon, 2013–2017
8. OHA, Four-year high school graduation rate by county, Oregon, 2017–2018
9. American Community Survey, 2014-2018 5 year estimates

OVERALL SOCIAL VULNERABILITY

Social vulnerability[9] refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human caused threats, such as toxic chemical spills. The Agency for Toxic Substances and Disease Registry's Social Vulnerability Index (SVI 2016)[10] County Maps depict the social vulnerability of communities, at census tract level, within a specified county. SVI 2016 groups fifteen census-derived factors into four themes that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access, see Figure 8 on the following page. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

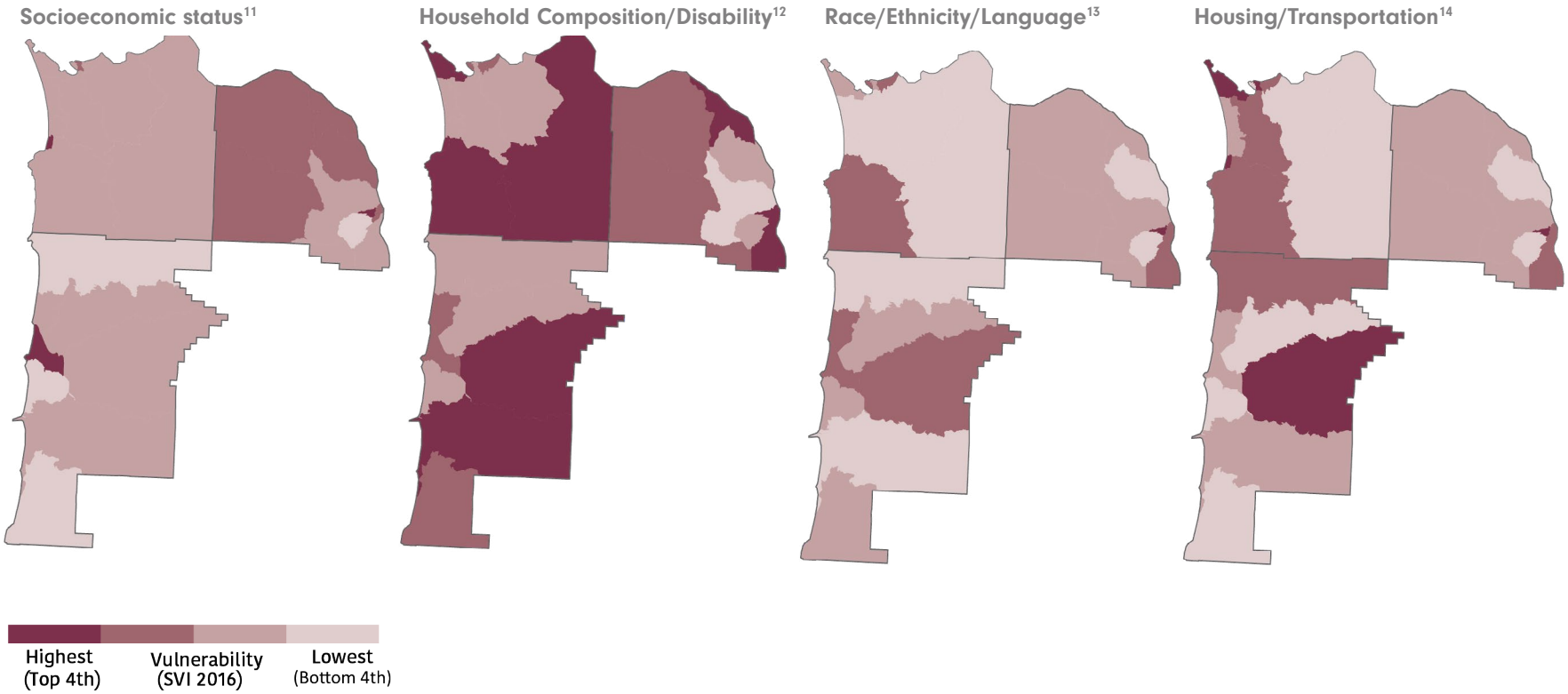
Figure 8: Regional Social Vulnerability (overall)[8]



Source: CDC/ATSDR/GRASP, U.S. Census Bureau, Esri® StreetMapTM Premium

notes:
8. Overall Social Vulnerability: All 15 variables.
9. Agency for Toxic Substances and Disease Registry, Division of Toxicology and Human Health Sciences, CDC's Vulnerability Index, 2016
10. The SVI combines percentile rankings of US Census American Community Survey (ACS) 2012-2016 variables, for the state, at the census tract level.

Figure 9: Social Vulnerability Index Themes



Source: CDC/ATSDR/GRASP, U.S. Census Bureau, Esri® StreetMapTM Premium

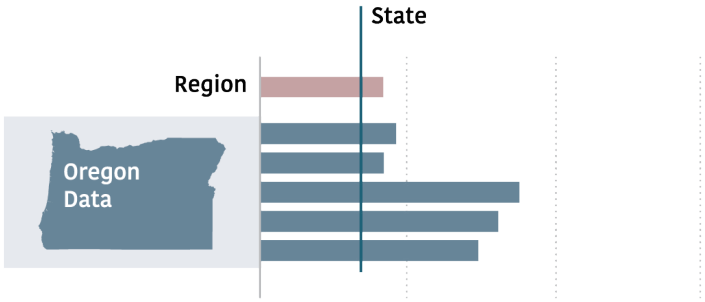
notes:
11. Socioeconomic Status: Poverty, Unemployed, Per Capita Income, No High School Diploma.
12. Household Composition/Disability: Aged 65 and Over, Aged 17 and Younger, Single-parent Household, Aged 5 and over with a Disability.
13. Race/Ethnicity/Language: Minority, English Language Ability.
14. Housing/Transportation: Multi-unit, Mobile Homes, Crowding, No Vehicle, Group Quarters.

READING THE CHARTS IN THIS REPORT

As mentioned in the limitations section of the report, specific data examining race/ethnicity, gender, sexual orientation, disability status, veteran status, and age across community health indicators were not largely available in the region. The absence of this data cannot be interpreted as the absence of health disparities in the region.

Throughout this Regional health equity assessment, disaggregated Oregon data is provided to illustrate potential disparities. These data were disaggregated by race/ethnicity, gender, sexual orientation, disability status, veteran status, and age depending on the community health indicator examined. The Oregon data are displayed in the charts as blue bars and labeled alongside an outline of the state (see chart example on the right).

The purpose of including this information is not to compare the regional data to the state-level disparity data, or to compare sub-populations to each other, but rather to highlight that there may be certain communities in the region experiencing health disparities.



MEDIAN INCOME AND POVERTY

Median household income represents the amount that divides the distribution of income in a community. Half of the incomes in the community are above the median and half of the incomes in the community are below the median. It is a way to compare income distribution across different communities. Both Clatsop and Tillamook County had lower median household incomes compared to that of Oregon, while Columbia County's median income is about the same as the rest of the state.

The percentage of people living in poverty in this region is similar to Oregon as a whole. State level data on disparities by race/ethnicity are shown to indicate potential disparities in the region.

Figure 10: Median income by race/ethnicity

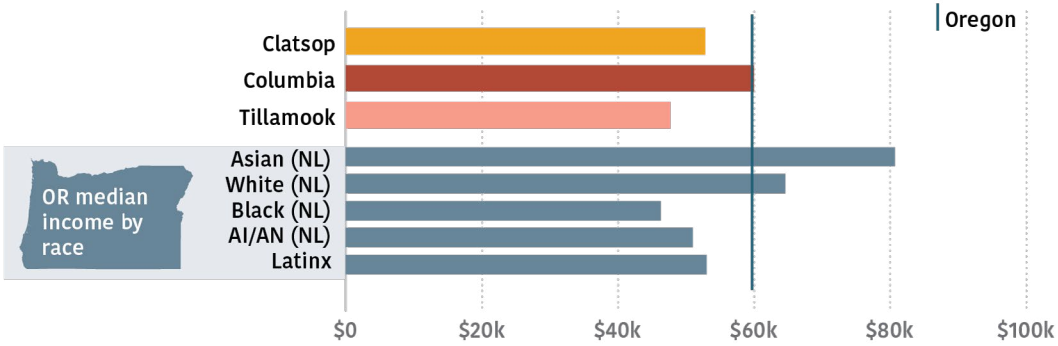
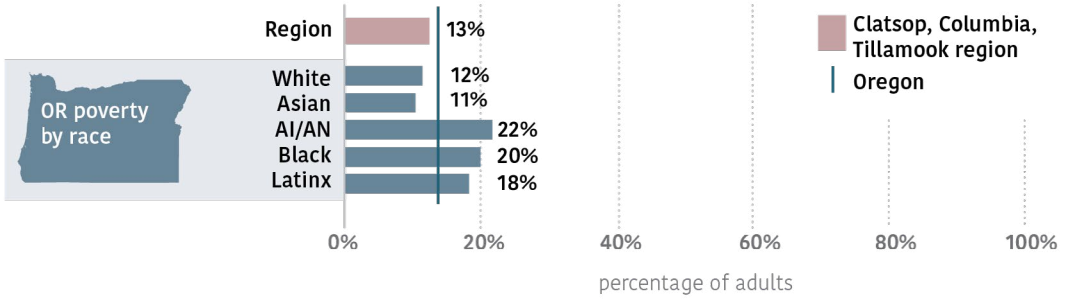


Figure 11: Poverty by race/ethnicity



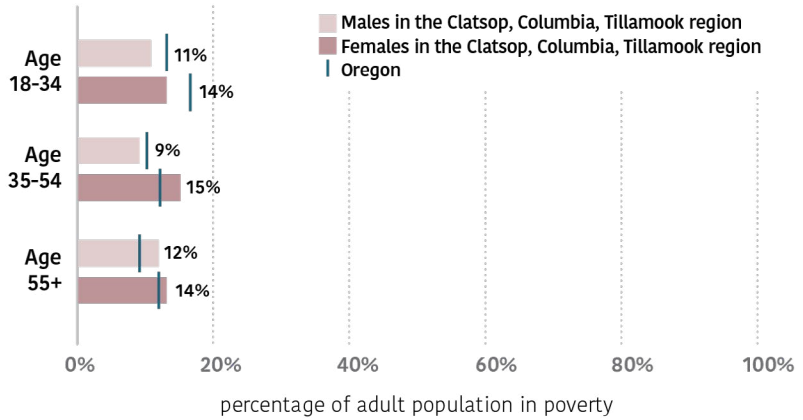
NL = non latinx

sources:
U.S. Census Bureau, Quick Facts, 2018
OHA, Population living below federal poverty level by county, Oregon, 2013-2017
U.S. Census Bureau, American Community Suvey, 2018

POVERTY BY AGE AND SEX

The Census Bureau uses a set of income thresholds that vary by family size and composition to determine who is classified as impoverished. If a family's total income is less than the family's threshold, then that family and every individual in it is considered to be living in poverty. In Oregon as well as this region, the largest demographic living in poverty are female. In this region, the largest demographics living in poverty are females 35 and older and males 55 and older. This region has lower rates of poverty among males and females between the ages 18-34 when compared to Oregon.

Figure 12: Poverty by age and sex



source:
U.S. Census Bureau, Quick Facts, 2018

RATES OF HOMELESSNESS

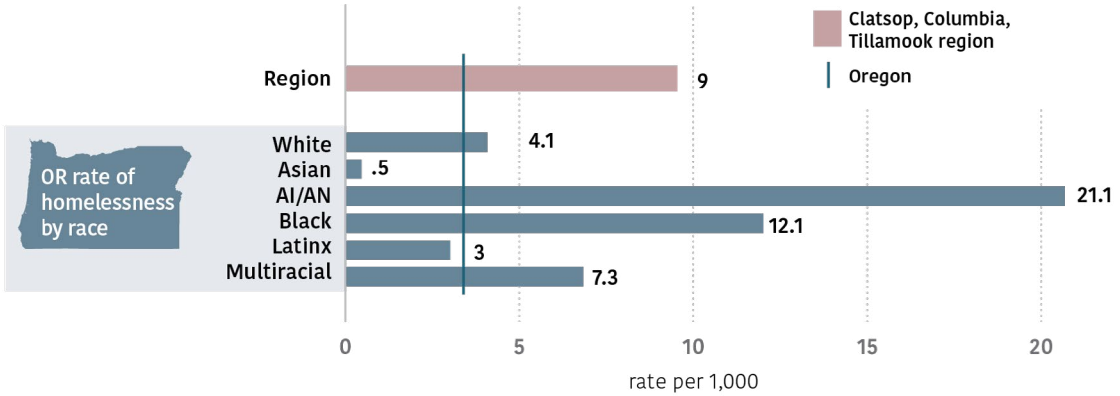
The Clatsop, Columbia, and Tillamook region has three times as many people experiencing homelessness in comparison to Oregon: 9 adults per 1,000 compared to 3 adults per 1,000 respectively.

In Oregon, American Indian/Alaska Natives, Black, and people identifying with multiple races have much higher rates of homelessness than the state rate. This data indicates these inequities may also exist in the rates of homelessness in the region.

UNINSURED POPULATION

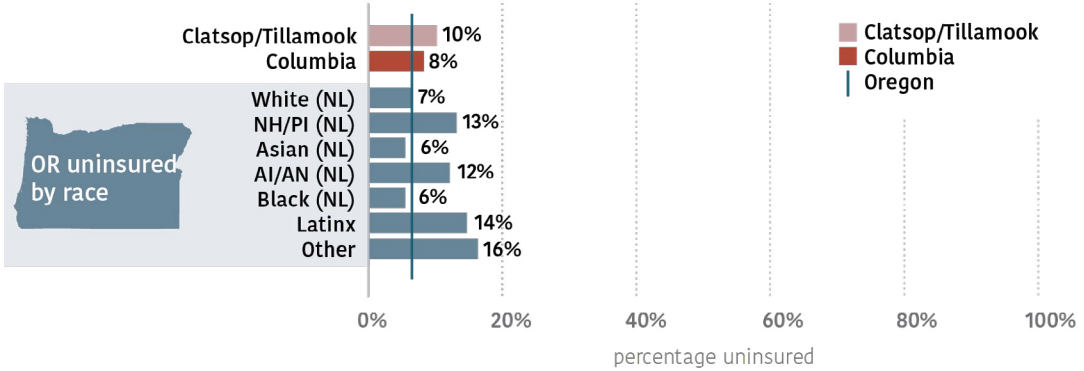
Clatsop, Tillamook and Columbia Counties have a slightly higher percentage of uninsured adults compared to the general population in Oregon (6%). As you can see by the state data, many communities of color experience a higher prevalence of being uninsured, including Native Hawaiian/ Pacific Islander, American Indian/Alaska Native, and Latino/a. Although there is no regional data by race, state data may be helpful in considering which communities may be experiencing inequities in the region.

Figure 13: Rates of homelessness by race/ethnicity



sources: U.S. Census Bureau, Estimates of the homesless population by County, Oregon, 2017
Race categories are inclusive of Latinx ethnicities

Figure 14: Uninsured population by race/ethnicity

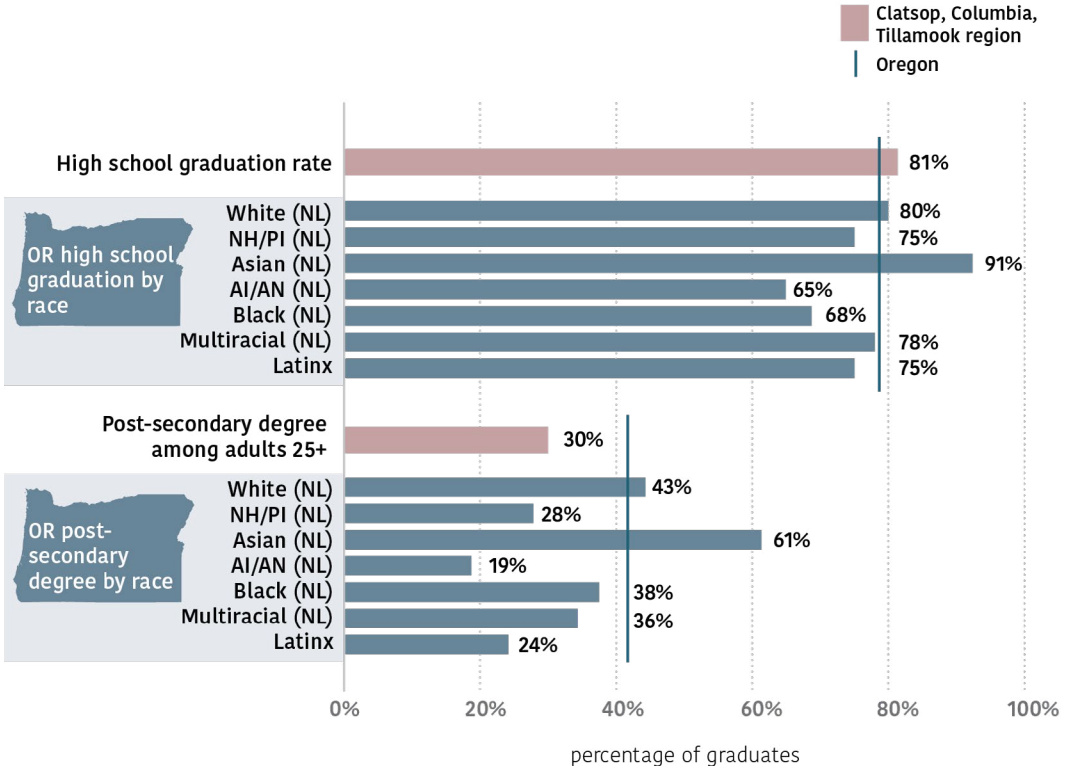


source: OHA, Oregon Health Insurance Survey, 2017
Race categories are exclusive of Latinx ethnicities

EDUCATION

Educational attainment is a key determinant of health. People who obtain post-secondary education are more likely to live longer, experience better health, and participate in more health promoting behaviors such as: limiting tobacco use, receiving timely health screenings, exercising regularly, etc.[15] Although the percentage of high school students graduating in the region are similar when compared to Oregon, adults in the region are less likely to achieve a post secondary degree.

Figure 15: Educational attainment by race/ethnicity



sources: OHA, Oregon State Population Health Indicators, Social Determinants of Health: Education Attainment, 2019
Race categories are exclusive of Latinx ethnicity

notes:
15. Robert Wood Johnson Foundation, Commission to Build a Healthier America. (2009) Issue Brief: Education and Health.

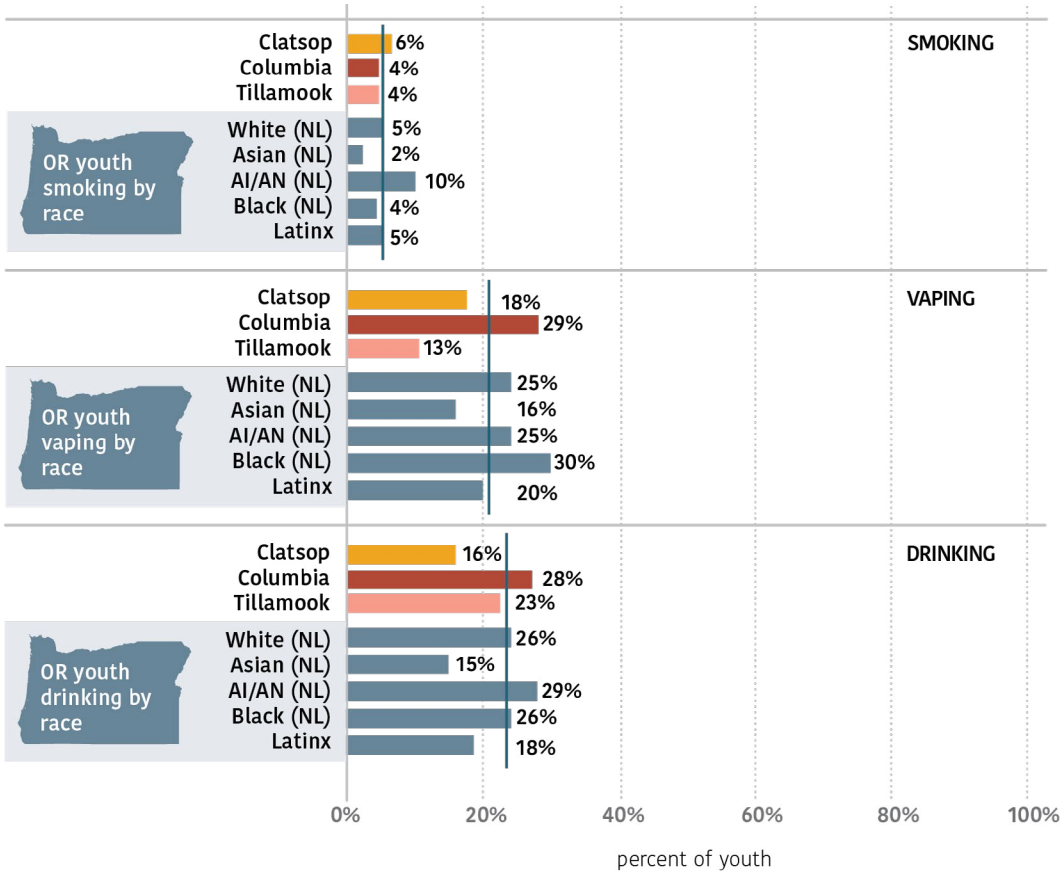
YOUTH RISK FACTORS

Data tables describe any use by 11th grade students on at least one or more of the past 30 days. Smoking refers to smoking cigarettes. Drinking means consuming any alcoholic beverage including beer, wine, liquor, wine coolers and malt beverages. Vaping refers to any vaping or e-cigarette use; the way the question is framed in the Oregon Healthy Teens survey does not explicitly exclude marijuana use, although there is a separate question that asks about mode of ingestion for marijuana. Because there are multiple substances that may be vaped, we do not know for sure that these numbers only represent nicotine products.

Cigarette smoking prevalence is similar in the region when compared to the state. For both vaping and drinking, Columbia has higher prevalence than the state and the other two counties in the region, while both Clatsop and Tillamook have lower prevalence of vaping among youth and Clatsop has lower prevalence of drinking.

State level data indicates that there may be inequities in the region for American Indian/ Alaska Native youth across all three indicators, and for White and Black youth for vaping.

Figure 16: Youth risk factors



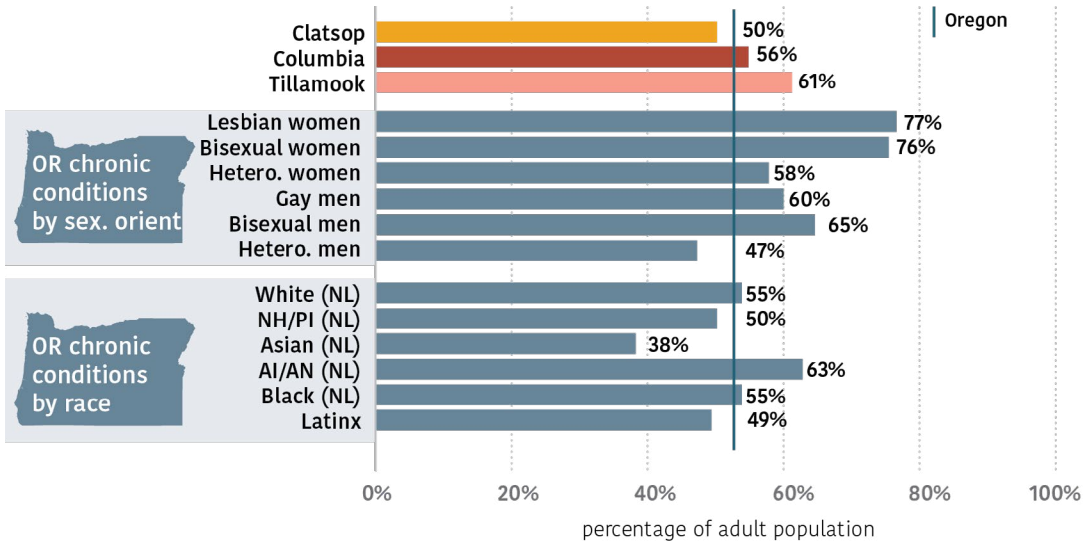
source: Oregon Healthy Teens Survey 2019
Race categories are exclusive of Latinx ethnicities

CHRONIC CONDITIONS

Chronic conditions include: arthritis, asthma, heart disease, heart attack, stroke, depression, diabetes, cancer, and chronic obstructive pulmonary disease. The percentage of adults with at least one of these chronic health conditions are similar in the three counties compared to Oregon, although Tillamook County is a bit higher.

Oregon racial/ethnic and sexual orientation data indicates that sexual minorities and American Indian/Alaska Natives in the region may be experiencing higher numbers of chronic conditions.

Figure 17: Adults with one or more chronic condition

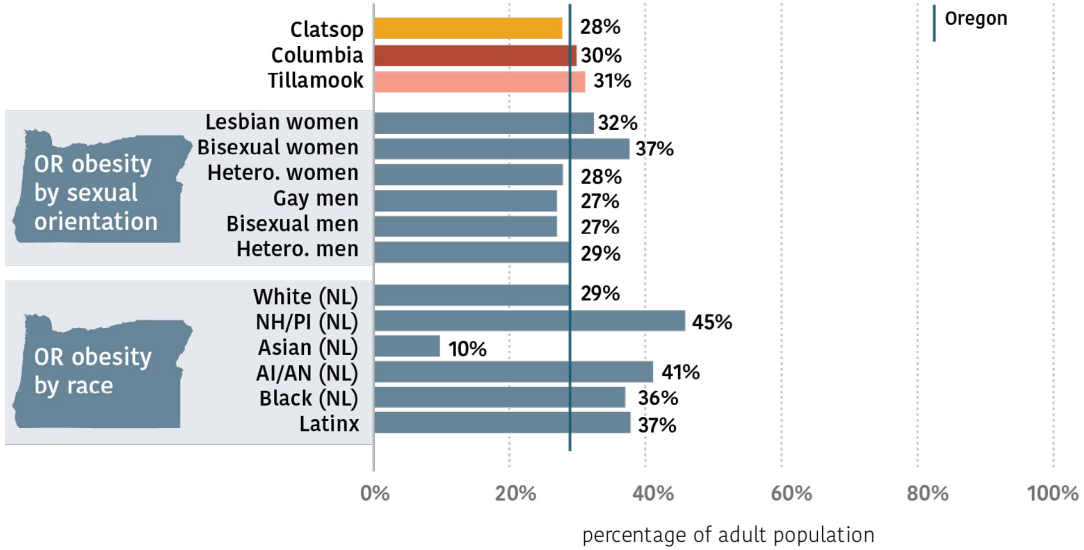


source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

OBESITY AMONG ADULTS

The region has a similar prevalence of obesity in comparison to the state. However, Oregon disparities data indicates that some groups within the region may have a higher prevalence of obesity, including sexual minority women and people of color (except Asian).

Figure 18: Obesity among adults



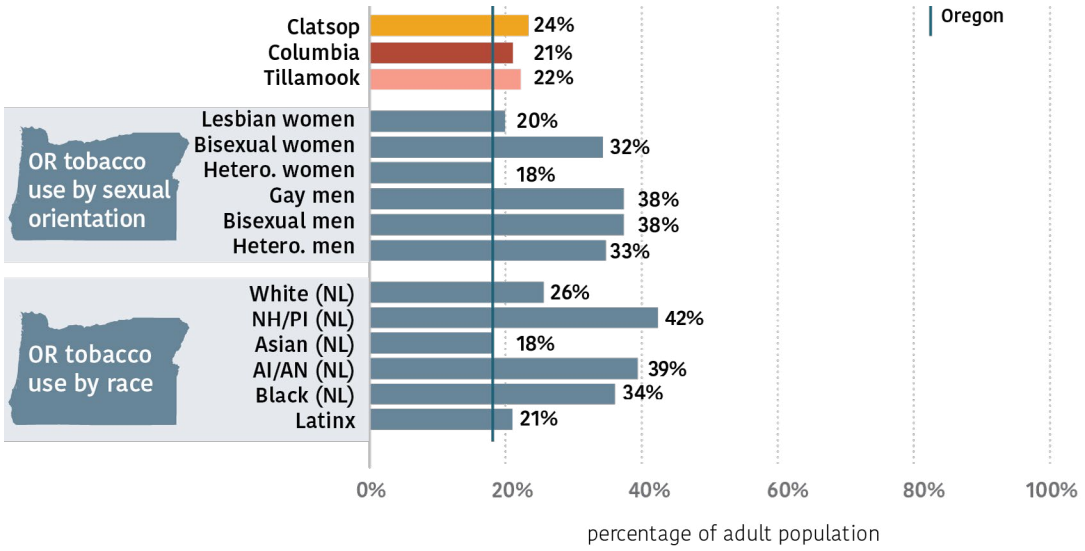
source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

TOBACCO USE AMONG ADULTS

The prevalence of adults who smoke cigarettes is higher in this region when compared to Oregon, which may contribute to higher rates of death from cancer and heart disease in the region compared to Oregon (see Figure 21 for details on preventable cause of death).

Oregon disparities data indicate that some communities in this region may experience a higher prevalence of tobacco use, including men, bisexual women, and communities of color (except Asian).

Figure 19: Tobacco use among adults

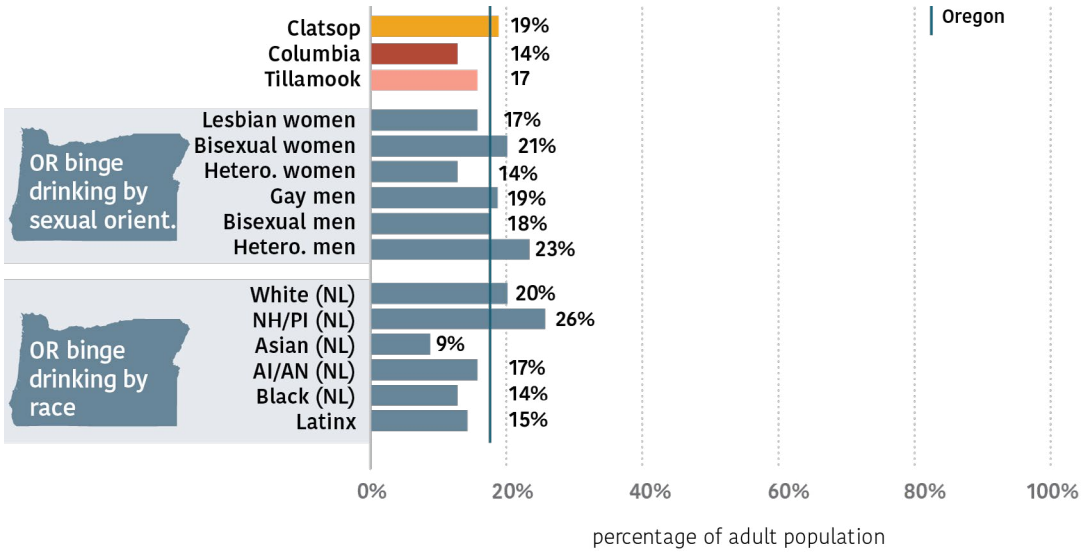


source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

BINGE DRINKING AMONG ADULTS

Binge drinking in the region is lower than the state, with the exception of Clatsop County. Some communities may binge drink more, including Whites, Native Hawaiian Pacific Islander, and bisexual women and heterosexual men.

Figure 20: Binge drinking among adults

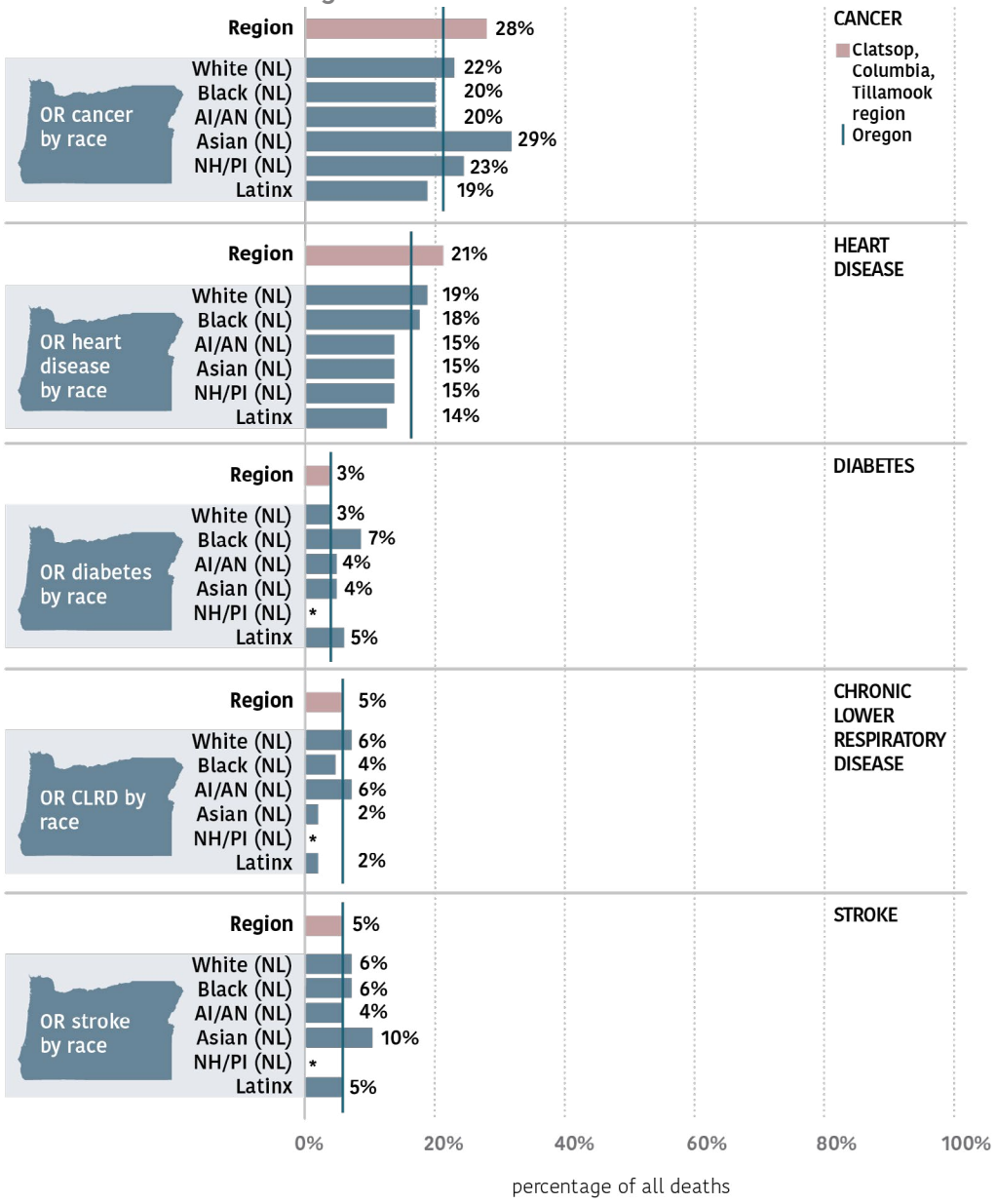


source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

PREVENTABLE CAUSES OF DEATH

Preventable causes of death are deaths that are associated with common modifiable behavioral risk factors, such as tobacco use, alcohol use, obesity and/or physical activity. Figure 21 shows the percentage of all deaths that were related to preventable causes of death. Cancer is the leading cause of preventable death in this region. The region has a higher percentage of deaths from cancer than the state of Oregon (21%). The region also has a higher percentage of heart disease than Oregon overall (17%). The percentage of deaths from diabetes, chronic lower respiratory disease and stroke are similar for all three counties and the state. Based on Oregon level data, potential disparities in preventable causes of death may exist for some communities, but vary by disease.

Figure 21: Preventable causes of death



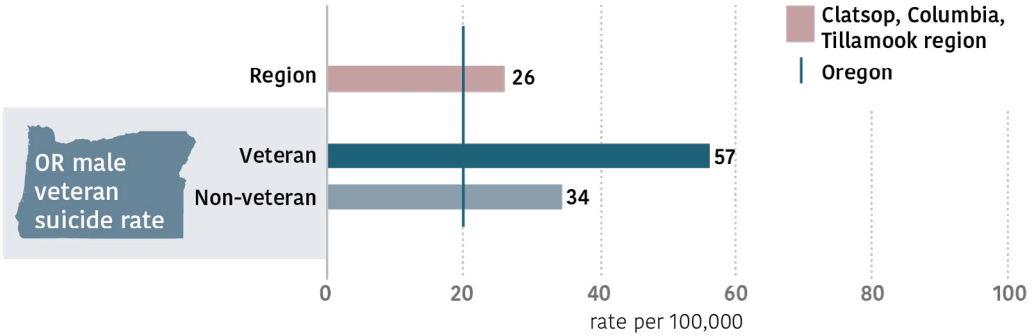
source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities
*numbers too small to be reliable

SUICIDE RATES

Suicide rates in this region are higher than in the state overall, at 26 per 100,000 (Clatsop, Columbia, Tillamook combined) vs. 20 per 100,000 for Oregon.

Veterans make up a higher percentage of the population in the region than in Oregon. The mortality rate for Oregon veterans is nearly five times higher than for non-veterans[16] and the overall male veteran suicide rate in Oregon in 2017 was considerably higher than for male non-veterans (see Figure 22). It is important to note that suicide among veterans is much higher among males (over 90%) than females, and is highest among ages 18-34.[17]

Figure 22: Regional suicide rate



sources:
Selected causes of death by county, Oregon residents, 2018
VA VetPop Veteran Population Model, 2017

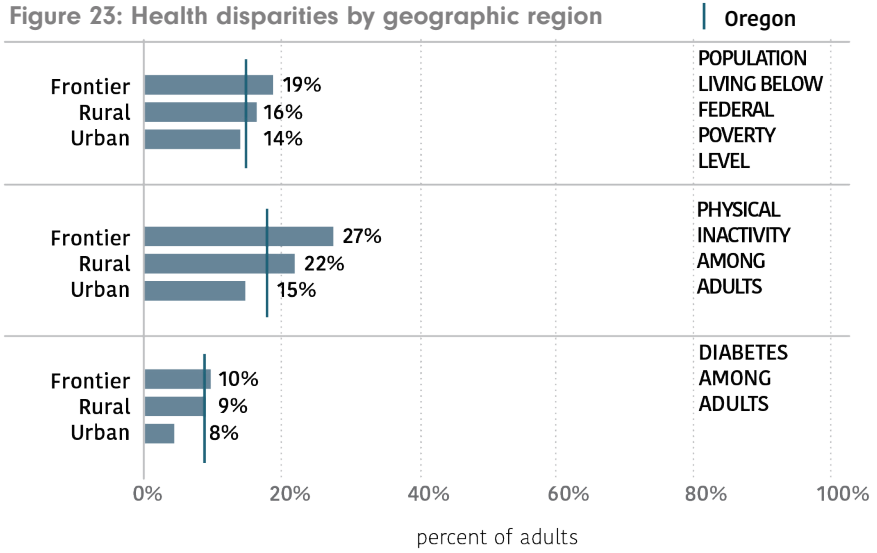
notes:
16. Oregon Vital Statistics Annual Reports (2013-2017).
17. https://onceasoldier.org/wp-content/uploads/2018/10/Oregon_2016.pdf

GEOGRAPHIC DISPARITIES

Living in a frontier or rural county in Oregon may increase risk of experiencing health disparities. Factors underlying rural health disparities include healthcare access, socioeconomic status, health-related behaviors, and chronic conditions.

Figures 23 and 24 show examples of health disparities affecting people living in rural and frontier counties in Oregon.

Figure 23: Health disparities by geographic region



sources:
OHA, Population living below federal poverty level by county, Oregon, 2013–2017.
OHA, Physical inactivity among adults by county, Oregon, 2014–2017
OHA, Diabetes among adults by county, Oregon, 2014–2017

Figure 24: Estimates of homeless populations by geographic region

source: OHA, Estimates of the homeless population by County, Oregon, 2017

2019 NOVEL CORONAVIRUS (COVID-19)

As of September 2020, Oregon had 32,994 cases of COVID-19, with nearly 500 in the Clatsop, Columbia, and Tillamook County region of the state. The rate of cases in the region is lower than the state as a whole, at 403 per 100,000 people who have had COVID-19 compared to 779 per 100,000 Oregonians.

Table 2 displays regional COVID-19 cases by sex, age and race/ethnicity. The percent of cases and percent of population is included in order to identify specific communities that may be experiencing a disproportionate impact of COVID-19 in the region. For example, 20-39 year olds represent 23% of the population, yet represent 38% of cases. This indicates that this age group is experiencing a higher rate of infection then would be expected if COVID-19 impacted all age groups similarly. Table 3 displays percent of COVID-19 deaths in Oregon by race in the same manner, indicating that deaths among non-White or Asian communities of color are higher than they would be if there was an equal distribution across racial/ethnic communities (data for deaths in the region is unreliable due to low numbers).

Not all communities are impacted equally: In Oregon and the US, people who are Latinx Pacific Islander/Native Hawaiian, American Indian/Alaska Native, and Black all have higher rates of COVID-19 cases compared to Whites. The rate among Black/African American people was the highest among all the race/ethnic groups in the three-county region (4768 per 100,000), nearly 20 times that of White people (273 per 100,000). The rate among Latinx people (1253 per 100,000) was more than four times that of White people. Data for other racial groups in the region may be unreliable due to small numbers.

Table 2: Regional COVID-19 cases by sex, age, and race/ethnicity

Sex, Age, Race/ethnicity		Percent of cases	Percent of population
Sex	Male	51%	50%
	Female	48.8%	50%
Age	<20 years	10.4%	21.7%
	20-39 years	**38%**	**22.8%**
	40-59 years	**37.1%**	**25.2%**
	60+ years	14.1%	30.3%
Race/ ethnicity	White (NL)	56.2%	86%
	NH/PI (NL)	1.9%	0.3%
	Asian (NL)	1.5%	1.2%
	AI/AN (NL)	0.6%	1.1%
	Black (NL)	**8.9%**	**0.7%**
	Multiracial (NL)	0.2%	3.0%
	Latinx	**21.2%**	**7.7%**

Table 3: Percentage of Oregon COVID-19 deaths by race/ethnicity

Race/ethnicity	Percent of deaths	Percent of population
White (NL)	73%	76%
NH/PI (NL)	**1%**	**0%**
Asian (NL)	4%	4%
AI/AN (NL)	**2%**	**1%**
Black (NL)	**3%**	**2%**
Multiracial (NL)	**2%**	**1%**
Latinx	**16%**	**13%**

DRAFT

health equity case study

Clatsop County COVID-19

case study: Clatsop County COVID-19

This case study provides an analysis of the strengths, gaps, and lessons learned from Clatsop County's experiences with COVID-19 outbreaks to illuminate the way that structural inequities and the social determinants of health contribute to health inequities.

Methods

Semi-structured interviews were conducted by Consejo Hispano staff with ten community members who were diagnosed with COVID-19 to identify common themes and important narratives. Consejo Hispano is a community based organization that supports the equitable integration of Latinx residents in Oregon and Washington. They offer programs and services that focus on education, health, financial empowerment, and advocacy & civic engagement. Because they are a trusted source of support, they were a natural partner for collecting data on the experiences of Latinx community members.

Interviews were also conducted by Rede with key public health staff involved in managing the outbreak, as well as with county leadership to provide contextual information about the circumstances of the outbreak. Document review of news reports and other media were also included in this analysis.

Overview of COVID-19 pandemic

COVID-19 was first identified in China in December 2019. COVID-19 is caused by the virus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a new virus in humans causing respiratory illness which can be spread from person-to-person. COVID-19 rapidly spread across the globe.

Figure 25: COVID-19 timeline in Clatsop County

DEC 2019	
•	Virus first identified in China
MAR 2020	
•	Global pandemic declared by the World Health Organization
•	Governor Kate Brown announced stay-at-home order
•	President Trump issued Coronavirus Guidelines for America identifying critical infrastructure industries to remain open, including seafood processing plants in Clatsop County
MAY 2020	
•	Outbreak at Bornstein Seafood processing where 15% of employees tested positive for COVID-19
•	Small outbreak at Pacific Seafood in Warrenton, Oregon with 14 cases of COVID-19
•	Consejo Hispano filed a complaint against Bornstein Seafood alleging a lack of social distancing and protective equipment
JUN 2020	
•	The Oregon Occupational Safety and Health Division stated that Bornstein Seafood had provided sufficient evidence that the hazardous conditions had been corrected
SEPT 2020	
•	Outbreak at Pacific Seafood with 94 total confirmed COVID-19 cases as of October 14th

National/state COVID-19 data

As COVID-19 has infected over 8,000,000 people and killed over 200,000 in the United States, patterns of inequities have quickly emerged.[18] Black, Indigenous, Latinx and other people of color are getting sick more and dying at higher rates than White people, and at rates that are higher than their share of the population.[19] Additionally, people of color are also experiencing higher risk of exposure, less access to testing, and higher severity of illness from COVID-19.

As seen in Figure 26, in the US, Native Hawaiians/Pacific Islanders are the most likely to have contracted COVID-19, and Black/ African Americans are most likely to have died.

As seen in Figure 27, in Oregon, Native Hawaiians/Pacifc Islanders are most likely to have been infected and most likely to have died.

source: Infection and Mortality by Race and Ethnicity. The COVID Tacking Project. Boston Univesity. October 22, 2020

*Based on fewer than 10 deaths among members of this race/ethnicity. Interpret with Caution

Figure 26: US COVID-19 cases and deaths by race/ethnicity

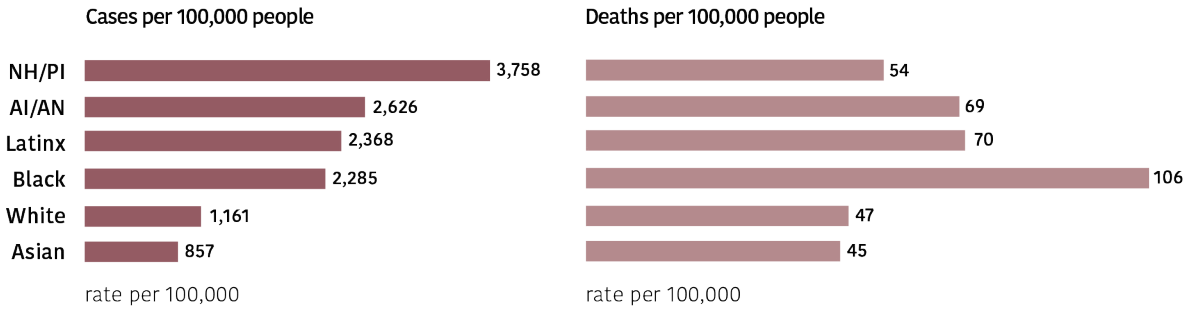
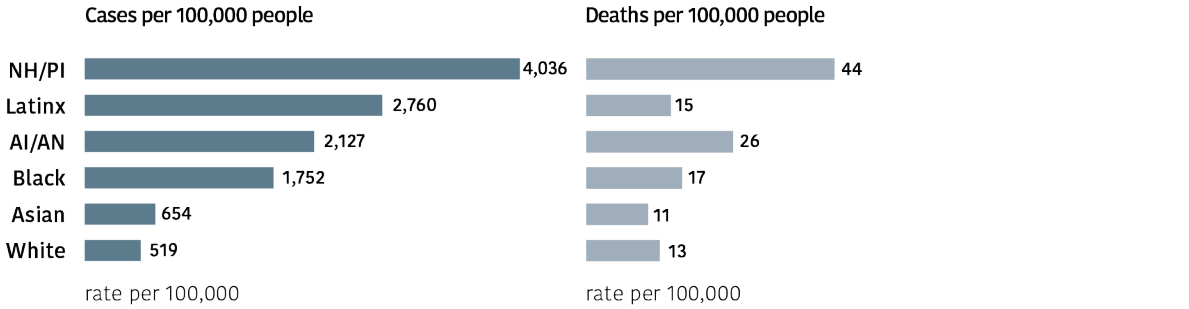


Figure 27: Oregon COVID-19 cases and deaths by race/ethnicity



Nationwide, 51 of 56 states and territories report race/ethnicicty information for cases and 50 of 56 report race/ethnicity for deaths. Graphic includes demographic data from all states and territories that report, using standard Census categories where possible, and scaled to the total US population for each Census category. Race categories may overlap with Latinx ethnicity. Some rates are underestimated due to lack of reporting of race and ethicity categories for COVID-10 cases and deaths.

Oregon has reported race data for 86% of cases and 88% of deaths, and ethnicity data for 86% of cases and 82% of deaths. Graphic only includes demographic groups reported by the state. Race categories and mutually exclusive and include both Latinx and non-Latinx ethnicity.

notes:
18.CDC COVID Data Tracker. Centers for Disease Contrl and Prevention
19.citation coming soon

Clatsop COVID-19 data

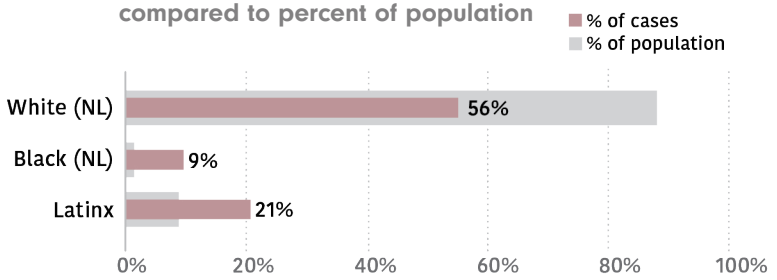
1. Clatsop County has a lower COVID-19 confirmed case rate in comparison with the rest of the state, at 545 per 100,000 as of 9/30/2020. There have been no deaths in Clatsop County due to COVID-19.

2. Data show that while the Latinx population in the Clatsop, Columbia, and Tillamook County region makes up less than 8% of the overall population, they represent 21% of COVID-19 confirmed cases.

    - 25-27% of COVID patients receiving services through the public health clinic are Latinx.

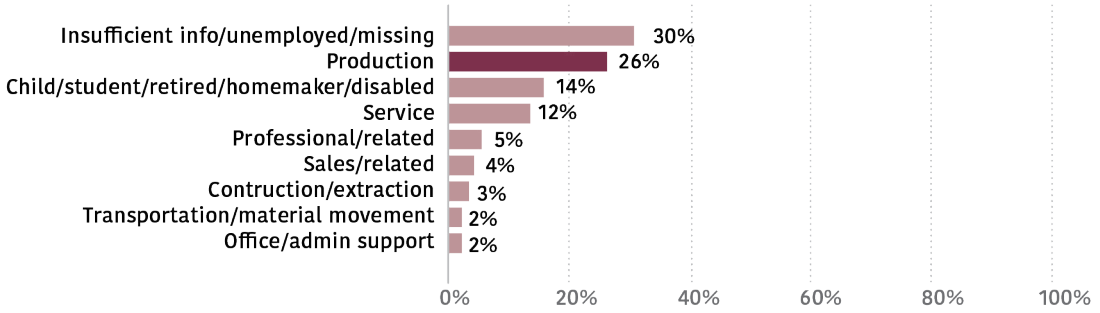
3. Type of occupation also carries different risks for contracting COVID-19. In the Clatsop, Columbia and Tillamook County region, of case information that exists by occupation, 26% of people who have had COVID-19 worked in production, which includes food processing plants.

Figure 28: Regional COVID-19 cases by race/ethnicity compared to percent of population



source:

Figure 29: Regional COVID-19 cases by occupation



source:

Health equity & COVID-19: Disproportionate impact on Latinx communities

When Clatsop began to see cases of COVID-19, it became clear that everyone was not being impacted equally by this disease outbreak. At one point at least 85% of cases were among the Latinx communities in Clatsop. This was largely in part due to the workplace outbreaks occurring in seafood processing plants, specifically Pacific Seafood and Bornstein Seafoods, where many employees are Latinx. It's important to emphasize that it is not that people who identify as Latinx are more likely to engage in personal behaviors that put them at higher risk. For example, according to an Oregon survey on COVID-19 awareness, beliefs, and behaviors, 70% of the Latinx community are very worried about COVID-19 and 72% are very concerned about getting sick.[20] Only about 4 in ten (42%) Oregonians are very worried about COVID-19. Eighty-seven percent of Latinx community members wear a mask indoors in public.

What leads to health inequities?

There are many compounding factors that potentially contribute to health disparities, including access to health care, poverty, type of employment (essential workers, no sick leave, etc.), immigration status, language barriers, co-existing health conditions, etc. These factors are considered the social determinants of health, which create the social and economic context that greatly contributes to health status. Race, gender, sexual orientation, disability status, etc. also directly impact one's health. In Clatsop County, some of the social determinants of health that led to a disproportionate impact of COVID-19 cases on Latinx communities include: low paying jobs with few benefits, and working in industries that are considered critical industries.

According to the US Census, the mean hourly wage for food processing workers in Oregon is $12.77, and the mean annual wage is $26,550. Seafood product preparation and packaging falls into the food processing workers category.

On March 16, 2020, the President issued Coronavirus Guidelines for America which identified critical infrastructure industries that were identified through the Department of Homeland Security. These critical industries include food processing employees, such as those working at seafood processing plants in Clatsop County. This means that while many workplaces have closed in-person operations, seafood processing plants are exempt from stay at home orders. While there are recommendations provided to increase safety for essential workers, they are not required. This is of special concern in that the guidelines allow asymptomatic employees who have had direct contact with a confirmed COVID-19 case to continue working, potentially infecting other employees.

notes:

20. Oregon Healthy Authority, Statewide COVID-19 Report, 2020. https://www.oregon.gov/oha/covid19/Reports/OHA-Statewide-COVID-19-Survey-Report-English.pdf

Workforce outbreaks

BORNSTEIN SEAFOOD:

In May 2020, there was a large outbreak at Bornstein Seafood processing, where over 15% of workers tested positive for COVID-19. Despite the public health emergency declaration, full crew production was still underway at the seafood processing plant, where 200 workers gathered daily. Due to concerns of the volume of workers and the confined space, Consejo Hispano filed a complaint against the seafood processing plant alleging a lack of social distancing and protective equipment. In early June, the Oregon Occupational Safety and Health Division wrote to Consejo Hispano and stated that Bornstein has at this point provided sufficient evidence that the hazardous conditions have been corrected or no longer exist.

PACIFIC SEAFOOD:

In May 2020, there was a small outbreak at Pacific Seafood in Warrenton, OR, with 14 confirmed COVID-19 cases. In September 2020, there was another outbreak at the same facility, with 94 total confirmed cases as of October 14. Initial reports pointed to a labor day picnic as the source of the outbreak, however, only eight of the employees who had confirmed cases attended the bbq. Internal memos for the company indicate that the majority of cases were among employees that live in off-site housing that Pacific Seafood arranged.[21]

Employee experiences

Interviews were held by Consejo Hispano staff with ten community members who had tested positive for COVID-19. The interview questions were developed by Rede Group, Consejo Hispano staff conducted the interviews in Spanish, took notes, and translated the notes back into English. The interview notes were then uploaded into Dedoose for thematic analysis by Rede Group. Employees who were infected by COVID-19 shared what impacted them most, what was difficult about their experiences, concerns about the future, what could have been done differently, and more.

Half of respondents reported fewer hours or less work due to COVID-19, and nearly half reported increased stress or fear. The majority reported that the most difficult thing about being infected was isolation or staying away from their family, with loss of wages or no work as the second hardest thing. The biggest concern about the future reported was a fear of being reinfected (or that a family member would be infected), followed by concerns about job loss and companies closing due to COVID-19.

> **"The most difficult thing was being infected, aside from the fact that it affected my health, I had to stay at home without working for three weeks."**
>
> **—Community member**

> **"We are economically behind. I relapsed, so I was about one month and a half without working. We must be vigilant and take it seriously."**
>
> **—Community member**

21. Oregon Live, Coronavirus Outbreaks At Oregon Seafood Processor Illuminates Challenges In Tracing Infection Origins 2020. https://www.oregonlive.com/coronavirus/2020/10/coronavirus-outbreak-at-oregon-seafood-processor-illuminates-challenges-in-tracing-infection-origins-limitations-in-states-response.html

Employee experiences continued

In terms of thinking about what could have been done differently to make the situation better for them, most respondents noted personal responsibility in taking the virus more seriously, and 30% of respondents wished their workplace had been more proactive in preventing COVID-19 infections.

> **"We weren't given any protection at work until we got infected, it was too late when we got our protection"**
>
> **—Community member**

Respondents agreed that work was their primary source of information about COVID-19, followed by social media, the news, health care providers and online research. However,it was clear that there are a lot of questions for interviewees about the disease and its impact.

> **"How many will be infected and what is going to happen? Are companies going to close and we'll be out of work again? How are we going to survive like that?"**

Public health response

The Clatsop County Health Department worked closely with Borstein Seafood when the first COVID-19 case was discovered. They immediately set up on-site testing for all employees to identify people who were asymptomatic. The company closed the plant for two weeks to clean and allow time for quarantine for all employees. Pacific Seafood did not have the same existing relationships with the County, so there was less collaboration between the two. For example, they did not have the County conduct their employee testing clinics.

Clatsop County staff provided information and support to people who tested positive for COVID-19 through daily phone calls from staff who spoke Spanish. They would discuss symptoms, quarantine practices, and provide general information about the virus.

Lessons learned

While information was being provided through many avenues, according to interviews with Latinx community members, there was not a lot that could be done with the information. Most employees at the Seafood processing plant were only provided one-week paid leave, however, those who tested positive needed to quarantine for at least two weeks. In addition, for those who wanted to be tested, few avenues existed to do so. Additionally, according to some of the interviews, employers were not providing the accommodations necessary to reduce COVID-19 transmission in the workplace (e.g. spacing out employees, providing personal protective equipment). There are a number of things that can be done to mitigate the impact of COVID-19 on Latinx communities, including:

- Working with large employers to implement safety protocols and testing
- Mandating testing for all food processing workers
- Providing financial and health services to assist those who do not have adequate resources
- Talking to the community about what is known about COVID-19, including symptoms, reinfection, etc.

Additionally, information about COVID-19 should be disseminated in Spanish via:

- Trusted public health programs (e.g. WIC)
- Workplaces
- Social media

DRAFT

LHD health equity capacity assessment

staff survey results

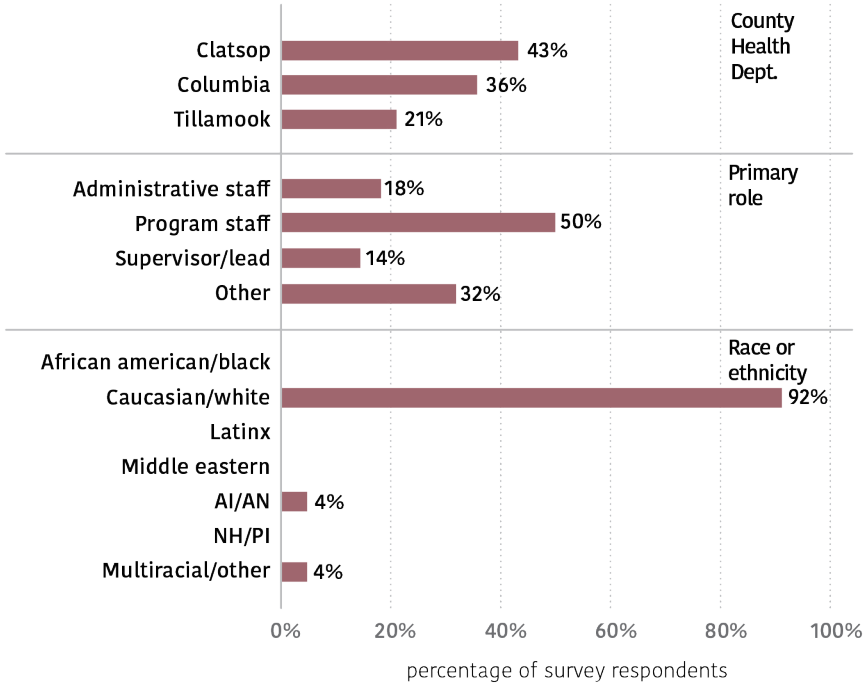
staff survey results

The charts and information provided in this section are reported regionally in aggregate due to the small number of staff working within individual counties. A total of 28 staff completed the survey in the three-county region: 12 staff from Clatsop County, 10 staff from Columbia County, and 6 staff from Tillamook County. Figure 30 shows demographic information of survey respondents including county, primary role within their organizations, and race/ethnicity.

Survey respondent demographics

The majority of the staff respondents identified as program staff (50%), however, a third of respondents (32%), described their role as 'other'. This 'other' group consisted of an environmental health specialist, permit technician, fiscal coordinator, health care provider, health inspector, communicable disease staff, and a few registered nurses (school district, public health, and clinic RNs). Several respondents (18%), described themselves as administrative staff and a few (14%), designated themselves as supervisor/program lead. The majority (92%) of staff identified as Caucasian/White, with the remainder identifying as Native American/Alaska Native (4%) and Biracial/Multiracial/Other (4%).

Figure 30: Respondent demographics



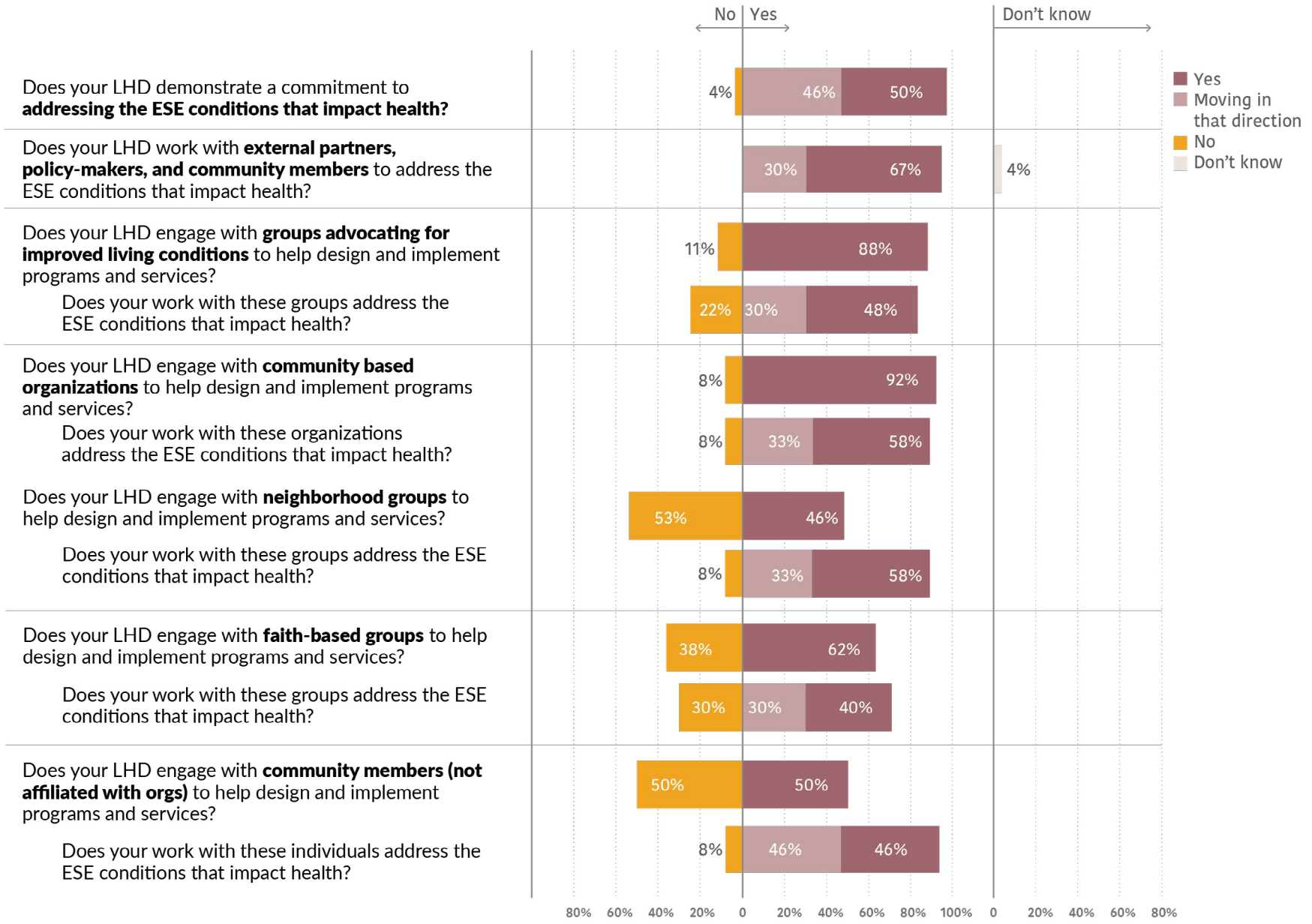
Community groups engaged to address the ESE conditions that impact health

Figures 31 and 32 display survey responses to questions focused on community groups engaged by the health department to address environmental, social, and economic conditions that impact health.

Nearly all (96%) respondents identified that their LHD either works with external partners, policy-makers, and community members to address the environmental, social, and economic conditions that impact health or were moving in that direction. Respondents were asked if they worked with specific groups to help design and implement programs and services and those that have worked with a group were then asked if their work with that group addressed environmental, social, and economic conditions that impact health. Among all groups at least 70% of respondents that engaged with a particular group were working with or moving in the direction of working with that group to address the ESE conditions that impact health.

Figure 33 charts the extent to which LHDs collaborate with public agencies and community-based organizations in seven public health areas according to survey respondents. Across all areas there were several (19% or more) respondents who were unsure about the level their LHD collaborated with public agencies and community-based organizations.

Figure 31: Health department focus



staff survey results

Figure 32: Community groups engaged to address the ESE conditions that impact health

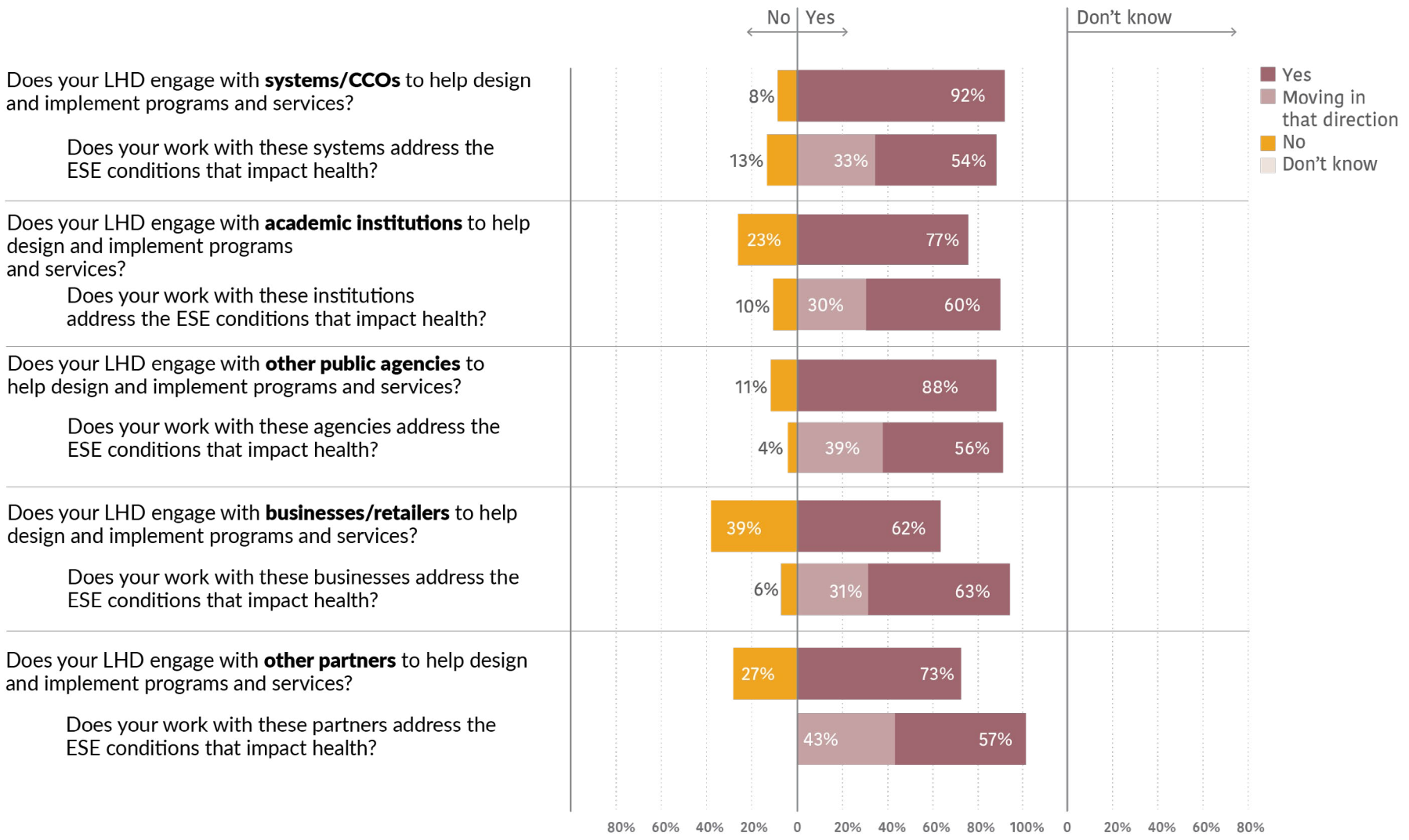
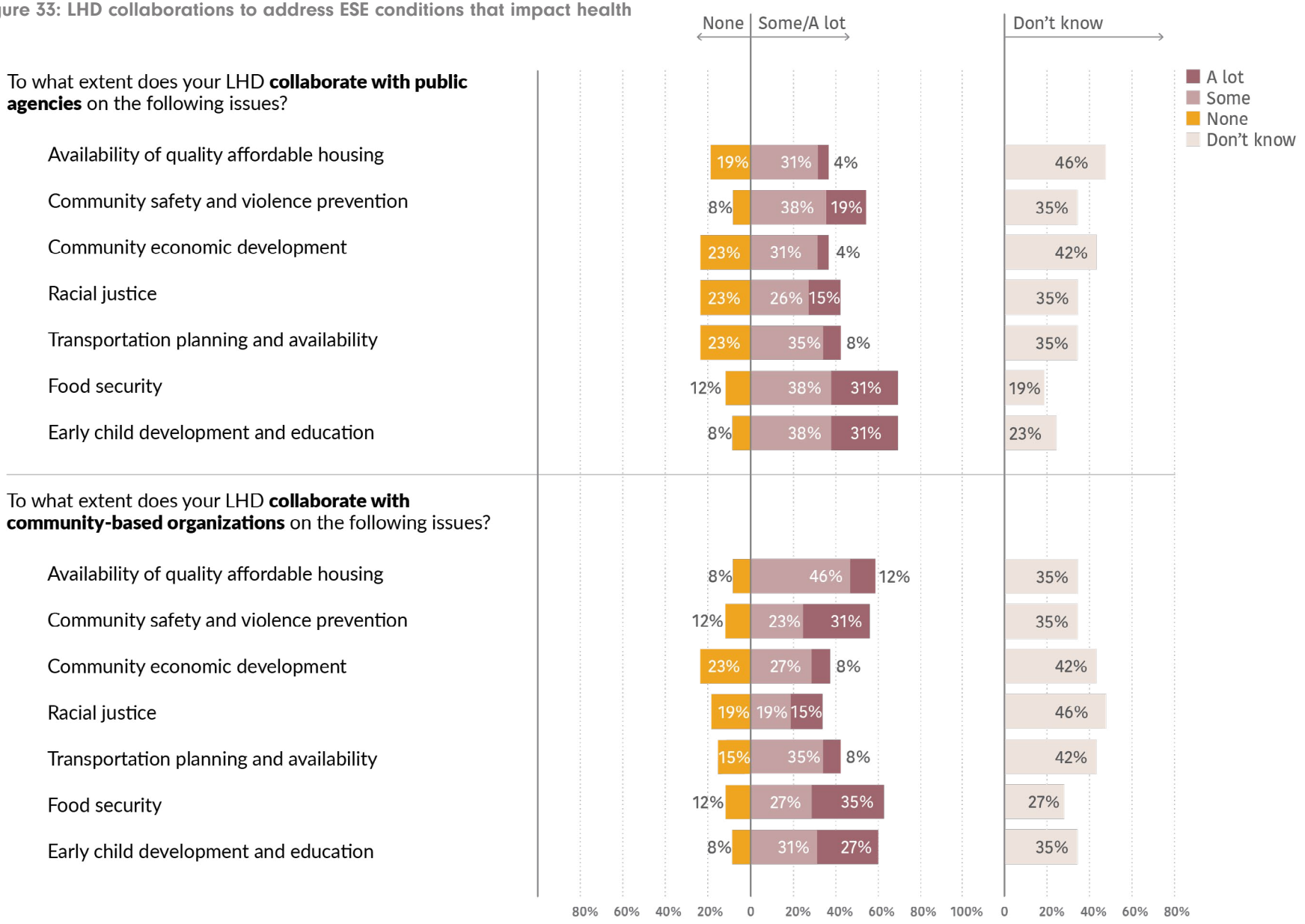


Figure 33: LHD collaborations to address ESE conditions that impact health



Addressing inequities

As seen in Figure 34, over half of respondents felt that their LHD implements a range of culturally appropriate services. Nearly 75% felt that their LHD distributes information that is appropriate for the cultural, linguistic, and literacy needs in the community. In addition, well over 80% felt that their LHD:

- Has trusting relationships with external partners
- Engages in discussions about how work could address the ESE conditions that impact health
- Have been able to take steps to enhance staff cultural humility and cultural competencies

However, nearly half were unable to answer whether or not individual efforts to address health inequities were considered in performance reviews, and whether or not periodic assessment were conducted to asses the culturally and linguistic needs of their community. Finally, 35% of respondents did not feel staff of diverse ethnic, racial, and cultural backgrounds were equitably promoted throughout the LHD, while 50% felt that they were.

Survey respondents identified the following ways their LHD is demonstrating a commitment to addressing the ESE conditions that impact health:

- Anti-tobacco programs
- Moving in that direction, but still working on basic structure and capabilities of health department first
- Tillamook County Wellness Advisory is coordinated by public health
- New opening of a hazardous waste facility
- More outreach
- Participation in CHART
- Providing free bus passes
- Access to Spanish speaker resources
- Tobacco retail licensing
- Planning Place Matters Conference
- Cost is not a barrier
- Providing trauma-informed care
- Increased services in areas like harm reduction
- Mobile vaccine clinics
- Rely on county and state grant funding which makes it hard to address ‘place’

Figure 34: Supporting staff to address the ESE conditions that impact health

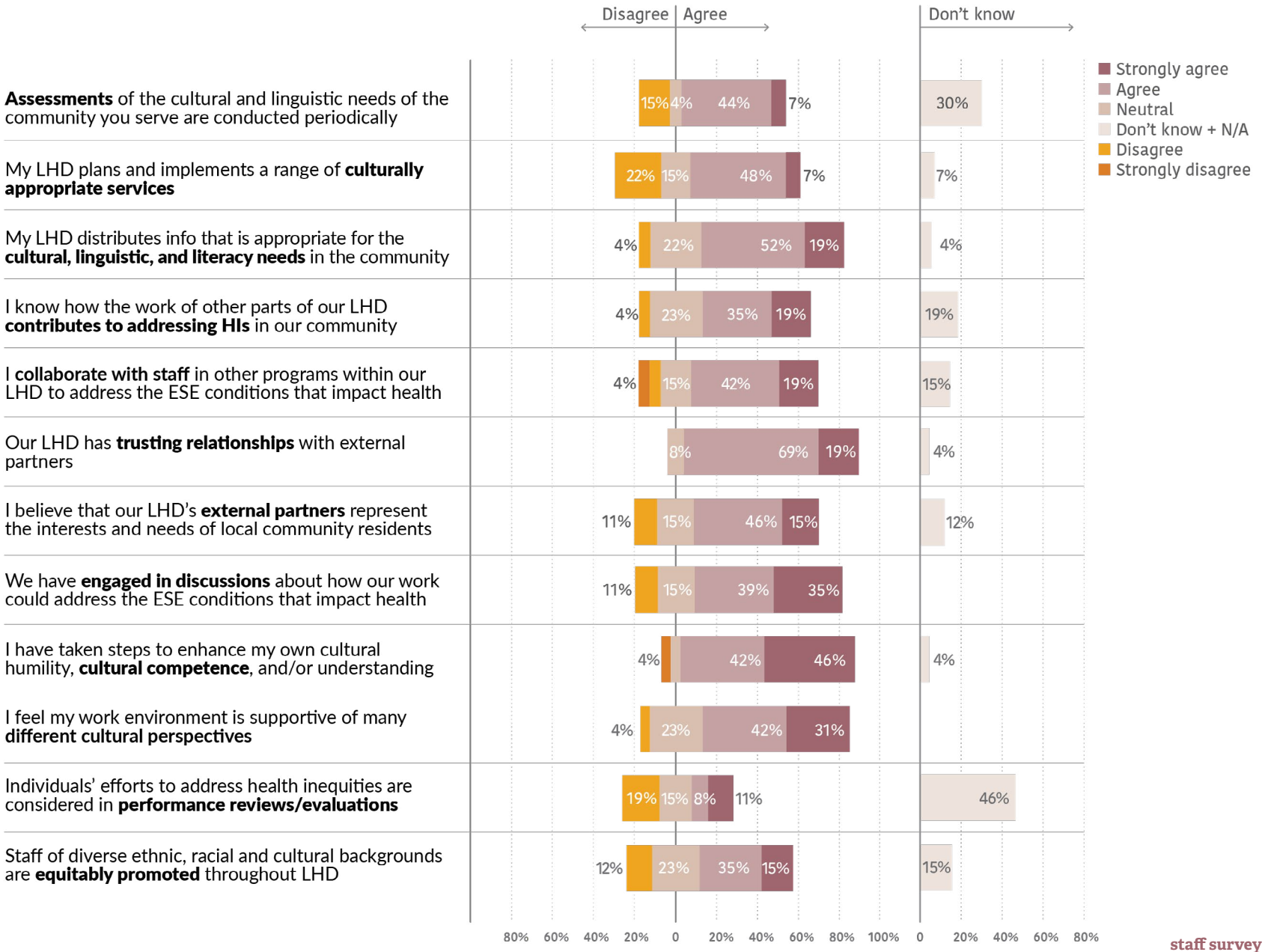
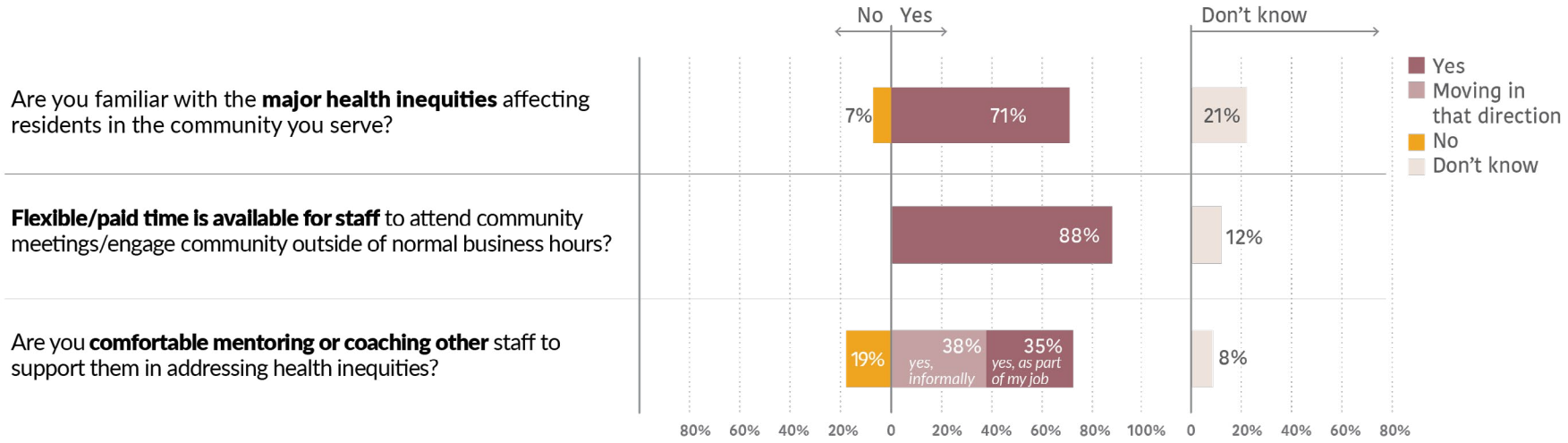


Figure 35: Supporting staff to address the ESE conditions that impact health continued



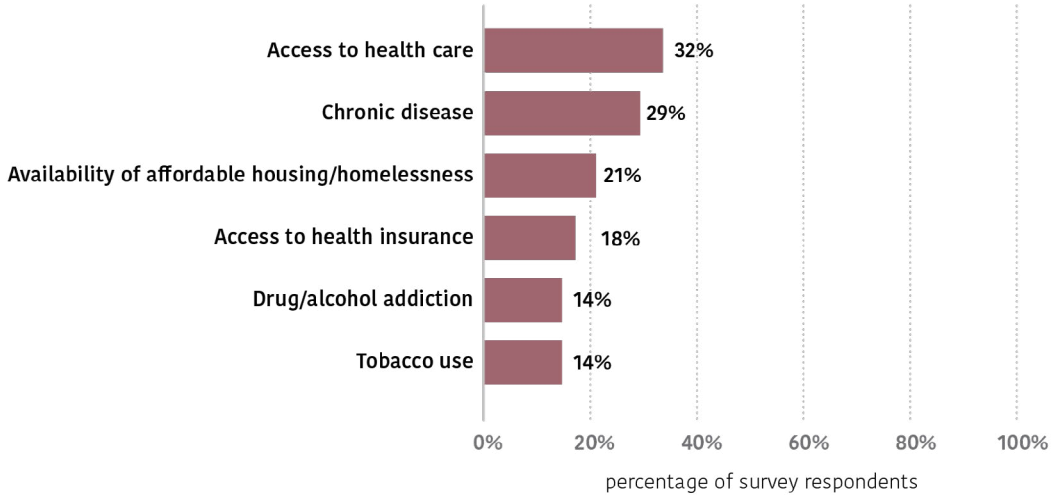
staff survey results

Survey respondents were asked to describe the top disproportionate and unfairly distributed health issues in their county. Figure 36 highlights the top six health issues identified by respondents.

Access to health care (including mental, behavioral, and dental) was the health issue mentioned by the greatest number of respondents (32%). Staff referenced multiple aspects of health care lacking in the region: provider availability, quality care, affordable care, local care, and mental health and addiction treatment services. A lack of access to health care was said to be disproportionately experienced by:

- Individuals living in poverty;
- Undocumented people;
- Rural communities;
- Individuals with a mental health condition;
- Individuals facing addiction;
- OHP beneficiaries;
- Individuals with developmental disabilities;
- People experiencing homelessness;
- Veterans; and
- People with HIV.

Figure 36: Disproportionately and unfairly distributed health issues



Chronic disease was identified to be unequally distributed among individuals with low income, without insurance, and non-White racial/ethnic populations. Respondents did not tie a lack of affordable housing or homelessness to particular groups of people but rather as a health issue facing the county as a whole. People who work in small businesses, are low income, unemployed, or undocumented were said to be less likely to have health insurance. Drug and alcohol addiction was described to more significantly impact those living in poverty. Individuals with low income, mental health conditions, and American Indian/Alaska Native were told to have disproportionate tobacco use rates.

Nearly a third of respondents (32%) were not familiar enough with the local health issues to describe the disproportionate and unfairly distributed health issues in their county.

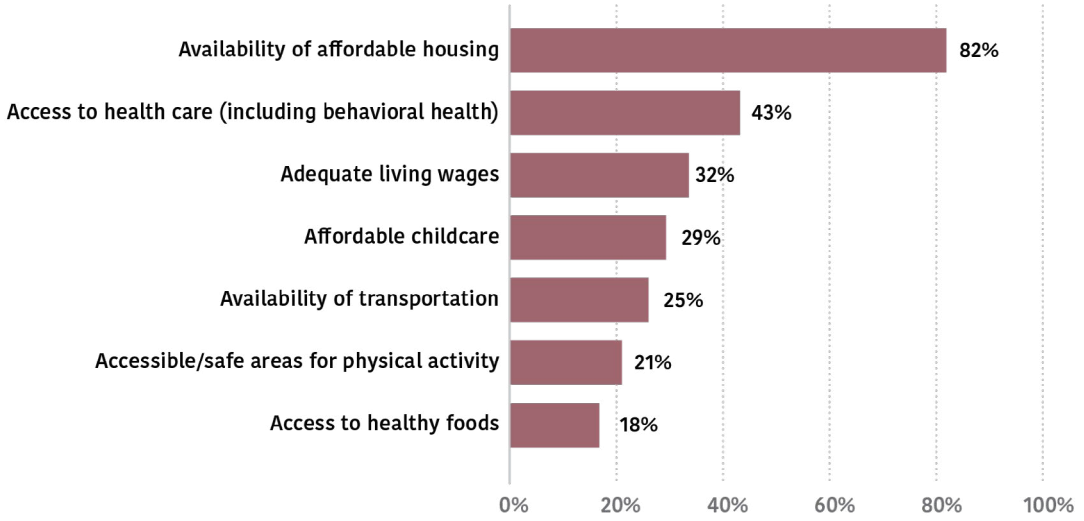
staff survey results

LHD staff were also asked to list what they believed are the most important environmental, social, and economic conditions that impact health in their county. Figure 37 demonstrates the top seven conditions impacting the health in their counties.

The availability of affordable housing was a condition mentioned by most respondents (82%) that impacts health in their counties. Respondents identified a lack of affordable quality housing and specified a need for a Housing First[22] program and standards for safety, cleanliness, and size.

Respondents identified a lack of access to health care, including behavioral health services, as the second most prominent condition that is affecting the health of individuals in their counties. Respondents described a shortage of health care providers for scheduling timely appointments, lack of local specialty health care providers, lack of local hospitals, and a need for more recovery programs and counselors.

Figure 37: ESE conditions that impact health



Affordable housing and access to health care were mentioned by many staff as both the top disproportionate and unfairly distributed health issue and the most important environmental, social, and economic condition impacting their community.

22.National Alliance to End Homelessness. Housing First. 2016. https://endhomelessness.org/resource/housing-first/

DRAFT

LHD health equity capacity assessment

leadership interview results

leadership interview results

Utilizing a modified BARHII interview guide, Rede conducted six interviews with three Public Health Directors, one County Manager, and two County Commissioners in the region. The purpose of the interviews was to assess the local health department's strengths and areas for improvement related to addressing health inequities in their communities. Each interviewee was asked questions specific to their local county health department. The following section describes findings from the interview analysis.

Organizational culture

WORKFORCE DIVERSITY

Interview respondents identified diversity among public health staff, included racial-ethnic (2/3 counties), bilingual (2/3 counties), age (1/3 counties), and LGBTQ (1/3 counties). However, staff survey data reported in the previous section identified 92% of respondents to be White. A lack of gender diversity was mentioned (2/3 counties), with predominantly female staff making up the health department. Interviewees from all three counties felt that a small number of applicants places limitations on the ability to hire a diverse workforce. Respondents identified high cost of living, location of the counties positioned near the Portland market, and not being known for being at the forefront of public health as reasons for a small pool of applicants. One interviewee described that more competitive pay for employees could be an opportunity to increase diversity among health department staff.

Two of three counties described that they are reliant on the HR department for hiring within the health department and it feels disconnected from their work. One interviewee said that HR staff are not trained in hiring a diverse workforce, one respondent was unsure, and one described that their HR manager was trained in this area but that that was not usually the case. One manager explained that they received training on managing a diverse workforce; one said the training was available but not mandatory. Another described that there was not training for managers specific to this topic.

"No one can afford to live here. The way the economy is and the housing prices limit the number of people. who could move out here and work."

—LHD Leadership

"Everybody is sensitive to it [encouraging diversity within the health department] and we want to be reflective of the communities we serve. We still have some work to do in that area, but it's not because of a lack of a commitment from staff, it's having some of the corporate structures in place to support that. It is a commitment, but it's one that's not as formerly reflected as we probably need to make it."

—LHD Leadership

LEARNING CULTURE & WORKFORCE DEVELOPMENT

Staff are supported and encouraged to utilize training and professional development opportunities in all three counties. Financial support is provided by the county to attend training (2/3 counties). One county described that staff are supported to advance within their LHD and that there is a concerted effort to hire people representing their community and those that have been consumers of county services. Bilingual staff have the opportunity to become certified interpreters and receive a 5% pay differential. Another interviewee described that supporting staff to advance within the LHD is a challenge because the union does not allow a lot of flexibility and relies heavily on time spent to evaluate employee promotions.

Interviewees described building capacity within their LHD to address health equity through presentations by organizations representing populations experiencing inequities during staff meetings (including information about how the county could support and partner) and opportunities to participate in different groups such as the health council.

Two counties mentioned supporting students through shadowing or positions on the health council to support development of the future public health workforce.

All three counties in the region described that staff have been encouraged to take risks and challenge assumptions. One interviewee described regular staff meeting time devoted to bringing up concerns. The same interviewee said that their risk-taking is evident by the counties' early adoption of policy, such as a tobacco retail license policy and the harm reduction program. Health department administrators trust and rely heavily on their staff to meet the needs of their community.

> **"Staff assessment when delivering services was that there are not consistent bilingual, bi-cultural staff in the community. They felt it was our responsibility to seek, train up, and outstation folks to provide those services."**
>
> **—LHD Leadership**

> **"Every staff person has a certain amount in their account per year to go to trainings or classes. I always encourage folks to go to free training webinars; we really do have a culture of learning. We have a number of folks who've taken us up on those options and have improved themselves."**
>
> **—LHD Leadership**

> **"During staff meetings once a month we got the harm reduction program started. We noted one of the big misses is the ability to do syringe exchange and use the opportunity to build trust within the intravenous drug users in the community to help them get into other services such as recovery."**
>
> **—LHD Leadership**

Strategic planning

Two of the three Counties currently engage in department-wide strategic planning while one county is planning to begin the process. One county conducts strategic planning yearly and another every few years. None of the county's strategic plans explicitly use the terminology 'health inequities'. Still, they include strategies for addressing access to public health services for specific populations such as low socioeconomic status or racial/ethnic groups.

Participants in the strategic planning process include:

- CCOs;
- community members;
- community partners;
- County Commissioners;
- health department staff at all levels;
- Human Services Advisory Committee; and
- partnering agencies such as behavioral health, hospitals, senior and disabled services.

Input is gathered on strategic plans through:

- Columbia Pacific CCO Advisory committee;
- county and regional health assessments and improvement plans;
- health council (primarily made up of consumer users);
- steering committee; and
- targeted surveys and focus groups to community members.

One interviewee described that strategic plans are shared through the county website and social media posts and another distributes summary reports across local and social media.

"Addressing equity issues is something that we are all committed to. We're going through a strategic planning process right now at the corporate level, at the countywide level, and that's one of the topics that we're going to be dealing with in a really broad corporate way."

—LHD Leadership

Addressing inequities

Interviewees described several health inequities in their community. A recurring theme among two counties was a lack of full-service hospitals and health care availability throughout all parts of the county. One county described a complete lack of hospitals, and another county explaining that hospitals lacked the full breadth of services needed in the community. In both cases, patients must seek services unavailable in their community in the Portland area, which is a challenge for low-income community members and Veterans. In addition to the lack of hospital services, access to clinics and other public health services is a challenge for rural communities.

Another theme that arose during interviews was community members' economic challenges, such as a lack of adequate paying jobs and affordable housing.

"We are very lucky to have two very good hospitals, but they aren't full-service hospitals. Many of our more extreme health issues have to be addressed with a trip to Portland. That is not too hard for affluent people, but it's extremely hard for our rural and poor communities. We have tried to increase our bus service to Portland, which has helped a lot because vets have to go to Portland for all of their health care. We've improved our transportation system, but it's the issue of space, of getting people to places where they can receive services."

—LHD Leadership

"We don't have a high number of high wage jobs. Almost all of our industries, tourism, seafood processing, have a fairly low wage predominance of jobs. And so that's an economic issue that we're trying to address."

—LHD Leadership

"We have a significant population of undocumented citizens, and that makes them nervous and always wanting to fly under the radar. It means that they often choose not to access services that might be available to them. We're working on that, but it's an issue."

—LHD Leadership

leadership interview results

CURRENT HEALTH EQUITY INTERVENTIONS

- Adding a public health facility and integrating clinics into rural schools to increase access to services.
- Events and activities to increase physical activities for older adults and youth.
- Harm reduction program partnership between two counties to support the health of injection drug users and connect them to additional public health services.
- Increased access to physical activity and healthy foods for individuals with a chronic disease through a funded position at a CBO, partially paid memberships, health coach, bilingual Diabetes Prevention Program classes, nutrition education, and food boxes at little to no cost.
- Increased availability of transportation to Portland for medical needs not met by local hospitals and all Veterans health care.
- Opioid use reduction task force to reduce stigma and increase delivery of medication-assisted treatment in multiple settings.
- Population health initiative that includes outreach to underserved populations with a focus on seniors and people with disabilities.
- Tobacco retail license policy to decrease youth initiation and the vaping epidemic.
- Virtual delivery of public health services.
- Provide bilingual services, including:
  - Spanish speaking public health staff at all levels, including behavioral health providers;
  - onsite interpretation in Spanish;
  - written materials in English and Spanish;
  - Spanish speaking staff to attend appointments outside of the health department where bilingual staff are not available; and
  - increased phone services for languages other than English and Spanish.

"The best thing about the [needle exchange] program is that we get to see and talk to the people who are using. Over time, we are able to earn trust and do a lot of referrals. Since we oversee the mental health programs in the County, we know who follows up and I think it's a huge plus."

—LHD Leadership

Interviewees were asked if their LHD regularly evaluates or reflects on its capacity, commitment, and effort to address health inequities. None of the interviewees described a formal process for doing this. One county explained that they try but face challenges when any type of health crisis occurs, such as COVID-19, and go into 'reactive mode' due to the county's small size. Another county described an informal department by department process for evaluating equity and making adjustments as opportunities arise. One county said that they do not have the resources to take on that process at this time.

Two of the three LHDs have been involved in local assessments of conditions that influence health, such as housing, education, and economic opportunity. The assessments were described to be focused on a particular topic such as alcohol and problem gambling or access to physical activity and tied to available funding. One county said they did not have the resources to do their own assessments. All three counties have been involved in the regional health assessment conducted by the local CCO.

WORKING WITH COMMUNITY TO ADDRESS HEALTH INEQUITIES

All interviewees described ways their LHD works with the community to address health inequities.

Interviewees stay aware of community needs, strengths, and resources through:

- Attending local events and meetings;
- Communication with board of county commissioners;
- Internal evaluations of individuals receiving public health services include the consumer assessment of health providers and systems (cahps) survey to adults and youth and a survey distributed by the health council;
- In-person meetings, calls (county commissioner only);
- Local CBO presentations at staff meetings;
- Monitoring social media pages for community input;
- Population health initiative;
- Staying informed of local city planning processes; and
- Strategic planning and the community health needs assessment and improvement plans.

Interviewees identified the following methods for building on community strengths:

- Collaboration with CBOs such as Consejo Hispano that have strong relationships with the populations they serve;
- Generating working groups to bring together community members with different strengths to move a project forward; and
- Utilizing feedback from community surveys to improve programs and services for the community.

One county noted that community members could participate in the health council or wellness committee as a way to support the community to assume leadership roles in health department efforts.

Community engagement in LHD decision making and planning was an area for improvement highlighted by one interviewee. Explaining that:

"One of the things we've been trying to do is, create an advisory board so that staff can interact with community members, and community members can give input on programs, program evaluation, budgets, how dollars are spent. Just continual feedback between community members and staff. We haven't done that yet, so that's our next goal."

—LHD Leadership

It was mentioned by one county that there are no public health funds available to fund community members or groups to support their self-identified concerns with respect to addressing the environmental, social, and economic conditions that impact health but that the CCO allocates funds to their Community Advisory Committee that can be used to fund local projects. Another interviewee described that they often provide resources in collaboration with community efforts when project goals are aligned.

leadership interview results

When asked about resources provided to community members to engage in LHD decision-making and planning, all three counties discussed a lack of financial resources to support community engagement. One county said they do not offer any resources at this time. Another said that they can provide the physical space and light refreshments during community engagement sessions and do their best to provide childcare when needed and conduct sessions during various times of the day.

One LHD seeks feedback from community members about community participation barriers through evaluation surveys during meetings and conversations with CBOs. It was mentioned that there is no formal channel for collecting feedback and could be an area for improvement.

Barriers to working with the community members to address health inequities included:

- Community members wanting to prioritize topics that don't align with the LHD priorities or available data;
- Lack of community member interest in providing input because they receive services outside of the county;
- Lack of meeting spaces to facilitate discussion with community members;
- Lack of resources to support community residents or groups to support their self identified concerns and needs with respect to addressing ESE conditions that impact health;
- Limited resources and competing priorities to address community-identified needs;
- Time of day of meetings; and
- Transportation to meetings.

"There aren't enough business opportunities or employers so people are always outside the county, and it's hard to create community. There's no central place that people go. The major challenge is infrastructure. Many people get all of their services outside the county. I don't think that they feel a strong need to participate because they're getting all of these things elsewhere, such as Portland and Hillsboro."

—LHD Leadership