HEALTH EQUITY

Assessment Report

POLK COUNTY HEALTH SERVICES

JUNE 2023

PREPARED BY REDE GROUP

Acknowledgments

This report was produced by Rede Group in June 2023

This report was produced by Rede Group on behalf of the Polk County Health Services (PCHS). Rede Group and PCHS extend our sincerest gratitude to PCHS leadership, PCHS staff, and community partners who shared their experiences and ideas as part of this assessment. Their invaluable input plays a vital role in enhancing PCHS's organizational understanding of equity practices and guides the way towards improved health equity at PCHS and in the Polk County community.

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Purpose + background

The primary objective of the Polk County Health Services (PCHS) Health Equity Assessment was to facilitate a comprehensive evaluation of PCHS's strengths and areas for improvement related to addressing health inequities. Health inequities are defined as "systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and unavoidable differences in health outcomes."[1] The assessment focused on both internal equity and PCHS's capacity to address health inequities in the Polk County community, including the following focus areas:

1. Systemic racism, institutional racial inequities
2. Language access
3. Workforce diversity
4. Data analysis and collection
5. Service access
6. Community engagement
7. Identification and development of staff skills, awareness, and or practices using an equity lens when providing services

The assessment involved all four divisions of PCHS: the Administrative Division, Division 1 (Forensic & Acute Care, Outpatient Addictions Services), Division 2 (Outpatient Mental Health, Community Support Services, Developmental Disabilities), and Division 3 (WIC, Emergency Preparedness, Psychiatric Services, Public Health Clinical Services, Jail Medical).

Findings from this assessment provide crucial insight for planning and expanding capacity to collectively address health inequities. This assessment aimed to guide PCHS in determining where to concentrate efforts to enhance its capacity, and will inform a 5-year Health Equity Plan.

1. The National Library of Medicine. (n.d.) *The Root Causes of Health Inequity*. https://www.ncbi.nlm.nih.gov/books/NBK425845/

Acronyms + terminology

Acronyms

BARHII	Bay Area Regional Health Inequities Initiative
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
IDD	Intellectual or developmental disability
OHSU	Oregon Health and Science University
PCHS	Polk County Health Services
SDoH	Social determinants of health
SWOT	Strengths, Weaknesses, Opportunities, Threats (assessment)

Terminology

HSD 1	Forensic & Acute Care, Outpatient Addictions Services
HSD 2	Outpatient Mental Health, Community Support Services, Developmental Disabilities
HSD 3	WIC, Emergency Preparedness, Psychiatric Services, Public Health Clinical Services, Jail Medical

Methods + analysis

Methods

Rede Group (hereafter Rede) collected comprehensive primary data for this assessment using a mixed-methods approach. Each assessment method sought to collect the perspectives and learn about the experiences of PCHS staff at different levels and of community partners who work closely with PCHS to serve the Polk County community. Data collection tools were adapted from the Bay Area Regional Health Inequities Initiative (BARHII)'s Local Health Department Organizational Self-Assessment for Addressing Health Inequities.[2] Rede condensed the data collection tools in collaboration with the PCHS project team with the objective of reducing participant burden associated with lengthy surveys and focus group guides. Rede also worked with PCHS to adapt the tools to encompass all of their Health Service divisions since the BARHII is designed to assess public health departments.

The BARHII model utilizes data collection to evaluate core competencies for addressing health inequities. There are nine competencies related to organizational characteristics and nine workforce competencies:

2. Bay Area Regional Health Inequities Initiative. (n.d.) *Local Health Department Organizational Self-Assessment*. https://www.barhii.org/evolution/local-health-department--organizational-self-assessment

Organizational characteristics:

1. Institutional commitment to addressing health inequities
2. Hiring to address health inequities
3. Structure that supports true community partnership
4. Supporting staff to address health inequities
5. Transparent and inclusive communication
6. Institutional support for innovation
7. Creative use of categorical funds*
8. Community-accessible data and planning
9. Streamlined administrative process*

Workforce competencies:

1. Personal attributes such as passion, self-reflection and listening skills
2. Knowledge of public health framework*
3. Understanding the social determinants of health
4. Knowledge of affected community
5. Leadership
6. Collaboration skills
7. Community organizing skills
8. Problem solving ability*
9. Cultural competence and humility

To evaluate each competency, the following data collection methods were employed:

Internal Survey: An internal survey was made available to all levels of staff at PCHS. The survey aimed to collect feedback and perspectives from employees regarding various aspects of the organization's practices and commitment regarding health equity. The internal survey was open from March 29th to April 20th, 2023, on the online platform SurveyMonkey and garnered 95 complete responses. See the internal survey data collection tool in Appendix A.

Demographic information was provided by internal survey respondents to ensure the survey reached a representative sample of PCHS staff.

Focus Groups: Focus groups were conducted exclusively with non-management level staff. These 90-minute sessions provided an opportunity for in-depth discussions and qualitative exploration of specific topics related to health equity at PCHS. Four focus groups were held: three in person at PCHS and one online over Zoom. Focus groups were held between April 10th and April 26th, 2023, and had 22 total attendees. See the focus group guide in Appendix B.

Leadership Interviews: All PCHS managers and supervisors were interviewed between April 4th and April 14th, 2023, totaling 23 60-minute

*This assessment did not evaluate the use of categorical funds and did not explicitly evaluate streamlined administrative processes, problem solving ability, or knowledge of public health framework.

interviews. These interviews aimed to gather insights into their perspectives, challenges, and strategies pertaining to health equity within the organization. See the leadership interview guide in Appendix C.

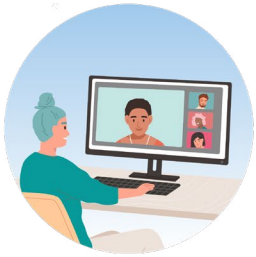
Partner Organization Survey: A survey was sent to partner organizations outside of the health department. Partners from each of the PCHS divisions were identified by PCHS staff. The survey sought to gain community partners' experiences and perceptions related to PCHS's health equity practices and their ability to address inequities in the community. The survey was open from April 17th to May 8th, 2023; 30 complete responses were collected. See the partner survey data collection tool in Appendix D.

Data analysis

After the completion of data collection, all data was downloaded/transcribed using Rev, an online transcription service. Qualitative data, including transcriptions from focus groups, interviews, and open-ended survey responses were coded to determine emerging themes. Focus group and interview transcripts were uploaded to Dedoose,[3] a qualitative analysis software platform,

Figure 1: Data collection methods and response rate

Internal survey
All PCHS staff (all levels)



Staff focus groups
Non-management PCHS staff

Leadership interviews
PCHS managers and supervisors

Partner survey
Community partners

RESPONSE RATE BASED ON GOALS			
60%	**44%**	**100%**	**31%**
95/159	22/50	23/23	30/98

3. Dedoose software. https://www.dedoose.com/

and coded a priori. The Rede Group team determined important themes and narratives that addressed the assessment's objectives.

Quantitative analysis for the internal survey and partner survey was performed in a spreadsheet using best practices for quantitative analysis to look for PCHS's strengths and areas of improvement regarding health equity. Surveys were considered complete and included in the analysis if the respondent answered 75% of the questions. For the internal survey, cross-tabulation was completed (where response rates were high enough to maintain the anonymity of respondents) to explore differences in experience and opinion between groups of staff. While preserving participant anonymity, responses could be stratified by race/ethnicity (staff of Color and White staff), division of service, and duration of service in current position.

After preliminary analysis was completed, Rede hosted three separate review sessions with assessment participants. Review sessions were held during the second and third week of June 2023, with PCHS management, PCHS staff, and community partners. The purpose of the review sessions was to confirm that Rede interpreted findings correctly, to provide additional context and meaning-making, and to provide direction for recommendations resulting from the assessment. Thirteen managers/supervisors attended the manager review session, thirteen staff attended the staff review session, and six partners attended the partner review session.

After review sessions, the Rede Group team met to identify important themes and discuss recommendations for PCHS to improve health equity-related practices.

Limitations

Self-selection bias and response rates

The Health Equity Assessment used a convenience sample, meaning participants opted in to participate; see response rates in the above table (Figure 1). Staff and partners who participated in the assessment may have felt more passionately about these topics than staff who did not, which has the potential to skew results. Staff and partners also may have had varying capacities to participate.

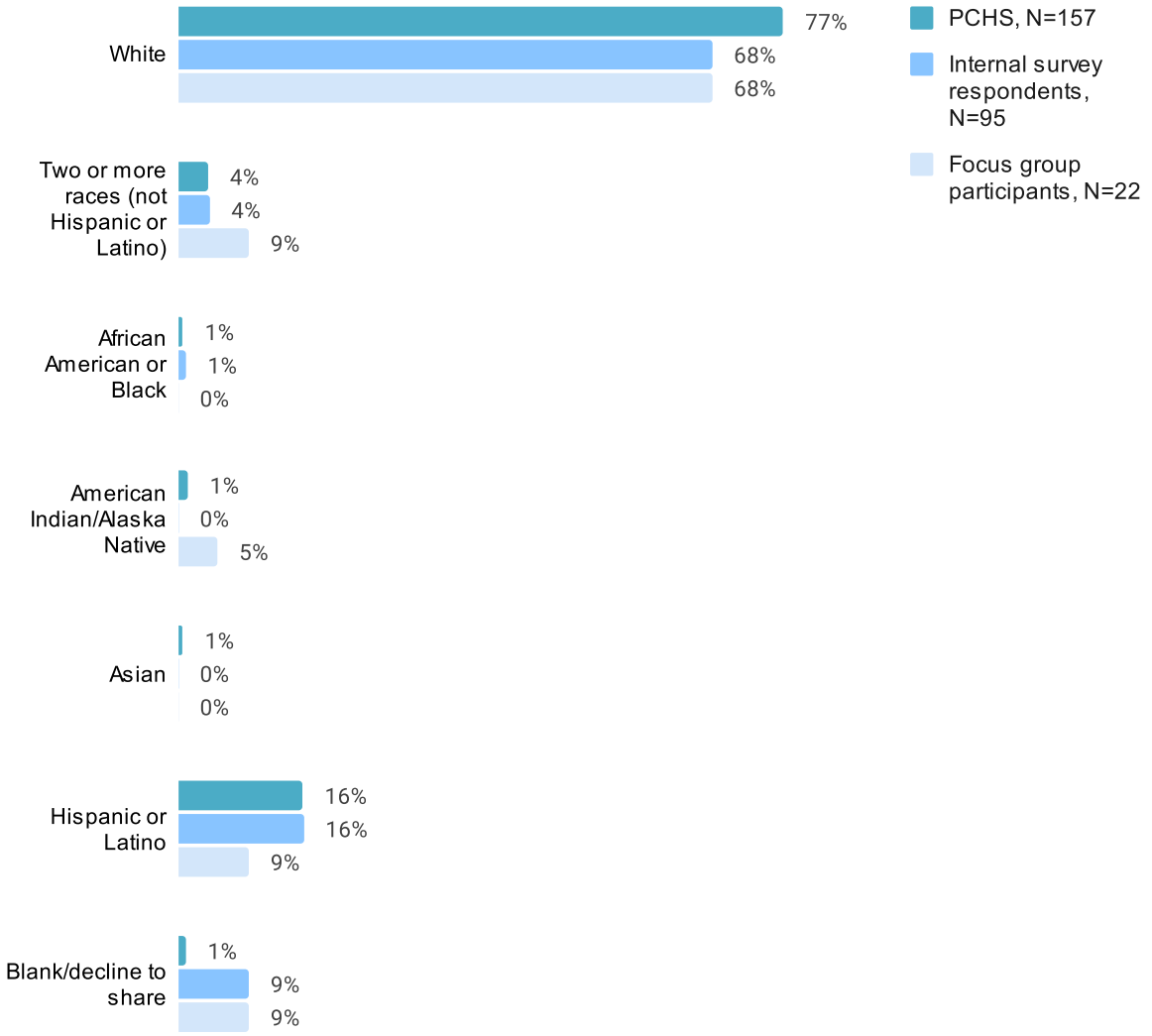
In hopes of increasing participant response rates, internal surveys, focus groups, and partner survey respondents were offered incentives to participate in the assessment. PCHS partners were all offered incentives, and PCHS staff were given the opportunity to be entered into a drawing to win an incentive.

While we could not reach all PCHS staff for participation in the assessment, the racial/ethnic representation of internal survey respondents and staff focus group participants was similar to the racial/ethnic makeup of all PCHS staff (information provided by PCHS); see Figure 2..

Subpopulation analysis

In order to determine opposing perspectives and themes across different subpopulations of PCHS staff, participant demographic data was collected in both the internal survey and the staff focus groups. Rede could not report subpopulation data by gender identity, sexual orientation, disability status, veteran status, or primarily language spoken because the sample sizes were too low to protect participant anonymity. Rede cross-tabulated data for staff of Color and White staff, by division of service, and by duration of service in current position. Due to small sample size and limited generalizability, it is important to remember that all findings in this report are descriptive.

Figure 2: Race/ethnicity of PCHS staff within the organization and among assessment participants



Differences in interpretation of questions or ability to respond to questions between assessment participants

At the partner review session, it was noted that some survey questions were unclear or out of the purview of the respondent. Some partner review session participants noted that they used the 'I don't know' response options because the were unsure how to answer the question, as written: for example, if their collaboration did not involve community meetings, they may have been unable to answer questions related to community meetings or if they only worked with one division of PCHS but the question was phrased to ask about qualities of PCHS as a whole, they were unsure in their response because they did not have experience with all aspects of the organization. A lack of understanding some assessment questions or differences in the interpretation of questions should be considered when reviewing partner survey data.

Findings

- Baseline assessment
- Organizational characteristics
- Workforce competencies

Baseline assessment of current health equity capacity at PCHS

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.[4] Because the criteria utilized was not created for BARHII, the fit may be somewhat imperfect and the categorization somewhat subjective. However, it is a way to see where the opportunities are for improving how PCHS addresses health inequities and the conditions that impact health.

While the assessment did not find that any PCHS competencies currently fit into the strong category, conversations with leadership indicate a commitment to using the findings from this assessment to make plans to progress into that category.

4. Office of Health Equity. (2022). *Organizational Assessment for Equity Infrastructure*. California Department of Public Health. https://www.cdph.ca.gov/Programs/OHE/Pages/Baseline-Organizational-Assessment-for-Equity-Infrastructure.aspx

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
Institutional support for innovation	Hiring to address health inequities Support staff to address health inequities Collaboration skills Community organizing skills	Institutional commitment to address health inequities Structure that supports true community partnership Transparent and inclusive communication Community-accessible data and planning Knowledge of affected community Leadership Cultural competence and humility	Personal attributes Understanding the social determinants of health		

Organizational characteristics

The following seven organizational characteristics have been identified as strongly correlated with a local health department's ability to effectively address health inequities. Rede has used these characteristics to assess Polk County Health Services' current practices to address health inequities and areas for improvement. These characteristics are important for an equity-centered approach, regardless of whether or not individuals within the organization see their job or mission as aligned with understanding or supporting communities to address social and institutional inequities.

Institutional commitment to addressing health inequities

The majority (86%, n=82) of PCHS internal survey respondents agreed there was an organizational commitment to addressing the environmental, social, and economic conditions that impact health or that the organization was moving in that direction (Figure 3). However, when responses were reviewed by division (see Figure 4), 14% (n=13) of respondents in HSD 3 (WIC, Emergency Preparedness, Psychiatric Services, Public Health Clinical Services, Jail Medical) said there was no organizational commitment to addressing the environmental, social, and economic conditions that impact health, much higher than the other divisions. Most HSD 3 respondents (79%, n=75) indicated the organization was moving in that direction (many more than the other divisions).

In alignment with PCHS internal survey responses, nearly all (90%, n=27) partner survey respondents agreed that PCHS should play a significant role in addressing the environmental, social, and economic conditions that impact health and that the organization and individual staff they have partnered with demonstrate a commitment to doing so (see Figure 5).

Figure 3: Staff perception of PCHS's commitment to addressing the environmental, social, and economic conditions that impact health, N=95

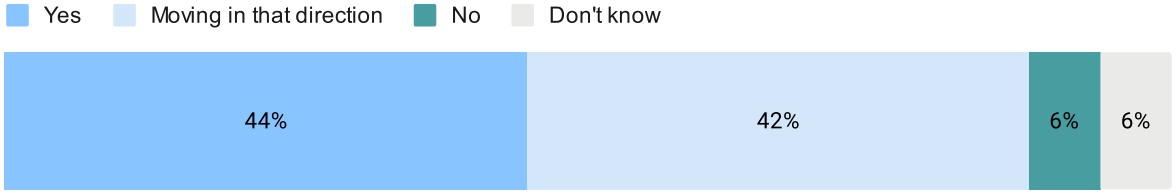


Figure 4: Staff perception of PCHS's commitment to addressing the environmental, social, and economic conditions that impact health by division, N=95

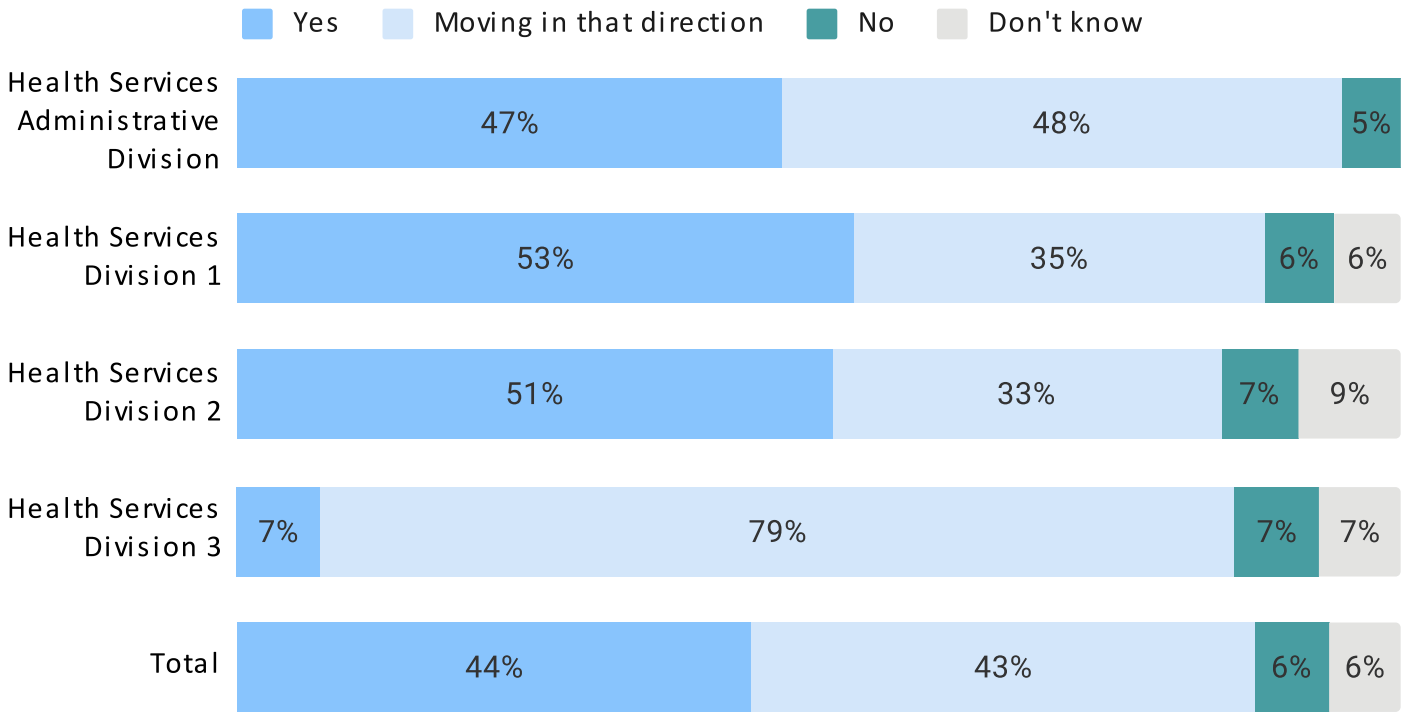
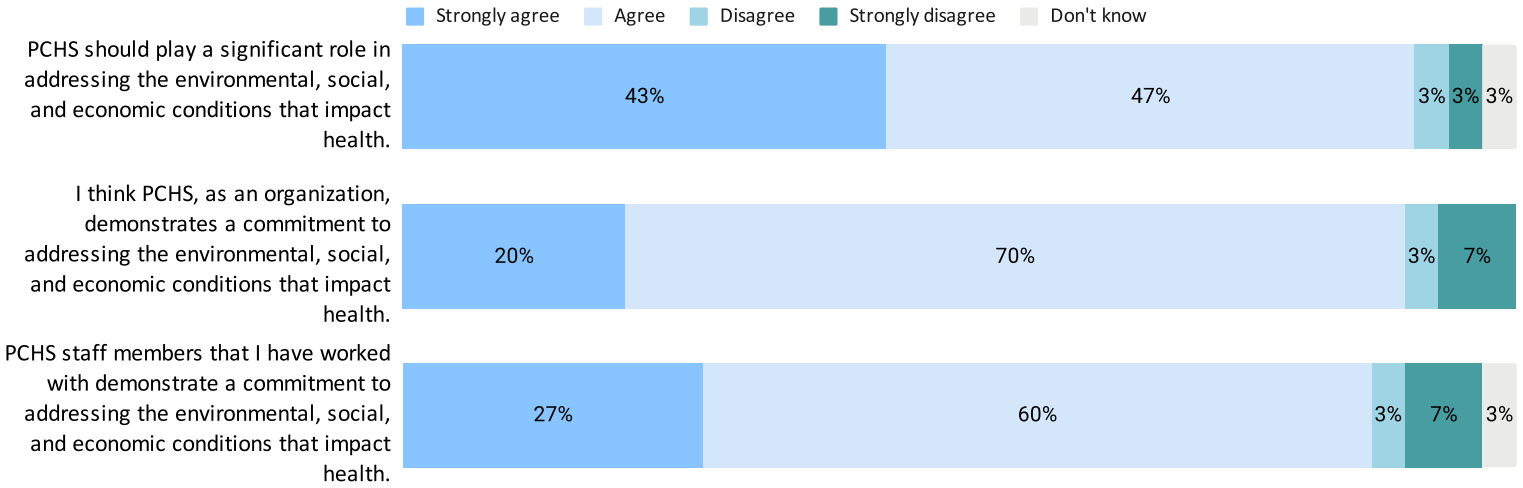


Figure 5: Partner perception of PCHS's role and commitment to addressing the environmental, social, and economic conditions that impact health, N=95



Focus on addressing health inequities

Nearly all PCHS staff focus group participants said that health inequities should be an area of concern for PCHS. Participants shared that since they serve a wide range of clients with varying needs, addressing health inequities would allow them to make a more significant impact on the community. While no focus group participants shared that health inequities should not be a concern, a couple were unsure.

While most focus group participants believed health inequities should be a focus for PCHS, 43% (n=41) of internal survey respondents reported that the organization had either no focus (3%, n=3) or not enough focus (40%, n=38) on addressing health inequities and a little over a third (34%, n=32) said there was about the right amount of focus (Figure 6). When comparing responses by division, the majority (64%, n=61) of HSD 3 (WIC, Emergency Preparedness, Psychiatric Services, Public Health Clinical Services, Jail Medical) respondents indicated that there was not enough focus on health inequities, and 7% (higher than any other division) said there was no focus on health inequities (Figure 7).

Figure 6: Staff perception of PCHS's focus on addressing health inequities, N=95

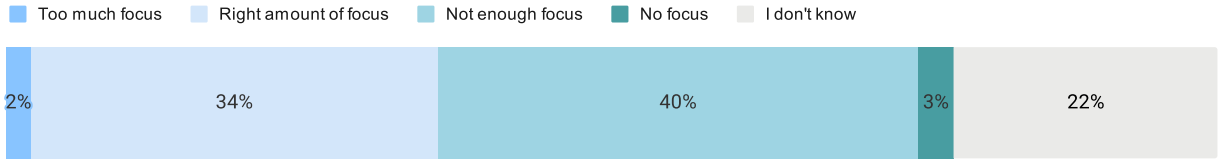
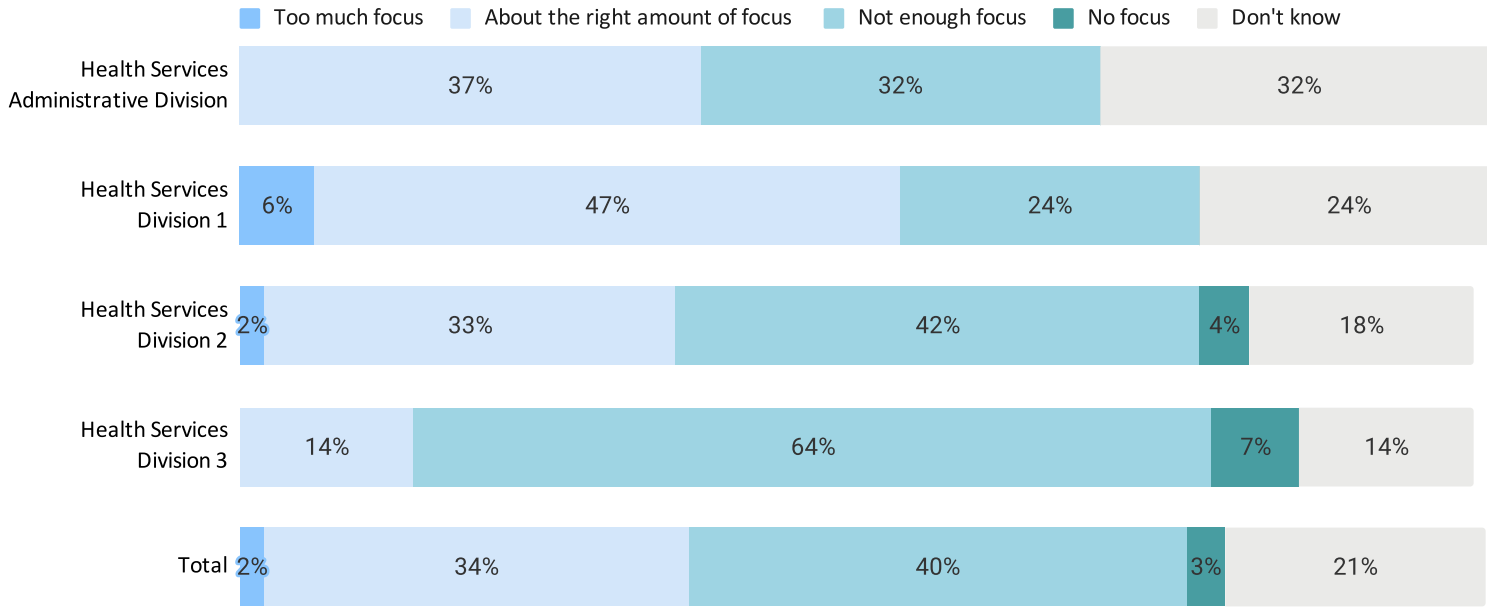


Figure 7: Staff perception of PCHS's focus on addressing health inequities by division, N=95



Hiring to address health inequities

Hiring to address inequities includes assessing the demographic makeup of current staff at all organizational levels, participating in intentional hiring practices that eliminate barriers, and actively recruiting candidates representing diverse populations.

Diversity of staff & hiring practices at PCHS

Staff focus group participants shared that PCHS staff reflected the diversity of the Polk County community. They noted that Polk County had limited diversity within the county population and that diversity within the organization at PCHS was a strength. To staff focus group participants, this felt intentional - hiring practices seemed to focus on a candidate's ability to support the needs of the community rather than a set amount of education or experience, which participants mentioned could discourage diversity. A couple of participants noted that the behavioral health staff did not reflect the population they served, as they had few Spanish-speaking clinicians or staff of Color as a part of management.

In alignment with staff focus group participants, more than half (68%, n=65) of internal survey respondents felt that they worked with culturally diverse staff (68%, N=65). In comparison, nearly a third (29%, n=27) of respondents did not agree, identifying this as an area for improvement. Internal survey respondents had varied opinions about equitable recruitment and hiring practices, with the majority agreeing that PCHS actively recruited culturally diverse staff to provide direct client services and that when appropriate, minimum requirements for positions were flexible to allow for relevant community experience in place of educational degrees. However, nearly a third of respondents were not sure about these practices within the organization. Staff were less likely to agree that PCHS actively recruits culturally diverse management and leadership staff or that during hiring, interview questions were designed to gain insight into an applicant's capability to address health inequities in the performance of their program responsibilities. Several respondents were unsure about these questions as well (see Figure 8).

Managers and supervisor interviewees more clearly conveyed gaps in intentional hiring practices, indicating that other than asking for people with bilingual and bicultural backgrounds, PCHS had no process of recruiting a diverse workforce. However, as participants discussed the absence of intentional recruitment practices, this was attributed to geographic and financial

"When the staff offering services are not representative of the community [they] serve, these minority populations who historically are underserved and in the greatest need are less likely to be understood, felt, seen, or be willing to access further services... it ends up undermining trust big time. This is why it's important to prioritize culturally appropriate care. A White dominant culture can't define what that is. It has to come from that population."

—Staff Focus Group Participant

issues. Managers and supervisors felt that PCHS's position as a rural county and their current funding levels made it difficult to compete with employee wages offered in urban counties limiting their ability to fill positions or develop equity-centered recruitment practices.

Managing and promoting a diverse workforce

Rede asked managers and supervisors if they received training in managing a diverse workforce. Most managers and supervisors shared that PCHS provided no formal or consistent training on managing a diverse workforce. Internal survey responses revealed that many staff were unsure if staff members' efforts to address health inequities were considered in performance reviews and if staff from diverse backgrounds were equitably promoted throughout PCHS (see Figure 9).

There were varied responses from manager and supervisor interviewees about whether they were aware of the types of diversity PCHS encouraged, including bilingualism, veteran status, sexual orientation, and if generally PCHS encouraged diversity. Interviewees explained that the diversity that PCHS encouraged was demonstrated by the diversity represented in its staff.

"We actively try to recruit, and we put it in our recruitment that we're looking for somebody bicultural, bilingual."

—Manager/Supervisor Interviewee

"I struggle as it is to fill the positions I have open. We interview everyone that comes in, but we don't have funding or time to make any sort of intentional ad."

—Manager/Supervisor Interviewee

"I think most people doing the hiring, for example, would say that they're excited to see diversity in applicants, but I don't think we have good overt directions about how to accommodate our interviews or how to welcome someone to apply and interview or come into the organization if they may be more of a minority in our agency culture."

—Manager/Supervisor Interviewee

Figure 8: Staff perception of PCHSS recruitment and hiring practices, N=95

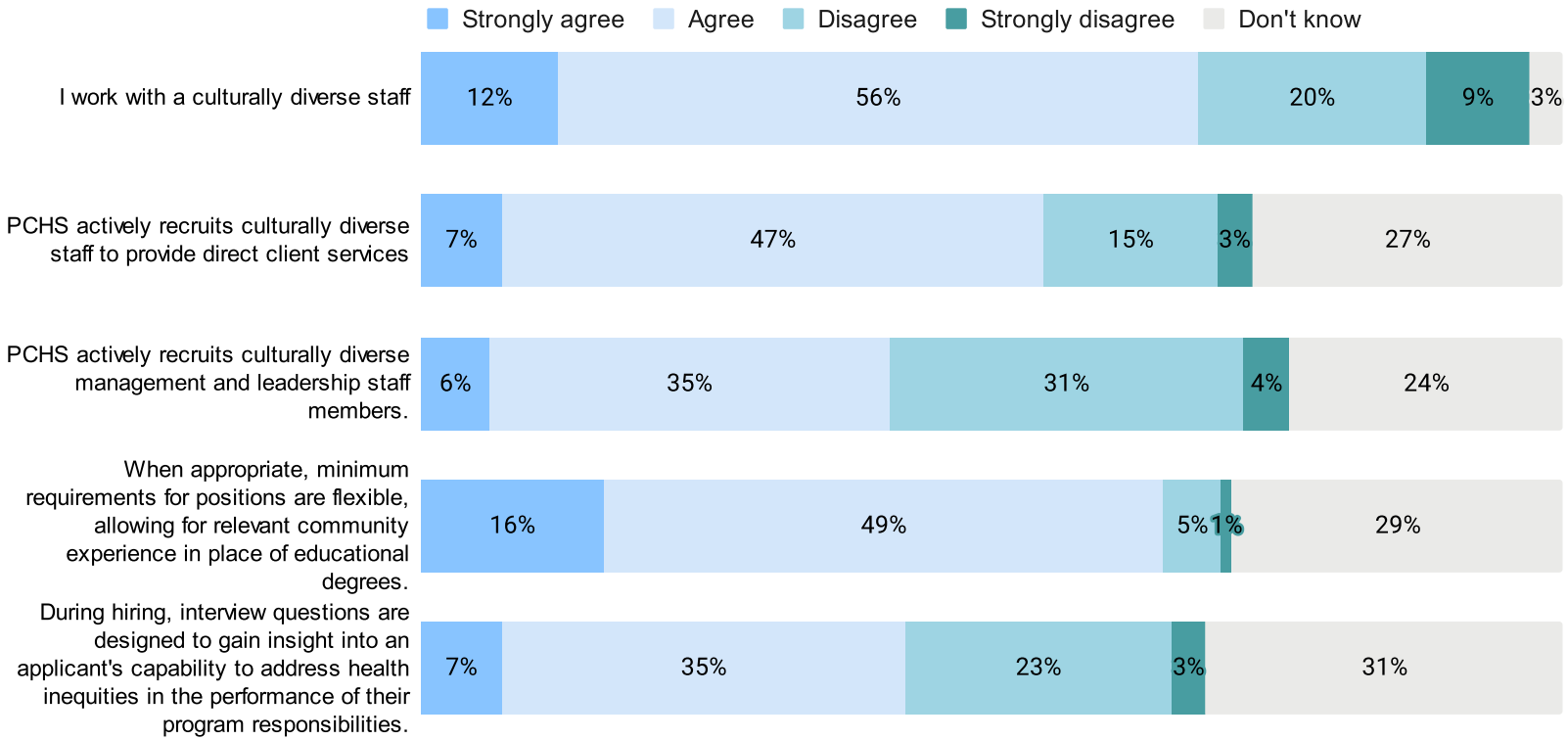
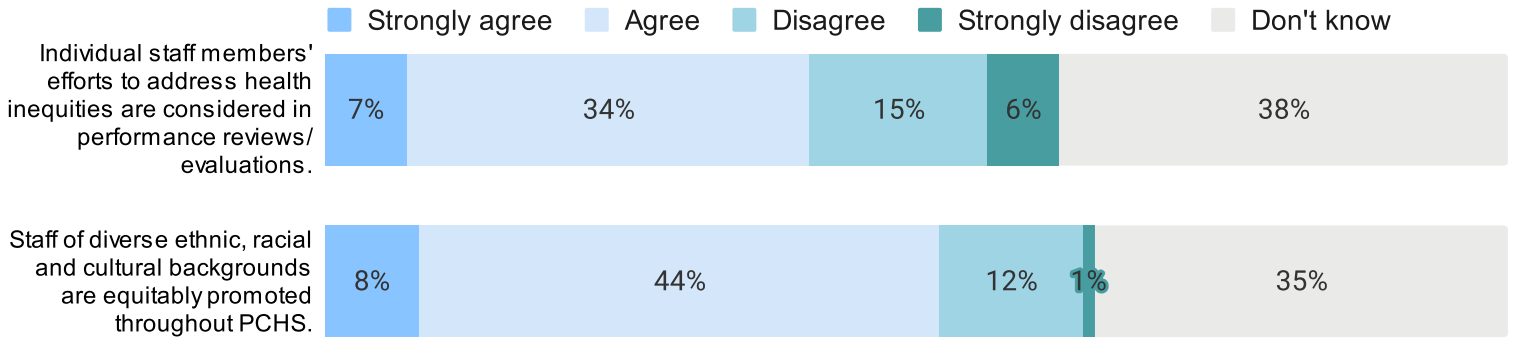


Figure 9: Staff perception of equity focus in performance reviews and promotion practices, N=95



Rede also asked manager and supervisor interviewees to discuss how they included the strengths of culturally diverse employees in the work that they do. Some interviewees mentioned that strengths were utilized the best they could. However, there is no formalized way to include the strengths of diverse staff; examples were given were limited to including "using" those who are bicultural and bilingual to communicate with bicultural community members.

For PCHS manager and supervisor interviewees there was a near-unanimous feeling that PCHS was a place that encourages growth. Most participants cited evidence that staff have developed skills from within, were supported through coaching, and were implored to continue education. A few participants mentioned that no specific policy or program pointed staff in the right direction, but even those few surmounted evidence that people are encouraged to learn and grow at PCHS.

"[We're] not sure if [we] can tie it specifically back to class and background, but [we] personally try to look at the strengths of the staff and try to build their positions around their strengths."

—Manager/Supervisor Interviewee

"I can speak for myself and my own experience here, I've always felt very supported in growing in my professional career and being included in opportunities where I could grow professionally and advance."

—Manager/Supervisor Interviewee

"So all the way down, we're encouraging people to expand, make sure they have the credits they need for their certification. We encourage them to move up within the agency or elsewhere. So we support ongoing growth at the agency just very consistently all the way down."

—Manager/Supervisor Interviewee

Structure that supports true community partnership

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.

Partner involvement in planning processes

When asked about their involvement in PCHS's planning processes, community partners shared a neutral perspective, with only about one-quarter (23%, n=7) of respondents saying that organizations like theirs were always invited to participate in the PCHS planning process and even less (17%, n=5) respondents saying they were always meaningfully involved (Figure 10). Half (50%, n=15) of partner respondents said organizations like theirs were sometimes involved in PCHS planning processes. However, most (83%, n=21) partners agreed or strongly agreed that PCHS valued input from organizations like theirs (Figure 11).

In manager and supervisor interviews, multiple interviewees mentioned involving community members or partners in decision making through the health advisory board.

Supporting and building capacity of community groups

Staff focus group participants reported that PCHS staff built relationships with community organizations in order to better serve their clients, whether it be to connect them to other services or to help them reach resources like food boxes. Sometimes these partnerships were built by staff on their own, and sometimes PCHS facilitated those connections.

In the internal survey, when staff were asked if PCHS had structures in place to support community efforts to address health inequities, a smaller proportion of respondents said that PCHS had strategies in place to mobilize community groups to address health inequities, support the work of community groups advocating for public health policies to address inequities, and minimize barriers to community participation compared to those who said PCHS was moving in that direction (Figure 12). About one-third (29-36%, n= n = 28-34) of internal survey respondents were unsure if PCHS had these strategies in place.

"Probably just through the health advisory board. So that openness to having people come and sit on that committee and be a part of that planning process and to be informed about what we're doing."

—Manager/Supervisor Interviewee

"I give the county four stars for community partnering for whatever available resources they have...They maintain fairly good relationships with hospitals, police, fire, and ambulance. They're very well integrated into the community that way."

—Staff Focus Group Participant

Figure 10: Partners' perception of organizational involvement in PCHS planning processes, N=30

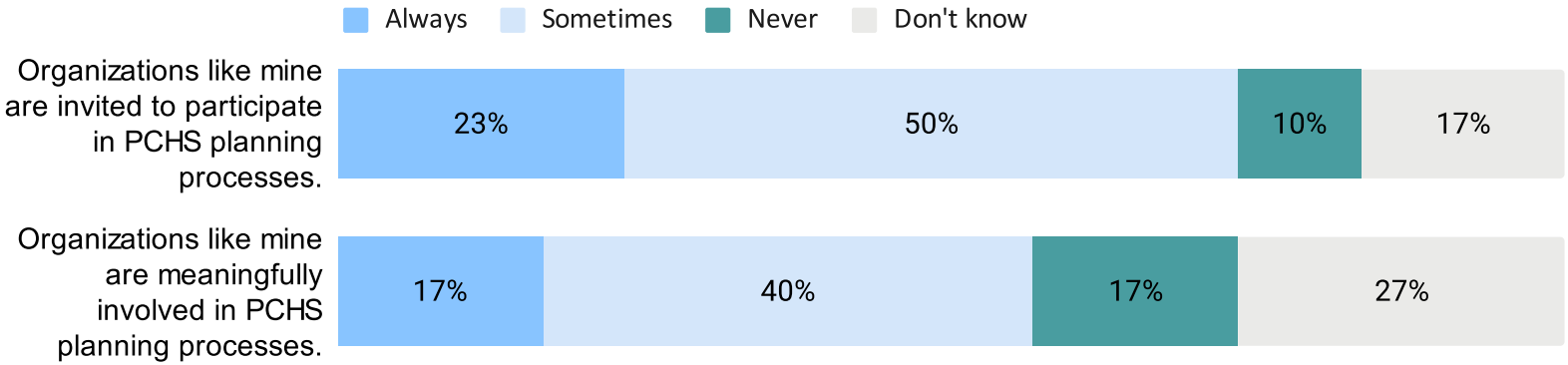
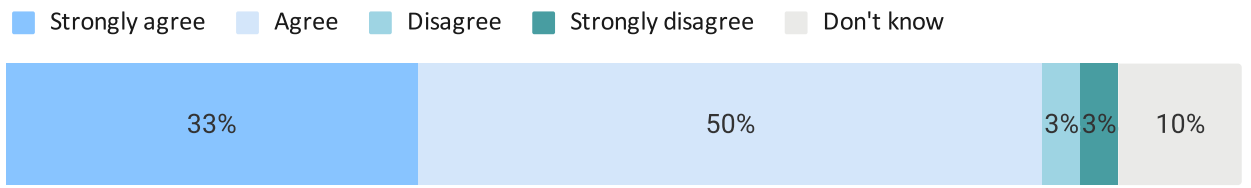


Figure 11: Partners' perception of whether or not PCHS values input from organizations like theirs, N=30



Over half (56%, n=54) of internal survey respondents said that PCHS made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting the conditions that impact health or that they were moving in that direction, and a higher proportion (70%, n=66) said that PCHS provided resources to community residents and groups to support their self-identified concerns and needs in respect to addressing the conditions that impact health or that they were moving in that direction. PCHS's partners were also asked if PCHS provided resources to community residents and groups to support self-identified concerns and needs; 60% (n=18) agreed that they did.

Partners were also asked if PCHS provided trainings to increase the knowledge and skills of community leaders to address the environmental, social, and economic conditions that impact health; about half (43%, n=13) were unsure and (32%, n=9) said they did.

In management and supervisor interviews, some interviewees offered evidence that PCHS supported community or community capacity building.

Only a few managers/supervisors could lay out how PCHS specifically supports community capacity. Some participants mention how building community capacity is not a thing that PCHS necessarily does (indicating this work may be division or program-specific).

Supporting partners'/clients' linguistic and cultural needs

One major concern voiced in focus groups was PCHS's ability to provide culturally appropriate services, especially those which were linguistically appropriate for the community. According to focus group participants, barriers and issues with languages services included:

- insufficient resources for translation/ interpretation service, which resulted in long wait times while working with clients
- poor quality translation services, leading to a disconnect between staff and clients
- contracting requirements made it impossible to lean into bilingual staff to help with translation/interpretation

"Within [program of employment], as we're reaching out to different community groups, different churches, different schools, different activities happening in the different communities within our community in order to engage those parts of our community to meet the needs of those people."

—Manager/Supervisor Interviewee

"I just think it's glaring, unbelievable in this day and age...It's astounding to me that they're not getting it in their native tongue."

—Staff Focus Group Participant

Figure 12: Staff perception of PCHS strategies in place to support community efforts to address health inequities, N=95

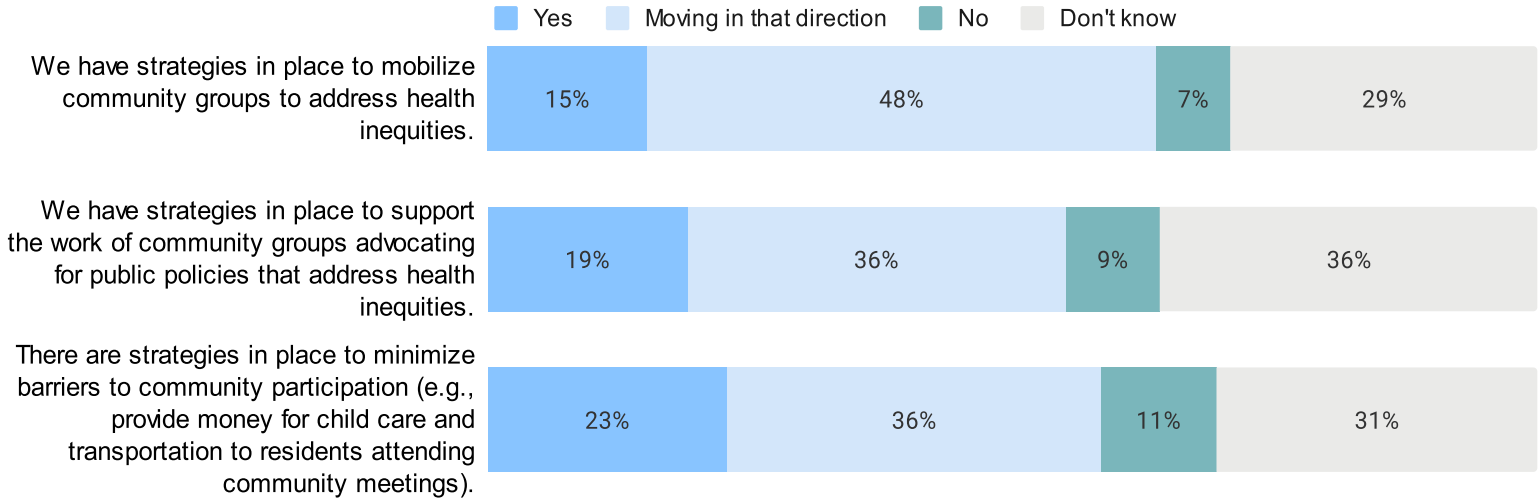
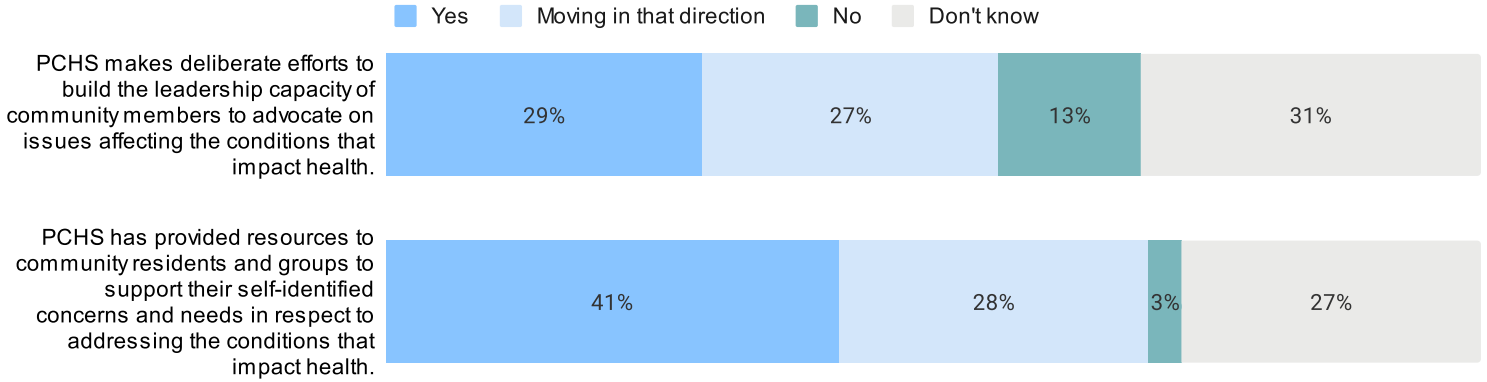


Figure 13: Staff perception of PCHS strategies to build community capacity, N=95



Support staff to address health inequities

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

Staff focus group participants shared a number of opportunities they had at PCHS to learn about health inequities and develop skills to address them. However, many participants contended that there were limited learning or skill-building opportunities provided to the entirety of PCHS and that the opportunities provided were out-of-date or that it had been a long time since they received those trainings. A few participants mentioned a training that they had participated in during their onboarding process that was a showcase of community organizations/programs and what they did. This was perceived as helpful in addressing inequities as it gave PCHS staff tools and resources to address clients' specific needs. Participants shared that since a lot of training was front-loaded, it was difficult to keep track of everything they learned and they wished there were more opportunities for refreshers.

Many staff focus group participants shared that the training they received was program or division specific. Staff focus group participants mentioned that some training was provided to certain staff in order to maintain needed certifications. Some staff focus group participants shared that their supervisors provided additional training opportunities, such as those provided by other entities.

There was discussion amongst some participants about a failed diversity training that happened in the past, which has not been reattempted; however a few participants were aware of a particular department having plans to incorporate more training and modules that help teach staff about addressing health inequities and social determinants of health.

Staff focus group participants shared gaps in opportunities to learn about and develop skills to address health inequities, including:

- organization-wide training was few and far between,
- organization-wide training often presented outdated or irrelevant information, and
- some staff members did receive training, but could not recall any focus on health equity.

When staff were asked in the internal survey whether they had ever received training on

"I was watching it [a training], and I was like, 'this is a waste of an hour of my time.' Why? Because I know, even at my base level where I'm at, more information that's correct versus what was provided in those videos. It's just so outdated."

—Staff Focus Group Participant

"We have mandatory yearly training, and there's been nothing covered [on health equity]."

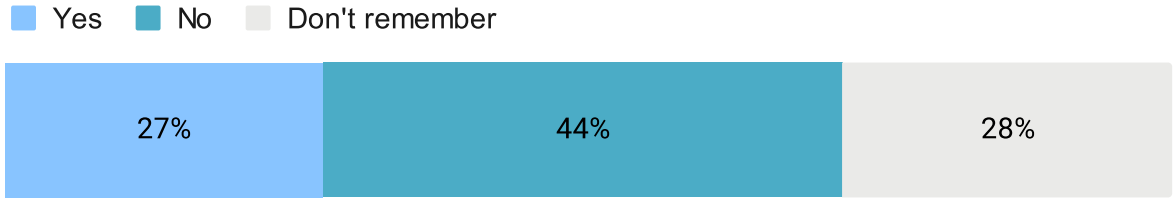
—Staff Focus Group Participant

strategies to address health inequities, only 27% only 27% (n=26) of staff said that they had. More staff said that they couldn't remember (28%, n=27), and close to half said they never had (44%, n=42).

Managers and supervisors shared similar experiences as staff focus group participants around health equity-related learning supports, although they were not able to provide as many examples or details about the available learning opportunities.

In addition to training of their current workforce, Rede asked managers and supervisors to describe how they actively work to build a workforce that addresses health inequities in Polk County. Managers and supervisors described their partnerships with advocacy organizations and universities and internal internship programs as methods for building a workforce that addresses health inequities in Polk County.

Figure 14: Staff who received training on strategies to address health inequities at PCHS, N=95



"We partner with Western Oregon University. They have a public health program as well as a nursing program through OHSU. We go to their health fairs. Basically all of our interns are from Western Oregon and we're just open to working with them and they kind of give us ideas of what their students and community need as far as educational opportunities. And we just have a really collegial relationship with them."

—Manager/Supervisor Interviewee

"We are building an entire training plan with several different modules that incorporate those components. We have a list of mandatory training that everybody has to do every year, but I am not sure any of them are geared to the equity piece."

—Manager/Supervisor Interviewee

"As far as inequities, we've partnered with OHSU, and Western Oregon to do studies. One research project that we hired them for was assessing all of our buildings for trauma-informed care."

—Manager/Supervisor Interviewee

Transparent and inclusive communication

The organizational characteristic transparent and inclusive communication includes:

- Clear communication
- Communication in multiple directions
- Seeking and utilizing input from the community
- Involving community partners in decision making

Effective and impactful initiatives to address health inequities include active stakeholder and community engagement to meet the needs of all communities and individuals that PCHS serves. Additionally, maintaining open, consistent, and transparent communication with interested parties demonstrates the organization's commitment and transparency in its efforts to promote health equity. All four data collection methods evaluated PCHS's communication efforts.

Internal communication

To find out about internal communication at PCHS, staff were asked in the internal survey whether or not they knew how the work of other parts of the organization contributed to addressing health inequities in the community. Some staff (28%, n=27) lacked knowledge about how the work of other parts of PCHS contributed to addressing health inequities (Figure 15). Staff focus group participants expanded on this idea, sharing a desire for greater connectivity between staff working in different divisions at PCHS to raise awareness of available programs, services, and resources. A better understanding of other programs at PCHS would help them serve their clients better. They also desired a system for keeping track of community resources to share with clients, and wanted the resource fair to be accessible beyond their onboarding.

Rede also asked management/supervisor interviewees about opportunities for staff to provide feedback as a part of clear, multi-

"We're a small county, and so we don't have a lot of... I mean, I wouldn't say we have tons of formal processes. Still, I think, like I said, there's always an invitation to discuss those things with people and with your supervisor, and if not your supervisor, a different supervisor that you like."

—Manager/Supervisor Interviewee

Figure 15: Staff agreement that they know how the work of other parts of PCHS contributes to addressing health inequities in the community, N=92

directional communication. In management and supervisor interviews, interviewees shared a feeling that PCHS is a place where feedback is welcome and oftentimes implemented.

Communication and collaboration with community members and partners

Clear communication

Nearly three-fourths (n=69%) of partners who completed the partner survey felt that PCHS communicates openly and honestly with community members and partners, and only 10% (n=3) disagreed (Figure 16).

In general, partner survey respondents had positive perspectives about their interactions with PCHS including PCHS's familiarity with the strengths and resources of residents and organizations in the community, and their ability to advocate on behalf of community members to influence how resources are made available. Most partner survey respondents (90%, n=27) felt like they had trusting relationships with PCHS staff.

"[We] meet with everybody once a month, if not more. They can reach out to me and talk to me anytime they want to, but we have at least one standard set meeting for one hour a month, sometimes more, it just depends on what they need."

—Manager/Supervisor Interviewee

Figure 16: Partners' perception of whether or not PCHS communicates openly and honestly with community members and partners, N=30

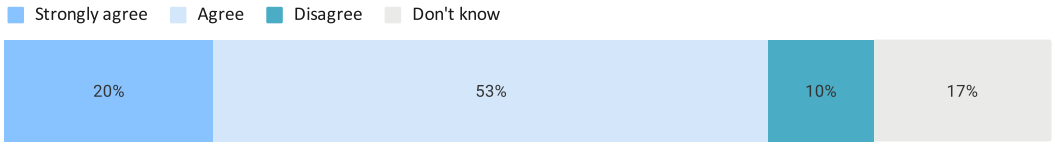
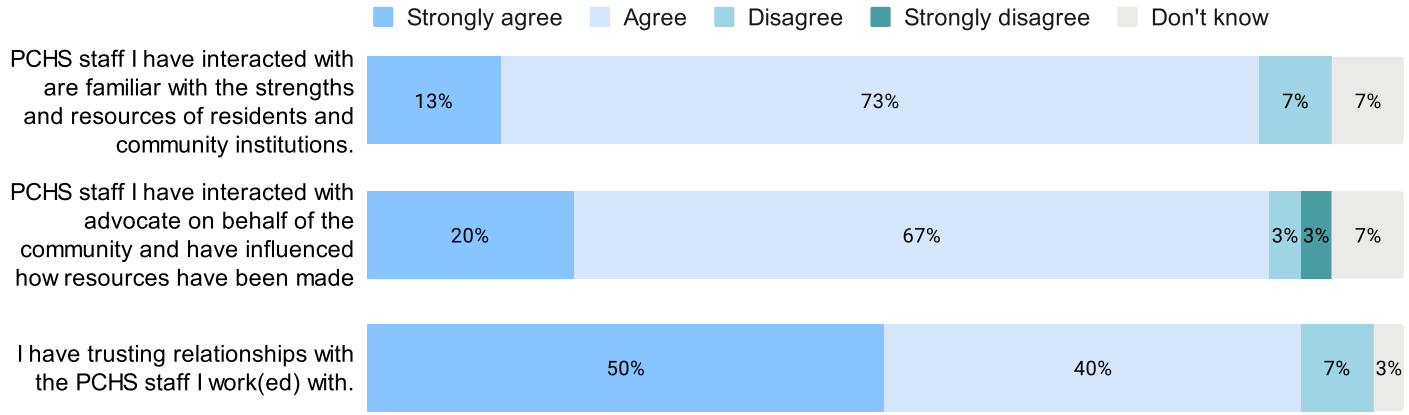


Figure 17: Partner survey respondent perceptions of interactions with PCHS staff, N=30



Communication in multiple directions

Although PCHS staff shared that community partnerships were fruitful, they shared in focus groups a need for a better mutual understanding of services provided by PCHS and partner organizations to avoid misleading clients. They wanted community partners to have a better understanding of PCHS's role.

When partners were asked about two-way communication about the results of community input into planning work, over half of partners were unsure if PCHS communicates with community groups about results of community planning efforts (Figure 18); while less than one-fifth (n=6) of partners said PCHS always communicated with community members and groups about the results of their input into planning.

When community input was not utilized, only one-quarter (n=8) of partner survey respondents said that PCHS communicated why those decisions were made (Figure 19).

Figure 18: Partners' perception of whether or not PCHS informs people and groups it works with about the results of community input into planning, N=30

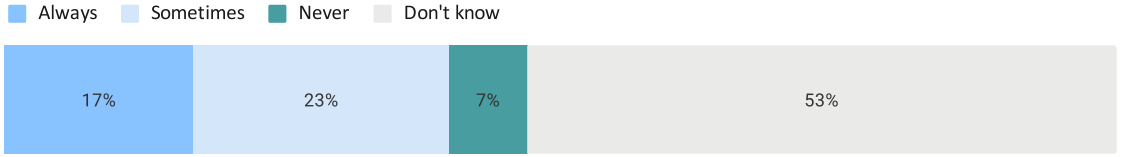
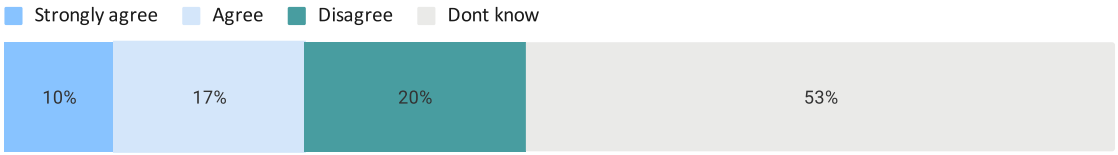


Figure 19: Partner's perceived agreement that when PCHS makes program decisions that don't reflect community input, it is known and clear why those decisions are made, N=30



Seeking and utilizing input from the community

All informant groups were asked about PCHS seeking and utilizing input from the community. Most staff respondents felt that PCHS was open and responsive to community stakeholders' feedback on its work, or that they were at least moving in that direction (59%, n=56). Partners responded similarly.

In management and supervisor interviews, interviewees shared several methods for collecting community input and feedback: Polk County Family and Community Outreach, various Public Health department efforts such as Community Health Assessment (CHAs), Community Health Improvement Plan (CHIPs) and community meetings. Many interviewees mentioned informal opportunities for the community to provide feedback, but mentioned that this feedback was not actively solicited. Some manager and supervisor interviewees mentioned their department isn't doing anything to gather community input.

Manager and supervisor interviewees discussed barriers to community participation: not being able participate due to a lack of public transportation options, PCHS being operated in a low-resourced rural area, and a lack of funding for community-participatory events.

Figure 20: Staff perception of PCHS openness and responsiveness to community stakeholders' feedback, N=95

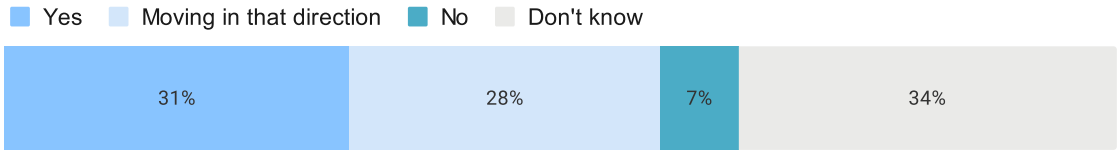
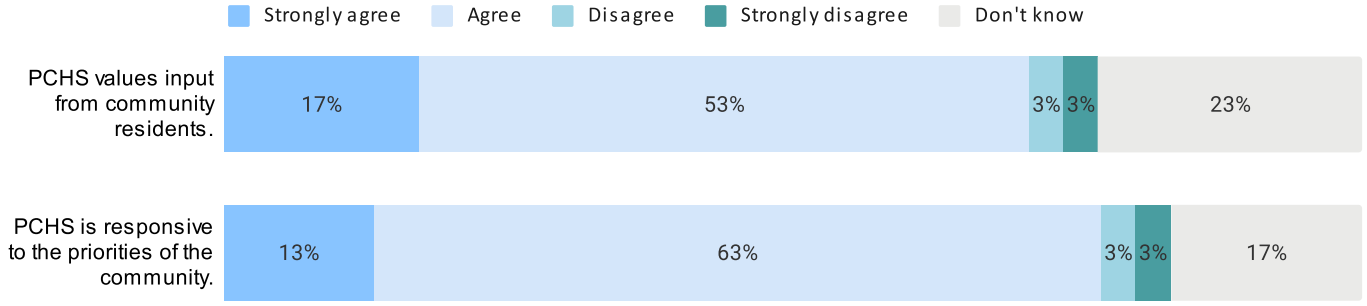


Figure 21: Partners' perception of PCHS responsiveness to community input, N= 30



"If there's a community committee that has community agencies, we get their input, but that's more informal and it's certainly not representative of the community at large."

—Manager/Supervisor Interviewee

"People can always call. They can call the main number."

—Manager/Supervisor Interviewee

"We don't create enough systems to ask for feedback."

—Manager/Supervisor Interviewee

Institutional support for innovation

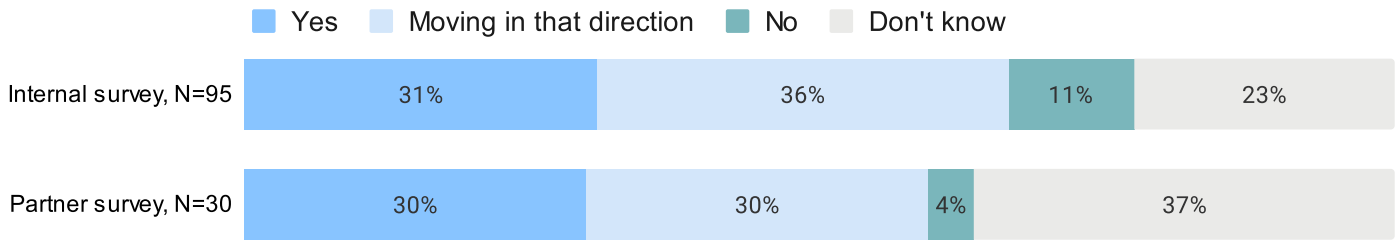
This competency describes how PCHS provides space and resources for trying new systems that can address health inequities. Innovation in service provision and program planning is important for serving the community and adapting to changes in the community. Management and non-management level staff were asked about PCHS's support for innovation in focus groups and interviews, and partners were asked about PCHS's ability to adapt to new communities and community needs in the partner survey.

Organizational adaptability to new communities/changes within the population

One aspect of innovation includes regularly assessing community or organizational needs and identifying areas for improvement. In management and supervisor interviews, interviewees were asked if specific departments conducted health equity evaluations of the communities they serve. Most manager and supervisor interviewees were not aware of these types of assessments happening within their division. Some discussed informal processes for determining health equity needs, or commented that the organization was committed to increasing equity. There was a lack of specificity and knowledge around division-specific health equity assessment, indicating a lack of standard practice for being up-to-date with community needs.

In the internal survey, only 31% (n=29) of staff indicated that PCHS was able to adapt to new communities and changes within the populations they serve; 36% (n=34) felt they were moving in that direction. Similarly, in the partner survey, 30% (n=10) of respondents felt that PCHS could adapt to new communities and changes within the populations they serve and 30% (n=10) felt they were moving in that direction. Many respondents were unsure.

Figure 22: PCHS ability to adapt to new communities and changes within the populations, internal and partner survey, N=95



Organizational support for innovation

In staff focus groups, participants provided more insight into institutional support for innovation. When asked how welcoming and supportive they felt PCHS was to new ideas and programs that would address health inequities and their causes, many participants felt that their supervisors were happy to discuss and problem-solve. Focus group participants felt that in their divisions, flexibility of workflows allowed them to accommodate community members' specific needs. However, many of these same participants shared that when ideas were taken to higher levels of leadership, they were unable to proceed with the new idea. Participants were not always sure at what level their idea was being shut down, but suggested that the organization as a whole was set in their ways and that the focus on productivity discouraged new ideas that would benefit clients.

Successful innovation in addressing health inequities

Focus group participants were asked about work to address health inequities that had been successful and what strengths led to these successes. Successes cited by participants included:

- Opening new buildings to serve clients with transportation barriers
- Expanding community-based programing
- Embracing peer support
- Making efforts for employee retainment, which helped better serve clients
- Hiring more staff members, especially those with lived experience and bi/multilingual capabilities

Along with flexibility in workflows allowing for PCHS to try multiple iterations of programs to ensure their success, some participants shared that in recent years, the organization had expanded their collective capacity, which allowed for program expansion and may have contributed to organizational support for innovation.

Innovation failures and barriers to implement new ideas to address health inequities

Staff focus group participants were also asked about work to address health inequities that had failed, and what challenges or barriers led to those failures. Focus group participants shared that PCHS, or even the overall Polk County community, was resistant to change. Working within a bigger public health and health care system, there were constraints that made it difficult to be innovative and meaningfully address health inequities. Other barriers presented by participants included funding and feeling like resources at PCHS were very siloed.

"I've had a really good experience. If I do something to bring up an idea, it'll be like, 'ooh, share that with the team'."

—Staff Focus Group Participant

"They want to continue to do it the way they're doing because if we try it a different way, then that could lower the productivity."

—Staff Focus Group Participant

"I kind of want to rattle the cage sometimes, but is rattling the cage going to be effective? I don't know."

—Staff Focus Group Participant

Community-accessible data and planning

This competency includes collecting, displaying, distributing, and using data in a way that is inclusive and appropriate for all. Community-accessible data includes accessibility, readability, and integration into planning processes.

Planning processes

In management and supervisor interviews, leadership was asked several questions regarding organizational and division-specific planning processes. These questions were about strategic planning processes, community involvement, use of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, and systems for workforce development.

When discussing strategic planning and SWOT analysis, managers and supervisors provided anecdotal evidence that some process was taking place, but leadership lacked knowledge of specific administrative processes or frequency. SWOT analysis was described to be more informal: some managers/supervisors shared that they gathered information on the strengths and weaknesses of their programs from individual staff on a regular basis, but by and large there was a lack of streamlined processes across divisions for strategic planning and organizational evaluation. For community involvement and workforce development, interviewees shared similar sentiments, see Transparent and Inclusive Communication and Support Staff to Address Health Inequities sections.

Focus group participants also discussed division or program-specific processes for community engagement and workforce development.

In the internal survey and the partner survey, respondents were asked whether PCHS collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community. In both the staff and partner surveys, only some (26%, n=25 and 21%, n=20) respondents agreed that data collection and sharing was community-accessible, while many respondents in both surveys were unsure. One fifth (n=19) of internal staff respondents said they were "moving in that direction", and a larger number (n=11) of partners said they were "moving in that direction". Interestingly, a smaller percentage (n=6) of partner survey respondents responded "yes." It seemed partners had a more neutral perspective on PCHS's data collection and sharing practices (Figure 23).

"If they do any strategic planning, it's done independently and within individual programs or departments. They don't all do it."

—Manager/Supervisor Interviewee

As for PCHS's practices related to sharing oral and written information that is linguistically and culturally appropriate information, community partner survey respondents indicated that PCHS is moving in that direction or already demonstrating this capacity; however, a high percentage of respondents selected "don't know". Staff were similarly likely to select that PCHS was moving in that direction or did create and distribute appropriate materials, and 12% (n=11) said they did not (Figure 24).

Figure 23: PCHS ability to collect and share data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community

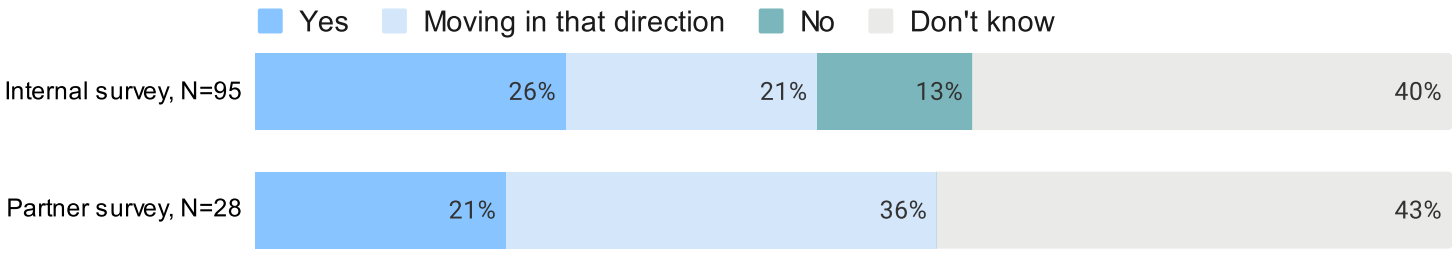
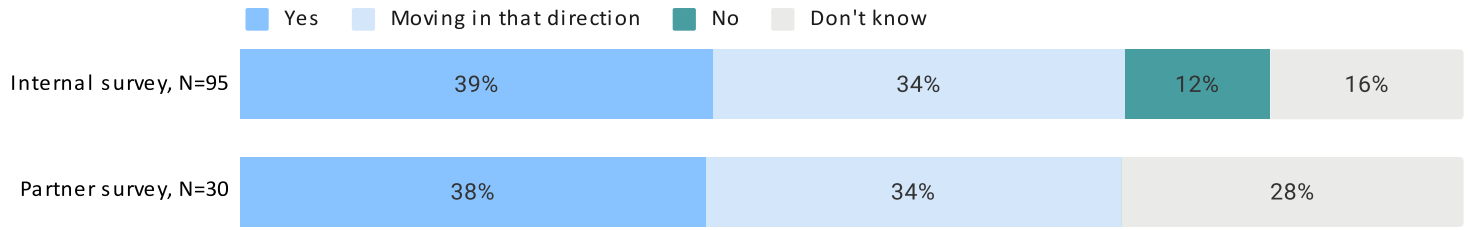


Figure 24: Staff and partner agreement that PCHS creates and distributes oral and written communications appropriate for cultural, linguistic, and literacy needs of the community



"There's monthly supervision of staff and group team supervision. So there's lots of opportunity in those areas to be able to talk about what are strengths, what's going well, and then weaknesses, what needs improvement, where do you need more support and training. So at the staff level, yes, if you're talking about program level, that [I] don't know."

—Manager/Supervisor Interviewee

Workforce competencies

Workforce competencies are the skills and abilities needed by local health department staff to effectively address health inequities. The eight workforce competencies evaluated in this assessment include personal attributes such as passion, self-reflection and listening skills. understanding the social determinants of health, knowledge of the affected community, leadership, collaboration skills, community organizing skills, and cultural competence and humility.

Personal attributes

There are several personal characteristics PCHS staff may have that lend to successfully addressing health inequities. Some of these characteristics include passion, the ability to self-reflect, the desire for continuous learning, and a reflection of the community they serve.

In staff focus groups, participants offered many examples of attributes they saw in PCHS staff that were helpful in addressing inequities. Participants shared that several PCHS staff had lived experiences similar to those their clients experienced, which allowed them to connect with and better serve clients. Focus group participants mentioned that more and more PCHS staff possessing this trait were being hired. They also discussed how passion and care were traits they needed to possess in their professional roles, and partially attributed their connection with clients and perseverance in problem-solving to these traits.

PCHS staff and managers were asked about their comfortability engaging in uncomfortable conversations or conversations about "isms" like racism and classism. In management and supervisor interviews, interviewees said they believed they were able to have uncomfortable conversations. In the internal survey, a large proportion of staff agreed that staff were comfortable talking about race and racism (60%, n=57), and class and classism (62%, n=59). They felt similarly about management's comfortability with these conversations, with 63% of staff respondents (n=70) saying they perceived management as comfortable talking about race and racism and 62% (n=59) saying they perceived managers were comfortable talking about class and classism.

Focus group participants shared a general comfortability with these conversations, and explained that other staffs' comfortability was dependent on intrapersonal relationships: they may be comfortable discussing these things with some colleagues but not others, and that these conversations did not happen at an organizational level.

"I think [youth/family support partners] automatically have that connection with families or individuals that's just hard to replicate with other people's roles."

—Staff Focus Group Participant

"[We] think it's not afraid to ask about cultural differences, even at the expense of looking silly, even if it's something simple like a food, how to pronounce something... It just breeds this trust. So it's about vulnerability and sharing our differences because they're strengths. Makes us stronger."

—Manager/Supervisor Interviewee

Figure 25: Staff perception of other staff they interact with comfortability talking about: race and class, N=95

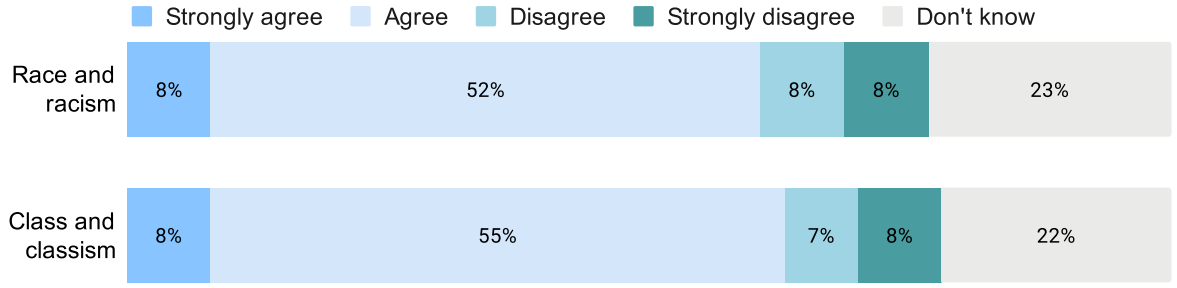
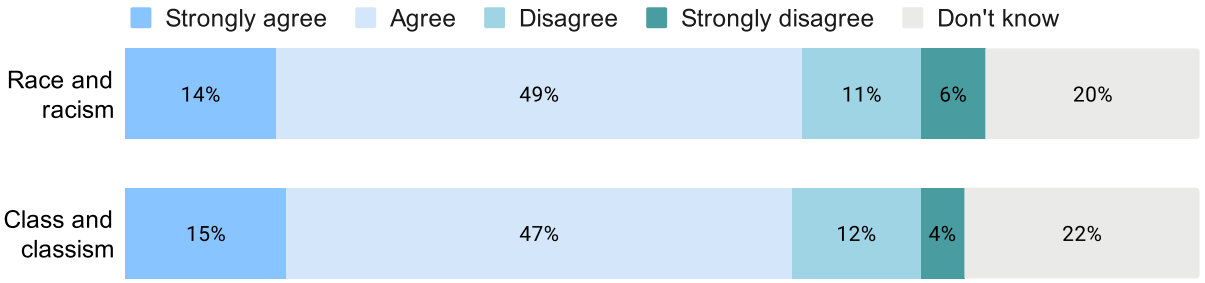


Figure 26: Staff perception of management comfortability talking about race and class, N=95

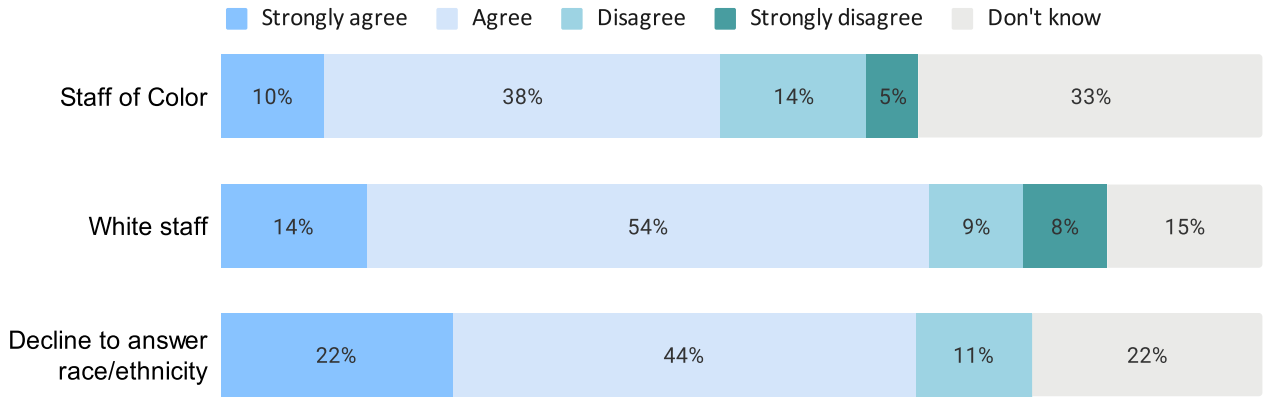


"In any workplace, you're going to find people who are safer to have conversations that may be controversial and other people who are not."

—Staff Focus Group Participant

When stratified by race/ethnicity, staff of Color were significantly less likely to agree that management they interacted with were comfortable talking about race and racism than White staff or staff who did not share their race/ethnicity, and were also more likely to respond "don't know" to this question.

Figure 27: Staff perception of management comfortability talking about race and racism, by race/ethnicity, N=95



"A lot of us are either, A, in the younger population or, B, in that other population of coming up with families members who are gay or are yourself. You have that ability to address people and have those easier conversations. So I think there's a lot of people who aren't exposed, so they're almost slightly more narrow-minded. We still have the older generation who's very set in their ways ...So there are staff members who are still on that narrow pathway of thinking instead of the greater world."

—Staff Focus Group Participant

Understanding the social determinants of health

Staff who understand the social determinants of health understand the underlying, systemic causes of health inequities and that addressing those would improve health outcomes and reduce health inequities. They understand the interconnection between race and ethnicity, class, gender, and health.

Staff were asked if they thought they understood what the environmental, social, and economic conditions that impact health were, and 84% (n=80) agreed that they did (Figure 28). Partners were asked if they thought staff they interacted with at PCHS understood the major causes of health inequities in Polk County, and a high proportion of these respondents thought so, too (73%, n=22) (Figure 29).

Internal survey respondents and partner survey respondents were asked what the most important environmental, social, and economic conditions that impact health among the populations that PCHS serves were. Many of the same issues were identified by both staff and partners:

- Economic conditions/socioeconomic status
- Access to transportation
- Community-wide lack of understanding of other community groups
- A lack of community knowledge around community resources
- Lack of access to health care
- Substance use
- Language barriers

Figure 28: Staff agreement that they understand what the environmental, social, and economic conditions that impact health are, N=95

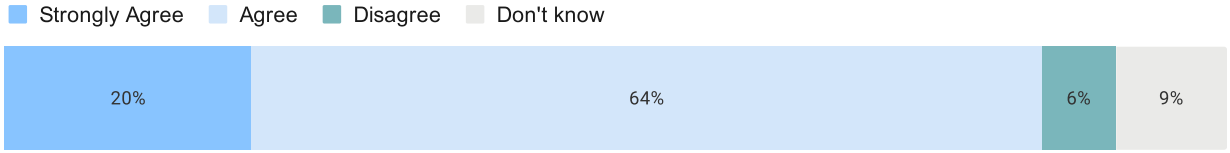
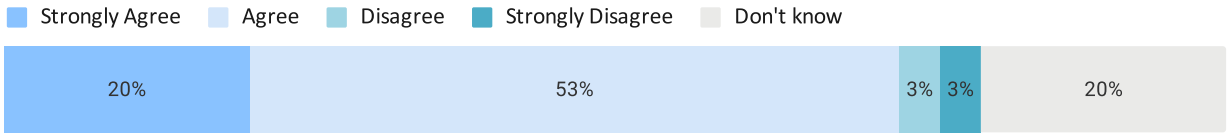


Figure 29: Partner perception that PCHS staff they interact with understand the major causes of health inequities in Polk County, N=30

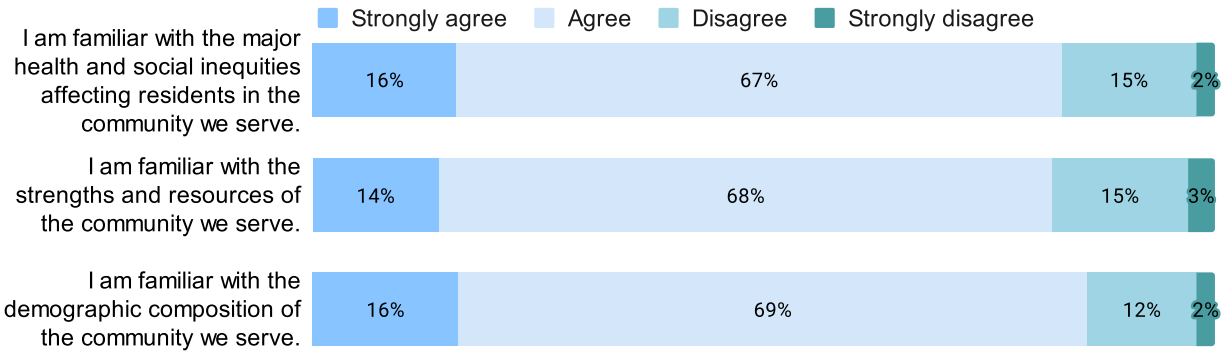


Knowledge of affected community

Internal survey respondents reported an overwhelming agreement that they were familiar with health inequities in the community (83%, n=79), strengths and resources of the community (82%, n=78), and demographic composition of the Polk County community (85%, n=81) (Figure 30).

When partners were asked similar questions about their perception of PCHS's staff's community knowledge, they confirmed that staff were knowledgeable, with 67% (n=20) agreeing that staff they interacted with understood residents' major concerns in the community and 73% (n=22) agreeing that staff they interacted with understood the major causes of health inequities in Polk County (see Understanding the social determinants of health) (Figure 31). They also agreed that staff they interacted with were familiar with the strengths and resources of residents and community institutions (86%, n=26) (Figure 32).

Figure 30: Staff knowledge of the community PCHS serves, N=95



In focus groups and management and supervisor interviews, participants demonstrated a knowledge of the Polk County community in discussion of service provision, such as the Spanish-speaking community and community members with behavioral health needs. They also spoke to the social context of Polk County, acknowledging that the county generally lacked racial and ethnic diversity and was resistant to change.

Leadership

This section covers leadership at PCHS and their ability to work well within PCHS and in the community and serve as a liaison between the two.

Maintaining community networks and partnerships

As a part of community leadership, PCHS should play an active role in developing, maintaining, and supporting networks in the community. Half of partner respondents (n=14) thought PCHS did this; 29% (n=8) thought they were moving in that direction (Figure 33).

Figure 31: Partners' perception of PCHS staff understanding of community's major concerns, N=30

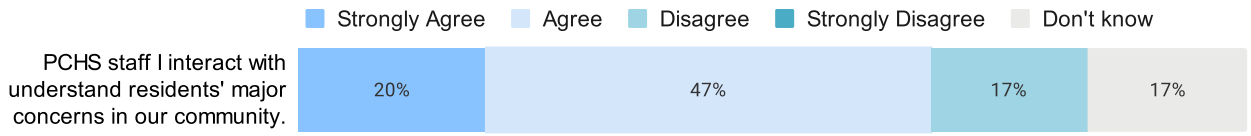


Figure 32: Partner survey respondent perceptions of interactions with PCHS staff, N=30

The same question was asked to staff, and a similar proportion (55%, n=52) thought they did or that they were moving in that direction (27%, n=26) (Figure 34). When cross-tabbed by race/ethnicity, all staff of Color thought that PCHS played an active role in developing, maintaining, and supporting networks in the community, indicating that these staff may have been more deeply involved in this work or more aware of this work happening (Figure 35).

Figure 33: Partner perception that PCHS plays an active role in developing, maintaining and supporting networks in the community, N=28

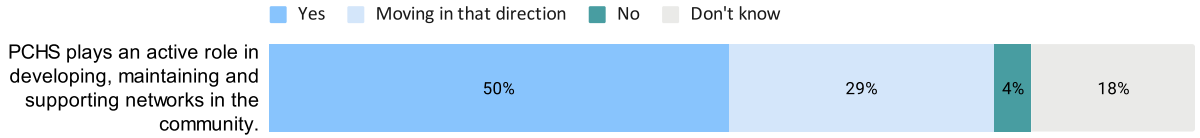
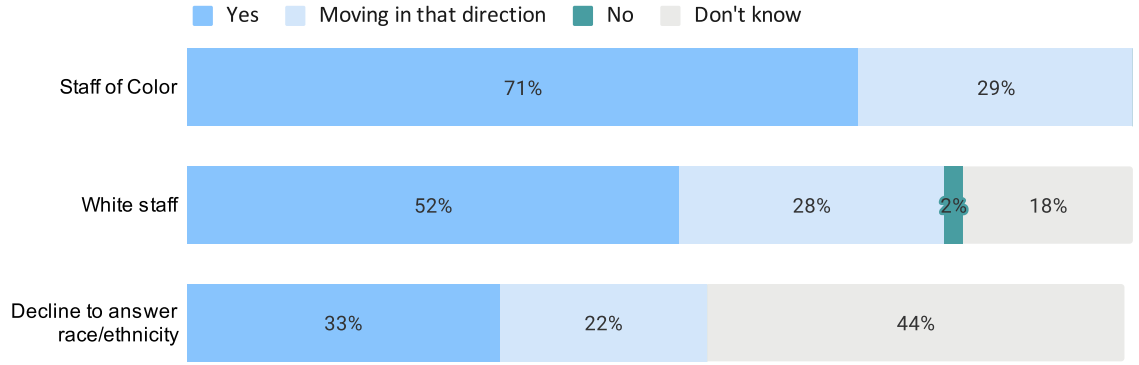


Figure 34: Staff perception that PCHS plays an active role in developing, maintaining and supporting networks in the community, N=95

Figure 35: Staff perception that PCHS plays an active role in developing, maintaining and supporting networks in the community by race/ethnicity, N=95



Supporting staff to become leaders

Manager and supervisor interviewees discussed that they feel PCHS was a place where leadership coaches and mentors staff can advance.

Understanding and navigating power dynamics

Manager and supervisor interviewees strongly indicated that PCHS was a very top-heavy organization, with only high-level management being involved in significant decision-making. Focus group participants shared the same sentiment, stating that their ideas were not always advanced beyond a certain level of the organization (although they were not aware which level of the organization). Interviewees did not offer information about navigating this dynamic.

In focus groups, non-management level staff shared about their comfortability discussing concerns and ideas with their direct supervisors, and felt that their supervisors worked with them to problem-solve collaboratively.

"So all the way down, we're encouraging people to expand, make sure they have the credits they need for their certification. We encourage them to move up within the agency or elsewhere. So we support ongoing growth at the agency just very consistently all the way down."

—Manager/Supervisor Interviewee

"Unfortunately, we are very top-heavy. I think that really, the way that we're structured, it's primarily management who really enacts change. It could be because a staff or line staff brought something to someone's attention that drove it, but really, there's not too much, through my perspective, direct line staff involvement in implementing those kinds of strategic planning changes."

—Manager/Supervisor Interviewee

Collaboration skills

In order to address health inequities effectively, PCHS must collaborate internally with other programs and divisions as well as work with the community. Successful collaboration necessitates cooperation, authentic inclusion of diverse viewpoints and backgrounds, and the establishment of trust.

Survey respondents were asked questions about collaboration among staff in other programs within PCHS. Almost half (48%, n=14) of the respondents agreed that they collaborated with staff in other programs within PCHS to address health inequities.

Internal survey responses about collaborating with other staff to address equity were consistent (at approximately 48%) across the Administrative Division, Division 1, and Division 2. In contrast, only 21% (n=6)of respondents from Division 3 reported collaborating with other staff in other programs to address the root causes of health equity.

Having trusting relationships with partners is a key indicator of collaboration skill; when internal survey respondents were asked if they had trusting relationships with their community partners, (71%, n=67) reported that they agreed or strongly agreed with this statement.

Respondents to the community partner survey indicated that PCHS staff collaboration with them had resulted in trusting relationships.

Figure 36: Partner survey respondent perceptions of interactions with PCHS staff, N=30

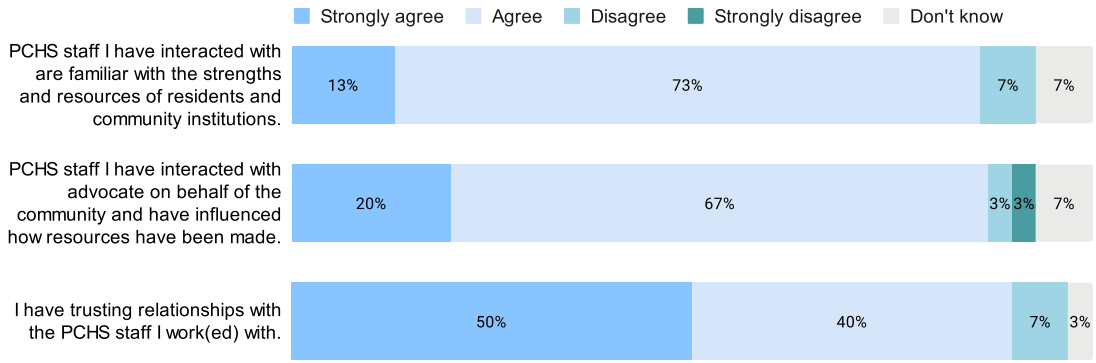


Figure 37: Staff knowledge of collaboration with other programs within PCHS to address the environmental, social, and economic conditions that impact health, N=95

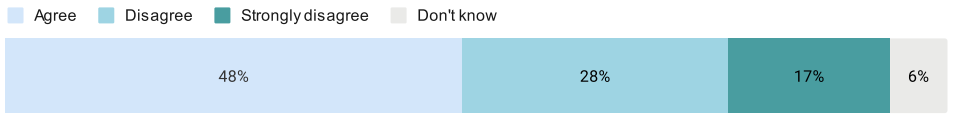


Figure 38: Staff knowledge of how work of other parts of PCHS contributes to addressing health inequities by division, N=95.

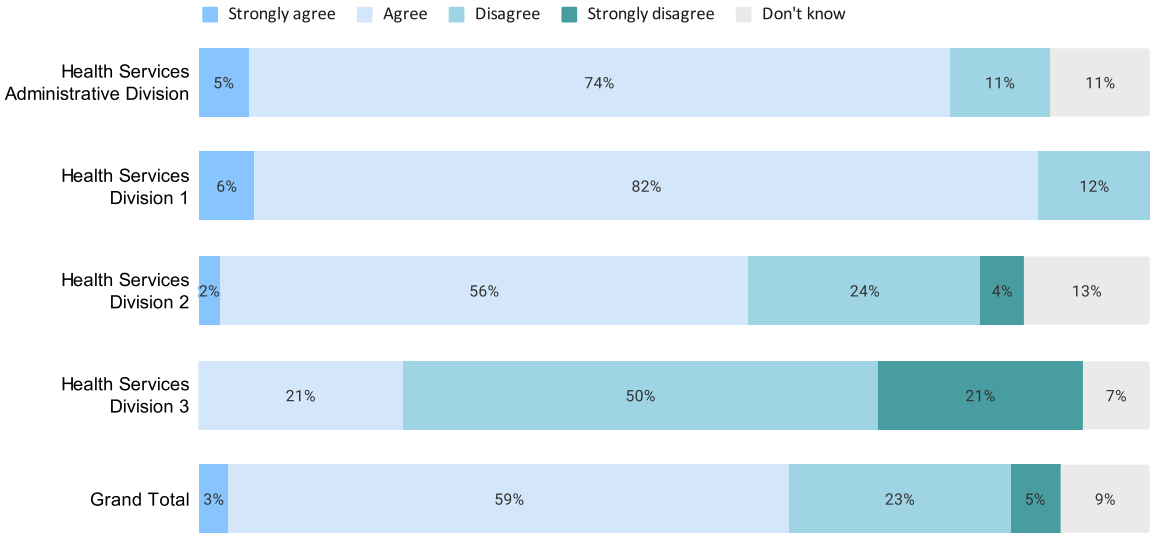
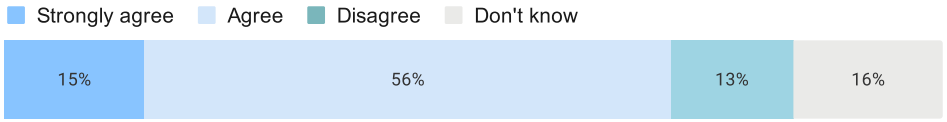


Figure 39: Staff agreement that they have trusting relationships with community partners, N=95



Community organizing skills

Community organizing skills are important for governmental agency staff because these skills can support communities to advocate for themselves to address specific problems and issues and promote a longer-term engagement and empowerment strategy. Longer-term objectives of community organizing are to develop the community-based capabilities and to increase the decision-making power and influence of underrepresented groups. With respect to health equity, there is broad consensus that progress toward equity is dependent upon "empowerment of individuals and groups to represent themselves" (WHO, 2008, AJPH, February 2023).[5]

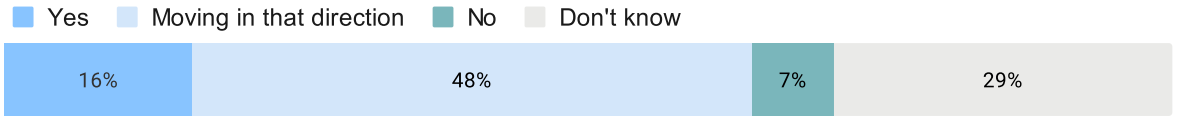
When asked about PCHS's ability to support the capacity of community or community-based organizations, only a few PCHS manager/supervisor interviewees shared ways that PCHS supports the community, specifically, and fewer still cited examples of PCHS skill in community organizing—instead, commentary centered around service delivery.

Internal survey respondents reported progress toward having strategies to mobilize communities to address health inequities; 15% (n=14) of respondents reported already having strategies in place, and 48% (n=46) reported that the agency was moving toward having community mobilization strategies in place (Figure 40).

"We have our tobacco, commercial tobacco use funds, and there's a fair amount of money there. And so [name] is wanting to target some CBOs that [this person] can distribute funds to help increase the work."

—Manager/Supervisor Interviewee

Figure 40: Staff perception that there are strategies in place to mobilize community to address health inequities, N=95



5. American Public Health Association. (2023, January 18). *Advancing Health Equity in Community-Based Climate Action: From Concept to Practice.* https://ajph.aphapublications.org/doi/10.2105/AJPH.2022.307143

Partner survey respondents, internal survey respondents, focus group participants, and manager and supervisor interviewees indicated PCHS has ground to work on to create more formalized ways of supporting community organizing, including the need for soliciting more feedback on barriers to participation from the community and addressing those barriers.

About one-third (31%, n=29) of staff were unsure whether PCHS had strategies in place to minimize barriers to community participation, like providing money for child care or transportation to residents who'd like to attend these events.

Cultural competence and humility

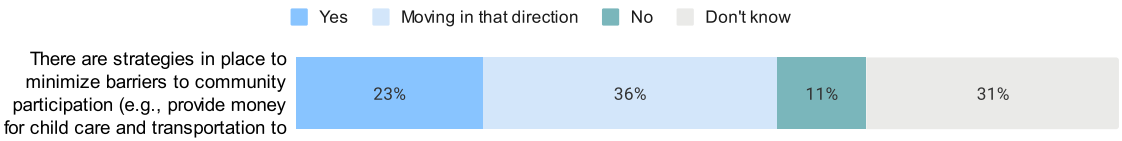
The workforce competency of cultural competence and humility includes cultural respect and humility, appreciation that diverse perspectives and roles are necessary to solve complex problems, effective cross-cultural communication, and interpreting data for diverse audiences. PCHS managers and supervisors, staff, and partners were asked questions to gain an understanding of this competency.

In interviews, managers and supervisors were asked about how they leveraged the strengths of culturally diverse employees in their work. Some manager and supervisor interviewees mentioned that strengths were utilized; examples of leveraging strengths included relying on those who are bicultural and bilingual to communicate with bicultural community members. A few respondents mentioned that while there wasn't concrete knowledge of having included diverse strengths/cultures in planning, problem-solving, and implementing programs, they knew to some extent that it was happening but were not able to give an example.

"Well, [we] mean definitely going back to our individual supervision, and then [we] have supervision with [the] supervisor who can point out [the] strengths and areas. And then part of [the] job is always to be looking for areas that we need to improve or to share about the areas we're doing really well. So [we] know there's a level of that internally.

—Manager/Supervisor Interviewee

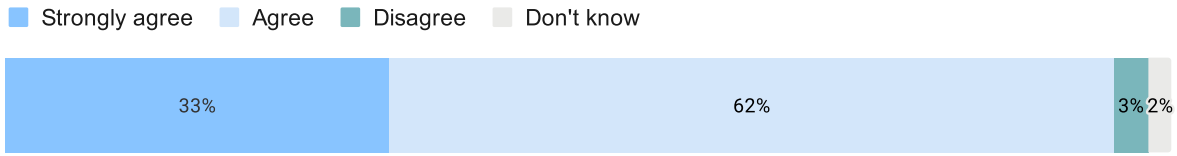
Figure 41: Staff perception of PCHS strategies in place to support community efforts to address health inequities, N=95



One interviewee shared their perspective about ways that PCHS staff demonstrate increasing trusting staff relationships through showing humility and curiosity, stating that staff were humble enough to ask questions that would increase their cultural understanding. Several focus group participants also acknowledged their inherent limitations in serving some community groups due to their individual identities, and lifted up those who possessed traits allowing them to best serve certain community groups.

As seen in Figure 42, the majority (95%, n=90) of respondents to the internal survey reported having worked to improve their own cultural humility.

Figure 42: Staff perception that they have taken steps to enhance their own cultural humility, cultural competence, and/or cultural understanding, N=95



Recommendations

- Organizational characteristics
- Workforce competencies

The following PCHS's health equity assessment recommendations are sorted by BARHII organizational characteristic and workforce competency. Please note the recommendations are not ordered by level of importance.

Organizational characteristics:

Institutional commitment to addressing health inequities

1. Develop a more proactive, systemic, and department-wide approach to addressing health inequities.

Hiring to address health inequities

2. Consider candidates' ability to connect culturally with the community, not just linguistically
3. Identify ways to intentionally recruit diverse staff
4. Train management/supervisors on leveraging a diverse workforce

Structure that supports true community partnership

5. Establish division-level standards for consistently and meaningfully involving partners in decision-making, with communication about how their input was used and progress updates

6. Communicate across PCHS how community engagement is happening
7. Support capacity building of partner organizations to address health inequities, including leadership development

Support staff to address health inequities

8. Develop an equity training/professional development plan and set aside staff time to engage in professional development activities on work time
9. Provide opportunities for consistent, updated, interactive, profession-based training for all staff specifically about health equity

Transparent and inclusive communication

10. Increase collaboration within divisions at PCHS and across divisions regarding work to address health inequities and opportunities to share resources
11. Increase understanding with partners about PCHS' role and services provided
12. Identify ways to overcome barriers to community participation, such as lack of public transportation or low resources to fund community events

Institutional support for innovation

13. Implement ongoing internal health equity assessments to measure progress and identify areas for improvement
14. Explore the role of supporting innovation as the first step of addressing health inequity
15. Work towards reducing administrative barriers that may hinder innovation
16. Explore balance between organizational productivity and innovation

Community-accessible data and planning

17. Improve data sharing, including sharing across divisions about data collected by PCHS
18. Create written policy/standards to ensure data collection and sharing is appropriate for the cultural, linguistic, and literacy needs of the community

Workforce competencies:

Personal attributes

19. Formalize a commitment across PCHS to valuing staff's ability to self-reflect and continually learn; include this competency in performance reviews

Understanding the social determinants of health

20. Stay up-to-date with staff's existing knowledge of the SDoH by offering ongoing training and ensuring new staff are trained about the SDoH

Knowledge of affected community

21. Continue assessing the community, sharing assessment data, and create shared accountability for using assessment data

Leadership

22. Increase transparency around decision-making hierarchies and develop horizontal decision-making strategies

23. Provide intentional leadership training about addressing health inequities to ensure organizational leadership is collectively working towards addressing inequities

Collaboration skills

24. Increase collaboration across programs and awareness of the work of other programs to address the environmental, social, and economic conditions that impact health

25. Consider the potential benefits of cross-divisional teams and/or training opportunities to increase collaboration and promote holistic understanding of equity

Community organizing skills

26. Increase organizational understanding about the benefits of community for addressing health inequities

27. If needed, dedicate funding to community events to reduce barriers to participation

Cultural competence and humility

28. Support staff's continued effort to increase their cultural humility and competence

29. Increase leadership knowledge and skills about leveraging the strengths of a diverse workforce

Appendix

A. Internal Survey Tool
B. Focus Group Interview Guide
C. Management Interview Guide
D. Partner Survey Tool
E. Data collection participant information

Appendix A: Internal Survey Tool

Internal Survey Tool

This survey is designed to help Polk County Health Department (PCHS) assess our overall capacity for addressing health inequities. While some questions do not deal explicitly with health inequities, all questions contain essential information about our overall capacity as an organization to impact the factors that influence community health and wellbeing, including institutionalized racism and social and environmental factors. For reference, we have included a glossary of these terms and other key terms that may be helpful when responding to survey questions.

This survey is being conducted by Rede Group, a neutral, third-party consulting firm contracted to engage in a health equity assessment for PCHS. Your responses are confidential and will never be linked to you individually in any reporting or documents shared with PCHS. The assessment covers Behavioral Health, Developmental Diversity, Healthy Communities, and Public Health. It does not include community health center functions.

The questions in each section help build a picture of how PCHS addresses the environmental, social, and economic conditions that impact health inequities.

This survey has 33 questions and will take approximately 15-20 minutes. If you are unable to complete the survey during one session, you can return to it as often as you'd like to make changes and complete it until you click on "Done" after the last question. Your honest responses to this survey are truly valuable. Thank you for your time!

Introductory Questions

First, please tell us a little about yourself. We'd like to get a sense of where you are situated in the organizational structure at PCHS.

1. Which best describes your position in the PCHS?

- ◯ Administrative staff
- ◯ Front line staff, including program coordinators
- ◯ Supervisor or Program Lead
- ◯ Manager
- ◯ Director
- ◯ Other (please specify)

2. Which division or program unit do you work in?

- ◯ Health Services Division 1 (Forensic & Acute Care, Outpatient Addictions Services)
- ◯ Health Services Division 2 (Outpatient Mental Health, Community Support Services, Developmental Disabilities)
- ◯ Health Services Division 3 (WIC, Emergency Preparedness, Psychiatric Services, Public Health Clinical Services, Jail Medical)
- ◯ Health Services Administrative Division (Business Services, HS Admin Support, Support Services, Health Services Applications)

3. How long have you been in your current position? (Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)

Years

Months

4. Do you work directly with community residents in your current position?

- ◯ Yes
- ◯ No
- ◯ Yes, but not often
- ◯ Other (please specify)

5. Do you supervise staff members who work directly with community residents?

- ◯ Yes
- ◯ No

6. Please list what you think are the most important environmental, social, and economic conditions that impact health among the populations that PCHS serves (examples: employment status, income, race, transportation, etc.).

7. In the populations served by PCHS, what are the top 5 disproportionately and unjustly distributed health and human services issues (examples: lack of health care providers, absence of translators, structural racism/ableism).

* 8. In your opinion, how much does PCHS focus on addressing health inequities? Health inequities are differences in health across population groups that are systemic, avoidable, unfair, and unjust. (Check only one box.)

- ◯ There is **no** focus on health inequities at all.
- ◯ There is **not enough** focus on health inequities.
- ◯ There is **about the right amount** of focus on health inequities.
- ◯ There is **too much** focus on health inequities.
- ◯ I don't know.

Mission, Vision, and Values

For the following statement, please indicate the response that most closely describes PCHS:

* 9. PCHS as an organization demonstrates a commitment to addressing the environmental, social, and economic conditions that impact health.

- ◯ No
- ◯ Moving in that direction
- ◯ Yes
- ◯ Don't know

Program Planning

The questions in this section are designed to help us understand to what extent health inequity considerations are included in program planning and whether program planning includes the perspectives of community members and other partners.

* 10. How much does PCHS program planning reflect a general understanding of the environmental, social, and economic conditions that impact health?

- ◯ None
- ◯ Some
- ◯ A lot
- ◯ Don't know

* 11. Please indicate how much you agree or disagree with the following statement:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Not applicable to my job function
My work has a role in monitoring health status and tracking the conditions that influence health inequities.	◯	◯	◯	◯	◯	◯

Collaboration

This section of the survey aims to better understand what aspects of PCHS make internal collaboration possible and how different kinds of collaboration within the organization function.

* 12. Please indicate how much you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I know how the work of other parts of PCHS contributes to addressing health inequities in our community.	○	○	○	○	○
I collaborate with staff in other programs within PCHS to address the environmental, social, and economic conditions that impact health.	○	○	○	○	○

Working with Communities

This section focuses on PCHS's collaboration with residents of Polk County. We are interested in knowing how much staff feel they know about the health issues, concerns, and inequities experienced by those living in the community served by PCHS. We also want to learn how collaboration with community groups and residents takes place in the everyday work of staff in PCHS and how this work addresses the environmental, social, and economic conditions that impact health.

* 13. Please indicate how much you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
I am familiar with the major health and social inequities affecting residents in the community we serve.	○	○	○	○
I am familiar with the strengths and resources of the community we serve.	○	○	○	○
I am familiar with the demographic composition of the community we serve.	○	○	○	○

The following question is about your work with community-based groups.

* 14. Please indicate how much you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I have trusting relationships with my community partners.	○	○	○	○	○
I believe that my community partners really represent the interests and needs of local community residents.	○	○	○	○	○

Collaborating Community Groups

* 15. Please indicate the response that most accurately describes PCHS:

	No	Moving in that Direction	Yes	Don't Know
We have strategies in place to mobilize community groups to address health inequities.	○	○	○	○
We have strategies in place to support the work of community groups advocating for public policies that address health inequities.	○	○	○	○
There are strategies in place to minimize barriers to community participation (e.g., it is possible to provide money for child care and transportation to residents attending community meetings, etc.).	○	○	○	○

Strategies to Support Community

* 16. Please indicate the response that most accurately describes PCHS:

	No	Moving in that Direction	Yes	Don't Know
PCHS makes deliberate efforts to build the leadership capacity of community members to advocate on issues affecting the environmental, social, and economic conditions that impact health.	○	○	○	○
PCHS is open and responsive to community stakeholders' feedback on its work.	○	○	○	○
PCHS has provided resources to community residents and groups to support their self-identified concerns and needs in respect to addressing the environmental, social, and economic conditions that impact health.	○	○	○	○

* 17. Please indicate the response that most accurately describes PCHS:

	No	Moving in that Direction	Yes	Don't Know
PCHS plays an active role in developing, maintaining and supporting networks in the community.	○	○	○	○

* 18. Please indicate the response that most accurately describes PCHS:

	No	Moving in that Direction	Yes	Don't Know
PCHS creates and distributes oral and written information that is appropriate for the cultural, linguistic and literacy needs in the community.	○	○	○	○
PCHS collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community.	○	○	○	○
PCHS is able to adapt to new communities and changes within the populations we serve.	○	○	○	○

Supporting Staff in Addressing Health Inequities through Training

* 19. Since you have been working at PCHS, have you ever received training about the different ways PCHS can address the environmental, social, and economic conditions that impact health? (Check only one box)

- ◯ Yes
- ◯ No
- ◯ Don't remember

Supporting Staff in Addressing Health Inequities through Time for Reflection

For the next set of questions we are interested in learning about your personal knowledge and experience related to various aspects of the environmental, social, and economic conditions that impact health.

* 20. Please indicate how much you agree or disagree with the following statement:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I understand what the environmental, social, and economic conditions that impact health are.	○	○	○	○	○

* 21. Please indicate how much you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I have taken steps to enhance my own cultural humility, cultural competence, and/or cultural understanding (for example through trainings, self-reflection, personal relationships, etc).	○	○	○	○	○
I feel my work environment is supportive of many different cultural perspectives.	○	○	○	○	○

Conversations about Inequities

For the next set of questions, we are interested in knowing how you think PCHS is doing with respect to having conversations about inequities in general. Please indicate how much you agree or disagree with the following statements:

* 22. **Management** I interact with at PCHS are comfortable talking about:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Race and racism	◯	◯	◯	◯	◯
Class and classism	◯	◯	◯	◯	◯

* 23. **Other staff** I interact with at PCHS are comfortable talking about:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Race and racism	◯	◯	◯	◯	◯
Class and classism	◯	◯	◯	◯	◯

Recruitment, Hiring, and Retention

* 24. Please indicate how much you agree or disagree with the following statements regarding the recruitment of diverse staff at PCHS:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I work with a culturally diverse staff	○	○	○	○	○
[PCHS] actively recruits culturally diverse staff to provide direct client services	○	○	○	○	○
[PCHS] actively recruits culturally diverse management and leadership staff members.	○	○	○	○	○

* 25. Please indicate how much you agree or disagree with the following statements regarding the hiring of diverse staff at PCHS:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
When appropriate, minimum requirements for positions are flexible, allowing for relevant community experience in place of educational degrees.	○	○	○	○	○
Individual staff members' efforts to address health inequities are considered in performance reviews/ evaluations.	○	○	○	○	○

* 26. For these statements about hiring and promotion practices at PCHS, please indicate how much you agree or disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
During hiring, interview questions are designed to gain insight into an applicant's capability to address health inequities in the performance of their program responsibilities.	○	○	○	○	○
Staff of diverse ethnic, racial and cultural backgrounds are equitably promoted throughout PCHS.	○	○	○	○	○

* 27. Please indicate how much you agree or disagree with the following statements about the cultural relevance of health and human services programming at PCHS:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
A range of culturally appropriate program delivery models are planned and implemented at PCHS.	○	○	○	○	○
Assessments of the cultural and linguistic needs of the community we serve are conducted periodically.	○	○	○	○	○

Demographics

The following questions are optional, but will help us understand more about the distribution of experiences and attitudes across your PCHS with respect to health inequities work. Your responses are anonymous and confidential.

28. What is the race or ethnicity that you primarily identify with?

- ◯ African American/Black
- ◯ Asian
- ◯ Caucasian/White
- ◯ Latino/Hispanic
- ◯ Middle Eastern
- ◯ Native American/Alaska Native
- ◯ Pacific Islander/Native Hawaiian
- ◯ Biracial/Multiracial
- ◯ Decline to share
- ◯ Not listed above (please specify):

29. What is your primary language?

- ◯ Arabic
- ◯ Chinese
- ◯ English
- ◯ Spanish
- ◯ Not listed above (please specify):

30. What is the gender identity you primarily identify with?

- ◯ Man
- ◯ Woman
- ◯ Transgender Male/Trans Man/FTM
- ◯ Transgender Female/Trans Woman/MTF
- ◯ Gender Nonconforming/Non-binary
- ◯ Decline to share
- ◯ Not listed above (please specify):

31. What is the sexual orientation you primarily identify with?

- ◯ Heterosexual or straight
- ◯ Gay
- ◯ Lesbian
- ◯ Bisexual/Pansexual
- ◯ Queer
- ◯ Decline to share
- ◯ Not listed above (please specify):

32. Have you ever served in the U.S. Armed Forces, Reserves, or National Guard?

- ◯ Yes
- ◯ No
- ◯ Decline to share

33. Do you consider yourself to have any sort of disability (e.g. having serious difficulty hearing, seeing, concentrating, or walking)?

- ◯ Yes
- ◯ No
- ◯ Decline to share

Thank you for taking this survey!

Your insights and perspectives are highly valuable. Findings from this survey will be shared and utilized to develop a health equity plan for PCHS. To thank you for your time completing the survey, we are offering to enter your name into a drawing for 5 $50 gift cards to a local coffee shop or grocery store. The drawing will take place after the survey closing on April 17th and we will reach out via email if your name is drawn. Your survey responses will not be connected in any way to your name in survey analysis or reporting. If you have any questions, please contact Elizabeth Paschal at elizabeth.paschal@redegroup.co.

34. If you would like to be entered into the raffle, please enter your name and email address below. If you do not wish to be entered, please leave this blank. Thank you!

Appendix B: Focus Group Interview Guide

Focus group interview guide

Introduction and overview

Thank you for joining us today to share about various aspects of PCHS related to health inequities. We really appreciate your willingness to share your time with us. My name is XX and XX is with me. We work for the Rede Group, a company that does strategic planning, research, and evaluation for nonprofit and public sector organizations. I'm first going to go over a few details before we start. If you have any questions, feel free to ask them as they come up.

PCHS is undergoing an organizational self-assessment of its skills and capacities for addressing health inequities. Our main purpose today in this group is to learn from you about the elements of PCHS's organizational culture and structure that you find support or interfere with the agency's ability to address health inequities. We are also interested in exploring the skills you think people at PCHS need in order to enable the organization to address health inequities. Prior to this focus group, you received a link to a handout that gives definitions of inequities and related terms. If you have any questions about anything in the glossary, let us know.

Results from this focus group will be combined with other data collected in the assessment and shared in a report to Polk County. We anticipate this report will be available in July.

We will be recording this focus group and taking notes in order to accurately capture all of your comments. What you say here today is confidential. There will be no names attached to any comments in the report. Moreover, the Rede Group will not use this recording for any other purpose other than developing the report. The recording will not be made available to anyone outside of the Rede Group and that includes PCHS. I want to ask each of you to respect the privacy of others in this group today. It is important that you commit to not sharing anything you hear from others today.

Please share only your experiences and beliefs and do not speak on behalf of others. If you agree with what someone says, speak up, rather than nodding your head or gesturing in some other way. This helps us capture agreement in our notes.

We have 90 minutes for our discussion today, and I will end the meeting promptly at XX ; in order to move the conversation along, I may need to interrupt or redirect the conversation. I may also ask individuals directly if they have anything to add. If you don't, that's fine, but we want to make sure everyone has an opportunity to contribute.

1. To start, can everyone go around and share your name and what you do here at PCHS?

2. Today we are meeting to discuss PCHS's capacity to address health inequities. As a reminder, health inequities are differences in health and social status across population groups that are systemic, avoidable, unfair, and unjust. These differences are sustained over time and generations and are beyond the control of individuals.

   Do you believe that health inequities should be an area of concern for your health department? If so, why? If not, why?

3. What has PCHS done to help staff at various levels learn about and develop skills to address health inequities? What impact has that had on your work?

4. How well-equipped are you and other staff to address health inequities?
   a. What are some skills and characteristics needed in staff and PCHS to address health inequities?
   b. Can you share whether you've seen these skills in action? Maybe you have examples of how you have demonstrated these qualities, or you've seen them in co-workers.
   c. What other training and help from PCHS is needed for staff to be more effective in addressing health inequities?

5. How welcoming and supportive is PCHS to new ideas and programs to address health inequities and their causes?
   a. In your experience what is the attitude that PCHS leadership has toward trying new things? (ask for an example if appropriate)
   b. How does PCHS, leadership, and staff respond when projects fail?
   c. How does PCHS and leadership handle differences in opinion?
   d. How do the reactions and attitudes of leadership impact staff performance?

6. How do you feel about the work PCHS and you do to address health inequities?
   a. How important do you feel this work is? What priority does it take over other work PCHS does?

7. Can you describe some examples of when PCHS work to address health inequities has been <u>successful</u>?
   a. What challenges, barriers, strengths, and resources led to success?

b. How has the work addressing health inequities been enriched by that experience?

8. Can you describe some examples of when PCHS work toward addressing health inequities that has failed?

    a. What challenges, barriers, strengths, and resources led to failure?
    b. How has the work addressing health inequities been enriched by that experience?

9. Can you describe the diversity in PCHS? Be sure to include all levels of staff.
    a. Does PCHS staff and decision-makers reflect the diversity of the people in Polk County? Can you describe how?
    b. Describe how PCHS's recruitment, hiring, and promotion practices promote or discourage diversity.

10. Have you experienced meaningful internal discussions about the impact of racism, classism, sexism, and other "isms" on health inequities at PCHS?
    a. Describe the comfort level of staff with these discussions.
    b. If these types of discussions have not occurred, why is that?

11. Describe your understanding of how PCHS works with community residents, community organizations, and community groups in addressing health inequities.
    a. What role does community play in addressing health inequities?
    b. What is the impact when community is involved?
    c. In what other ways do you think that community residents, organizations, and groups should be involved in this work?
    d. What is challenging about working with community residents, organizations, and groups?

12. Given your knowledge of current and future program areas, do you have any suggestions for PCHS to improve and expand its work towards addressing health inequities?

13. What more can PCHS do to improve its ability to address health inequities?
    a. How can PCHS support staff at all levels to become leaders in addressing health inequities?

Management Interview Guide

Introduction and Overview

Thank you for taking the time to speak with me today. My name is XXX, and I work for the Rede Group, a company that does strategic planning, research, and evaluation for nonprofit and public-sector organizations. These interviews are part of an organizational self-assessment that the Polk County Health Services Department is undertaking to assess its capacity to address the environmental, social, and economic conditions that impact health in Polk County.

We will be recording our discussion today and taking notes. There will be no names attached to any comments in the report. The Rede Group will not use this recording for anything other than developing a report. The recording will not be made available to anyone outside of the Rede Group, including our client, PCHS. What you say here today is confidential. We will only report feedback as overall themes and insights from all our interviews. Nothing you say in this interview will be attributed to you personally, and nothing you tell us will be used against any person or program.

The assessment aims to help PCHS define areas of particular strength and opportunities for improvement related to addressing health inequities, identify where to focus on building capacity and provide benchmarks for future assessments. We are interested in hearing your experiences and opinions.

The interview should take about 60 minutes. During our conversation, I may interject or redirect. This is not to be rude, I just want to be respectful of your time and do my best to ask all of the questions in 60 minutes. Do you have any questions for me before we begin?

Interview Questions

Introduction questions

1. How long have you been in your current position?
___Years and___Months

2. How long have you been working at Polk County?
___Years and___Months

   a. What division do you work in?

3. Do individual divisions do their own strategic planning? (Interviewee may only be able to comment on her/ his own program or unit. If so, rephrase questions to reflect this change)
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. (If a program or unit strategic plan is in place) Does the strategic plan include specific strategies and objectives for addressing inequities?

4. How does your (division) manage community input into planning processes? Can you share an example of a time when your (division, program, unit) sought and used community input for decision making?
(Use prompts for example:)
    a. How did you get community input (i.e., methods)
    b. Who from the community was asked for input?
    c. At what point(s) in the planning processes did you seek community input?

5. How does PCHS (your division, program, or unit) conduct community assessments about the conditions that influence health, such as housing, education, economic opportunity, systemic racism, food insecurity or trauma?

6. Is there a process for regularly assessing PCHS's strengths and areas for improvement in its work to address inequities (such as a SWOT [Strengths, Weaknesses, Opportunities & Threats] analysis, organizational assessment, or strategic planning process)?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. Is the assessment conducted internally or externally, such as by a third-party evaluator or another type of consultant?

7. How does PCHS regularly evaluate or reflect on its capacity, commitment, and efforts to address health inequities? Is there a formal process for evaluation and reflection? Please describe the process.

8. Would you say PCHS has a culture that encourages learning, growth, and change? If so,
    a. (Probe: How are staff encouraged to challenge assumptions and the status quo? How does PCHS give positive incentives for feedback? How does PCHS leadership respond if an idea does not succeed?)
    b. Are there any other examples of how PCHS may or may not foster a learning culture?

9. Would you say the attitudes and expectations within PCHS encourage diversity (Probe: Consider multiple types of diversity such as class/class identity, gender, etc.). How is this evident?
    a. What types of diversity does PCHS successfully encourage?
    b. What could PCHS do to change the attitudes and expectations it conveys to encourage other types of diversity?

10. How does PCHS intentionally recruit employees with class or racial/ethnic backgrounds, sexual orientation, ability, gender identity, veteran status, etc, reflective of the communities it serves?
    a. Do managers receive training in managing a diverse workforce?
    b. Do hiring committee staff receive relevant training when hiring diverse staff?
    c. How are staff members who reflect the community supported to gain the qualifications necessary to advance in PCHS?

11. How does PCHS provide opportunities for staff feedback about strategies and efforts to address inequities? In what ways is staff input encouraged or supported?
    a. (Non-senior leadership)
        - How is the feedback used?
        - Can you give an example of a time you have given feedback? What was the result of the feedback you gave? How were the results communicated back to you?
    b. (Senior leadership) -
        - How is the feedback used?
        - Can you give me an example of what happened when a lower-level staff member submitted an idea in the past? What happens to that idea? Who else is it communicated to? How is it considered? What was the result? How was that result communicated back to the person who gave that input?

Value cultural and linguistic diversity

12. How do you include the strengths and assets of people from diverse cultural and class backgrounds in the programs and initiatives undertaken by the department?
    a. Can you describe some specific examples where this has happened?
        - In what ways do you validate or include these strengths? How are resources directed to build on those strengths?)
        - How is this integrated into department-wide strategic planning and initiatives?

Participatory and Transparent Decision-making Process

13. How are staff from multiple levels of the department involved in making major decisions?
    a. In what ways are staff involved in decision-making?)

14. Can you share some ways that this multi-level involvement from staff has enhanced the department's ability to address health inequities?

Community Capacity Building

15. What strategies does PCHS use to build the capacity of community members and CBOs to advocate for community health concerns? What strategies does PCHS use to build the capacity of community members and CBOs to influence decisions made by PCHS?

16. What strategies does PCHS have to increase community awareness about inequities and their root causes in Polk county?

17. How does PCHS provide administrative and logistical support for involving community members in decision-making and planning? This includes the arrangements for community meetings in terms of locations, hours, childcare, physical environment, etc.
    a. What barriers make it difficult for community members to participate in PCHS decisions? What can PCHS do to address these?
    b. How does PCHS arrange meetings so they are welcoming and familiar to community members (i.e. providing food, ensuring that the times and venues of the meetings are community-friendly, etc.)?

18. Does PCHS seek feedback from community members about the barriers of community participation? How? Can you give me an example of how PCHS has responded to such feedback?

Staff knowledge of community issues and resources

19. How do you stay aware of community issues as well as community resources and strengths? If interviewee supervises staff who work with community, also ask: How do you ensure that your staff stays aware of community issues as well as community resources and strengths?

Workforce development

20. What steps has PCHS taken to cultivate a workforce that is prepared to address health inequities?
Possible prompts
    a. Partnering with advocates to increase agency capacity to address the environmental, social, and economic conditions that impact health inequities?
    b. Pipeline programs to increase diversity of potential PCHS workforce?
    c. Partnering with local universities and schools of public health?
    d. Influencing curricula?
    e. Hosting internships/ field placements/ student research related to inequities? Efforts to recruit from community?
    f. Efforts to provide mentorship and support professional development to give people with non-traditional qualifications the knowledge and skills to be promoted at a management level (i.e. coaching, paid classes, and training)?
    g. Efforts to change promotional practices to increase diversity of PCHS workforce at any levels?

h. Other?

21. Does PCHS have a written succession plan for its leadership?

Possible prompts

a. If so, are commitment to addressing health inequities and cross-departmental collaboration explicit parts of the succession plan?
b. Does the succession plan include strategies and benchmarks for ensuring/ promoting diversity in PCHS leadership?

22. What types of support (such as training and/or coaching, continuing education/conferences) does PCHS provide for staff to learn about health inequities and addressing the social determinants of health, etc.?

Possible prompts

a. What are some of the topics covered?
b. How does PCHS relay its commitment to addressing health inequities to new employees? (Probe.) Is this covered in a formal orientation?
c. Does PCHS implement in-house trainings?
d. Are these trainings required?
e. What segments/levels of staff are involved?

Appendix D: Partner Survey Tool

Partner Survey Tool

The Rede Group is conducting this survey on behalf of the Polk County Health Services (PCHS). This survey is to help PCHS assess their overall capacity to address root causes or health inequities: the systematic, avoidable, unfair and unjust differences in health status and death rates across population groups. While some questions do not deal explicitly with health, all questions contain important information about the PCHS's capacity as an organization to impact factors that influence community health and well being, including institutional racism and social and environmental conditions such as access to healthy, affordable food, safe neighborhoods, quality education, jobs, etc.

The assessment covers Behavioral Health, Developmental Diversity, Healthy Communities, and Public Health. It does not include Polk County's community health center functions.

A glossary of key terms that may be helpful while completing this survey can be found here. These terms may be familiar to you; the glossary provides a point of reference for all participants to have a common understanding of the major concepts used in the survey. This process is intended to assess how well PCHS is prepared to address the underlying causes of health inequities, and therefore, will deal with many topics that are not always associated with health and human services. When you are answering the questions in this survey, please keep that in mind.

This survey is being conducted by Rede Group, a neutral, third party consulting firm contracted to engage in a health equity assessment and planning process for PCHS. This means your responses are confidential, and will never be linked to you individually in any reporting or documents shared with PCHS. No survey response will be used against individuals, groups and organizations. Findings will not affect any contract, staff resources, or other relationship you have with PCHS currently or in the future. If you have concerns about the confidentiality of your responses, or you have other questions about this assessment, please contact Elizabeth Paschal at elizabeth.paschal@redegroup.co.

The survey should take between 15 and 20 minutes.
Your honest responses on this survey are truly valuable. Thank you for your time!

Introductory questions

* 1. Which of the following best describes your organization, group, or institution?

- ◯ Academic institution/ school
- ◯ Community-based organization
- ◯ Community group/coalition
- ◯ Community member/resident unaffiliated with an organization
- ◯ Faith-based organization
- ◯ Healthcare
- ◯ Private sector business
- ◯ Public agency
- ◯ Other health care
- ◯ Other (please specify)

2. What does the agency you work/volunteer with primarily do? (Check all that apply)

- [ ] Direct health care
- [ ] Direct social services
- [ ] Other direct services
- [ ] Health advocacy/policy
- [ ] Other advocacy/policy
- [ ] Research
- [ ] Other (please specify)

3. Does your organization have a focus on any of the following populations? (Check all that apply)

- [ ] Immigration or documentation status
- [ ] Intellectual/developmental disabilities
- [ ] Lesbian, Gay, Bisexual, Transgender, Queer, +
- [ ] Low education level
- [ ] Low income
- [ ] Physical disabilities
- [ ] Race/ethnicity (including American Indian, Alaska Native, Black or African American, Hispanic, etc.)
- [ ] Refugee
- [ ] Rural
- [ ] Unhoused
- [ ] Veterans
- [ ] My organization does not focus on a specific population
- [ ] Other (please specify)

4. How long has your organization/ group worked with Polk County Health Services?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ More than 5 years
- ◯ Not currently working with PCHS
- ◯ Not sure/I don't know

Relationship with PCHS

5. Our relationship with PCHS has been primarily one of:

- ◯ Networking or sharing information
- ◯ Coordinating activities
- ◯ Collaborating on shared strategies
- ◯ Cooperating with/assisting
- ◯ Other (please specify)

6. In your community, what are the top 5 unevenly and unfairly distributed health issues? (examples: lack of health care providers, absence of translators, structural racism/ableism. See glossary of key terms here.)

7. What would you describe as the leading environmental, social, and economic conditions that impact the health issues you identified above? (examples: employment status, income, race, transportation, etc.).

8. Please indicate how much you agree or disagree with the following statement:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know
My organization's/group's work with PCHS addresses the environmental, social, and economic conditions that impact health in some way.	○	○	○	○	○

9. Please indicate the response that most accurately describes the awareness in Polk County with respect to health inequities. (Check only one box per statement.)

	Yes	Moving in that direction	No	Don't know
I think there is a general awareness of the environmental, social, and economic conditions that impact health among organizations or groups like mine in Polk County.	○	○	○	○
Addressing the environmental, social, and economic conditions that impact health in Polk County's communities is a high priority among organizations or groups like mine in Polk County.	○	○	○	○

10. Has your organization or group been a part of collaborations with PCHS to address any of the following issues?

	Yes	Moving in that direction	No	Don't know
Arts and culture	◯	◯	◯	◯
Availability of quality affordable housing	◯	◯	◯	◯
Community economic development (e.g. job creation, business development, etc.)	◯	◯	◯	◯
Community safety and violence prevention	◯	◯	◯	◯
Early childhood development and education	◯	◯	◯	◯
Environmental justice	◯	◯	◯	◯
Food security	◯	◯	◯	◯
Land-use planning	◯	◯	◯	◯
Quality public education	◯	◯	◯	◯
Racial justice	◯	◯	◯	◯
Recreation opportunities, parks and open space	◯	◯	◯	◯
Transportation planning and availability	◯	◯	◯	◯
Youth development and leadership	◯	◯	◯	◯

Other (please specify)

11. Please indicate how much you agree or disagree with the following statements: (Check one box per statement.)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
PCHS should play a significant role in addressing the environmental, social, and economic conditions that impact health.	○	○	○	○	○
I think PCHS, as an organization, demonstrates a commitment to addressing the environmental, social, and economic conditions that impact health.	○	○	○	○	○
PCHS staff members that I have worked with demonstrate a commitment to addressing the environmental, social, and economic conditions that impact health.	○	○	○	○	○
PCHS staff I interact with understand residents' major concerns in our community.	○	○	○	○	○
PCHS staff I interact with understand the major causes of health inequities in Polk County.	○	○	○	○	○

12. Please indicate how much you agree or disagree with the following statements: (Check one box per statement.)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
PCHS staff I have interacted with are familiar with the strengths and resources of residents and community institutions.	○	○	○	○	○
PCHS staff I have interacted with advocate on behalf of the community within Polk County and have influenced how resources have been made available to support community residents and/ or community institutions in addressing community concerns.	○	○	○	○	○
I have trusting relationships with the PCHS staff I work(ed) with	○	○	○	○	○

13. Please indicate how much you agree or disagree with the following statements: (Check only one box per statement.)

	Always	Sometimes	Never	Don't Know
PCHS holds community meetings that are welcoming, comfortable and familiar to community members.	○	○	○	○
PCHS provides food and childcare at the community meetings it holds.	○	○	○	○
The community meetings that PCHS holds are scheduled at times that are generally convenient for community members (meetings are held in the evenings, on weekends, etc.).	○	○	○	○

14. Please indicate how much you agree or disagree with the following statements: (Check one box per statement.)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
PCHS values input from community residents.	○	○	○	○	○
PCHS values input from organizations like mine.	○	○	○	○	○
PCHS is responsive to the priorities of the community.	○	○	○	○	○
PCHS communicates openly and honestly with community members and partners.	○	○	○	○	○
When PCHS program decisions do not reflect community input, it is clear why those decisions were made.	○	○	○	○	○
PCHS has provided resources to community residents and partners to support their concerns and needs for addressing health inequities.	○	○	○	○	○

15. Please indicate how often you find the following statements about PLANNING at PCHS to be true. (Check only one box per statement.)

	Always	Sometimes	Never	Don't know
Organizations like mine are invited to participate in the PCHS planning processes.	○	○	○	○
Organizations like mine are meaningfully involved in the PCHS planning processes.	○	○	○	○
PCHS informs the people and groups it works with about the results of community input into planning.	○	○	○	○

16. In your experience, what role(s) do **leaders from the community** in Polk County play in PCHS program planning and delivery? (Check all that apply)

- [ ] Provide input in the beginning of the planning process
- [ ] Review program planning documents and give feedback
- [ ] Collect feedback from larger groups of community members and communicate the feedback to PCHS
- [ ] Maintain active involvement throughout the planning process as appropriate
- [ ] Participate in the decision-making of program planning and delivery
- [ ] Other (please specify)

17. In your experience, what role(s) do **other governmental/public agencies** in Polk County play in PCHS program planning and delivery? (Check all that apply)

- [ ] Provide input in the beginning of the planning process
- [ ] Review program planning documents and give feedback
- [ ] Collect feedback from larger groups of community members and communicate the feedback to PCHS
- [ ] Maintain active involvement throughout the planning process as appropriate
- [ ] Participate in the decision-making of program planning and delivery
- [ ] Other (please specify)

18. Please indicate the response that most accurately describes the PCHS. (Check only one box per statement.)

	Yes	Moving in that direction	No	Don't know
PCHS creates and distributes **oral and written materials** that are appropriate for the cultural, linguistic, and literacy needs of the community.	○	○	○	○
PCHS collects and shares **data** in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community.	○	○	○	○
PCHS provides trainings to increase the knowledge and skills of community leaders to address the environmental, social, and economic conditions that impact health.	○	○	○	○

19. Please indicate the response that most accurately describes the PCHS. (Check only one box per statement.)

	Yes	Moving in that direction	No	Don't know
PCHS plays an active role in developing, maintaining and supporting networks in the community.	○	○	○	○
PCHS builds the leadership capacity of community members to advocate on issues affecting the environmental, social, and economic conditions that impact health.	○	○	○	○
PCHS helps community members and community-based organizations assume leadership roles.	○	○	○	○
PCHS is able to adapt to new communities and changes within the populations living within Polk County.	○	○	○	○
PCHS works with non-health-focused networks in the community to address issues that can impact health.	○	○	○	○

20. What has been positive about the collaboration between PCHS and organizations/groups like yours?

21. What has been challenging about the collaboration between PCHS and organizations/groups like yours?

22. What do you think should change about the way PCHS collaborates with organizations/groups like yours?

Gift card

* 23. Would you like to receive a $15 gift card to a local coffee shop as our thanks to you for completing this survey?

- ◯ Yes
- ◯ No

Mailing information

24. What is your first and last name? This will only be used to mail your gift card.

25. What is your mailing address? This will only be used to mail your gift card.

Address

Address 2

City/Town

State/Province -- select state --

ZIP/Postal Code

Thank you!

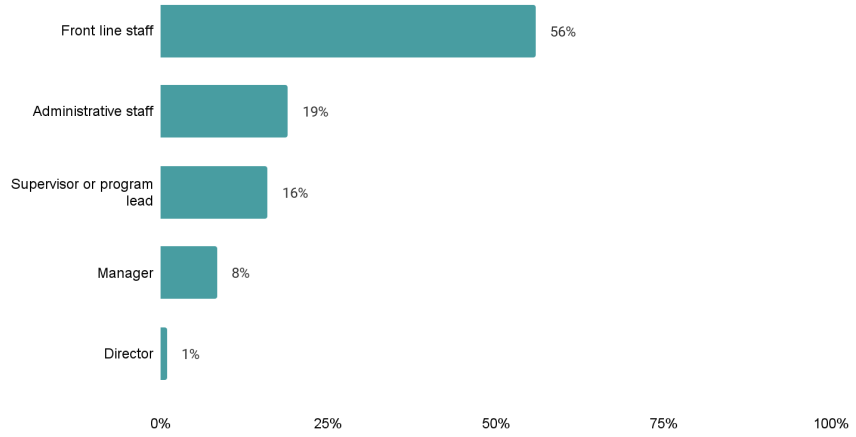
Thank you for your time and attention to this survey. Your responses will help Polk County Health Services identify opportunities to work towards eliminating health inequities.

Appendix E: Data Collection Participant Information

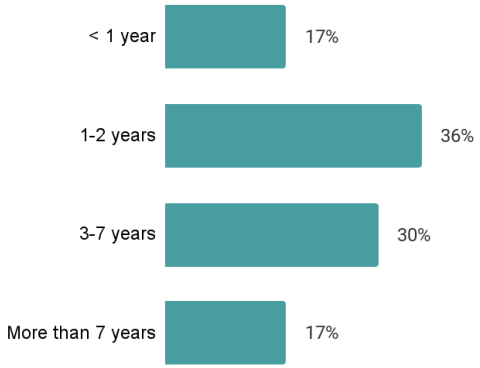
Internal survey respondent position & demographic information

The Rede Group received 95 completed internal surveys from PCHS staff. The following charts and table show information about the internal survey participants who completed the survey.

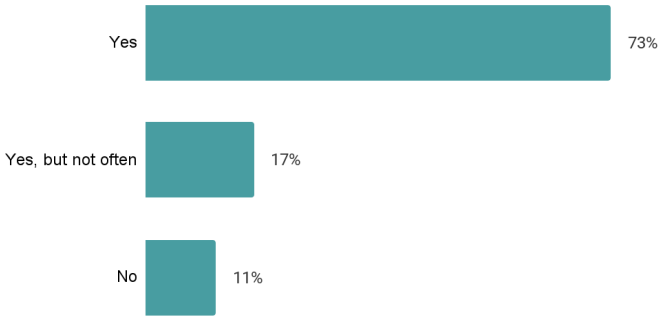
Position at PCHS, N=95



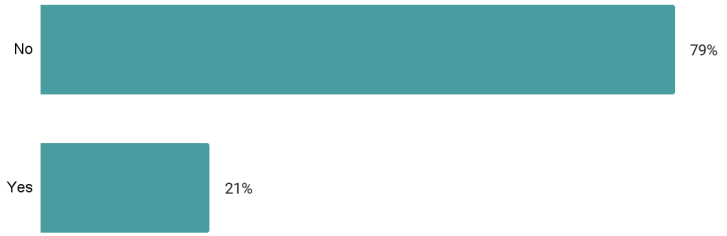
Time spent in current position, N=94



Respondents work directly with community residents, N=95



Respondents supervise staff members who work directly with community residents, N=95



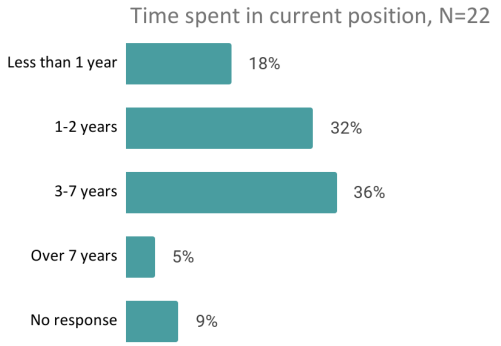
Internal survey respondents	% of respondents, N=95
Race/ethnicity	**N=95**
Caucasian/White	68%
Hispanic/Latino	16%
Biracial/multiracial	4%
Pacific Islander/Native Hawaiian	4%
Black/African American	1%
Decline to share	9%

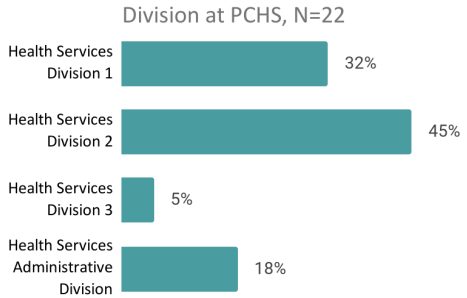
Internal survey respondents	**% of respondents, N=95**
Primary language spoken	**N=95**
English	93%
Spanish	7%
Gender identity	**N=95**
Woman	77%
Man	16%
Gender nonconforming/nonbinary	1%
Decline to share	6%
Sexual orientation	**N=95**
Heterosexual or straight	79%
Bisexual/pansexuall	3%
Gay	2%
Lesbian	2%
Queer	1%
Decline to share	13%
Disability status	**N=95**
No	80%

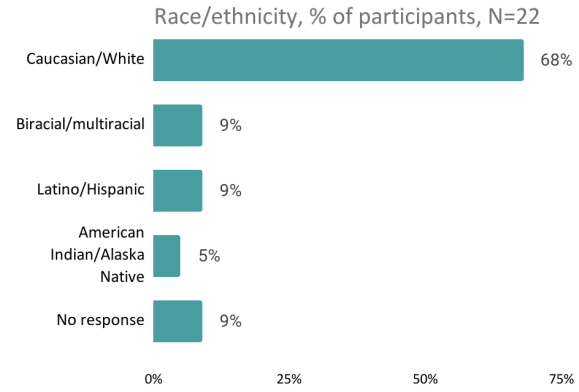
Internal Survey Respondents	**% of respondents, N=95**
Yes	11%
Decline to share	9%
Veteran status	**N=95**
No	92%
Yes	2%
Decline to share	6%

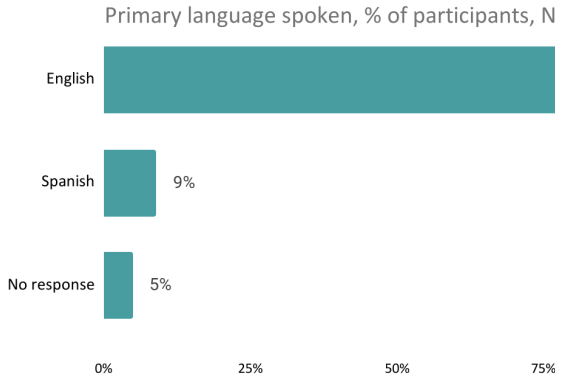
Focus group respondent information

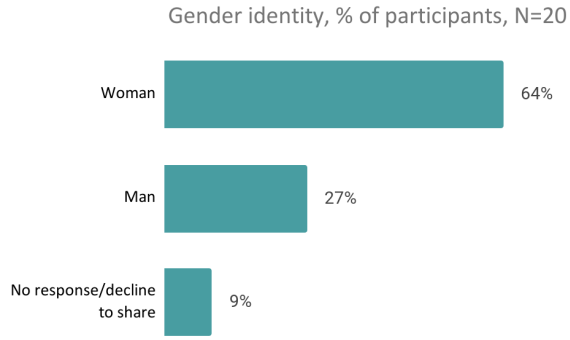
Rede conducted four focus groups with a total of 22 staff (non-managers and non-supervisors). The figures below show information about foucs group participants.

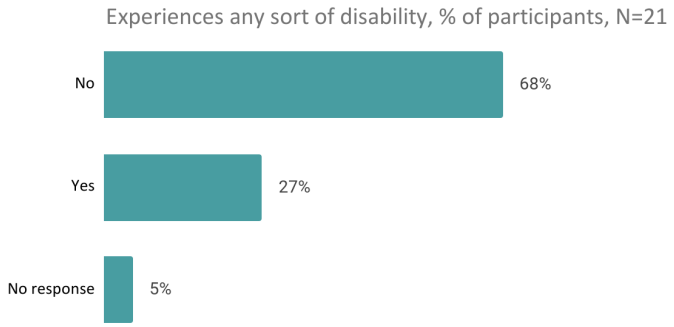


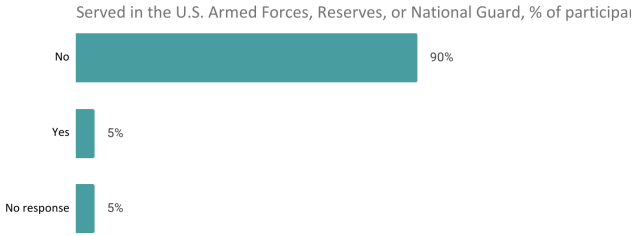







Gender identity, % of participants, N=20
Woman
64%
Man
27%
No response/decline to share
9%


Experiences any sort of disability, % of participants, N=21
No
68%
Yes
27%
No response
5%


Served in the U.S. Armed Forces, Reserves, or National Guard, % of participa
No
90%
Yes
5%
No response
5%

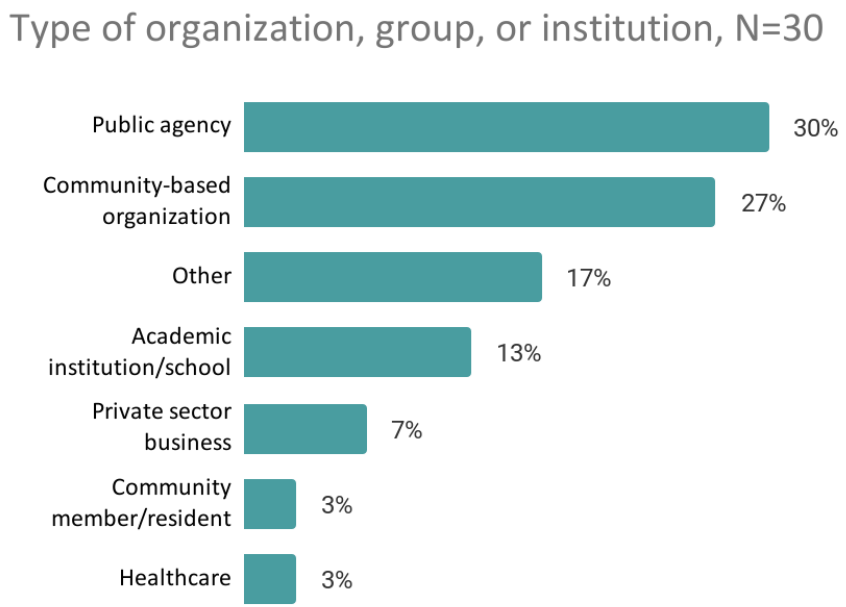
Manager and supervisor interview respondent demographic information:

Rede conducted interviews with all PCHS managers and supervisors. The table below summarizes the interviewees time in their current position.

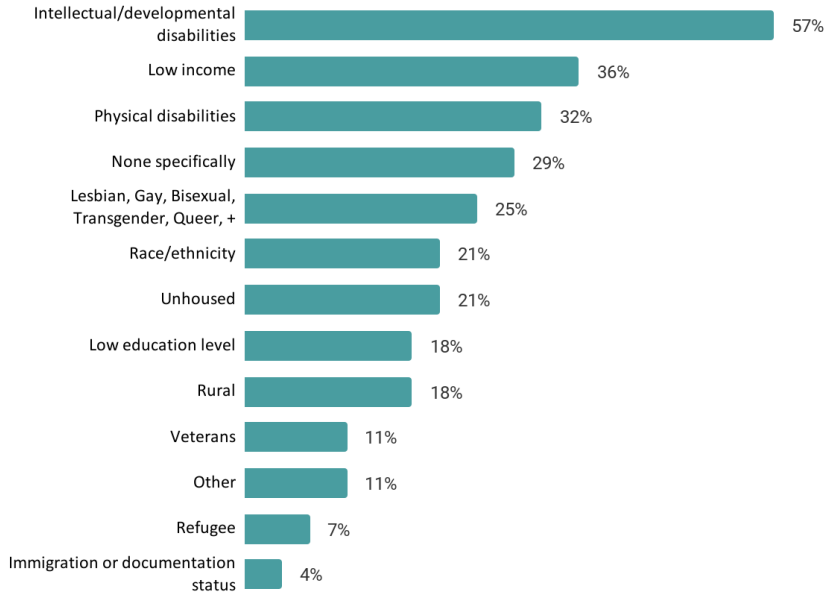
Time in position	**N=22**
Less than a year	9%
1-2 years	22%
3-7 years	45%
7+ years	22%

Partner survey respondent information

Rede received 30 completed surveys from PCHS's partners. The figuresbelow show informaiton abou the partners who completed the survey.



Population served, % of respondents, N=28



Length of partnership with PCHS, N=28