# Regional Health Equity Report

*Clatsop, Columbia, Tillamook*

October 2021

A SOCIAL IMPACT COMPANY
»redegroup

## acknowledgments

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

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

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# introduction, methods, analysis, & limitations

## Background

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

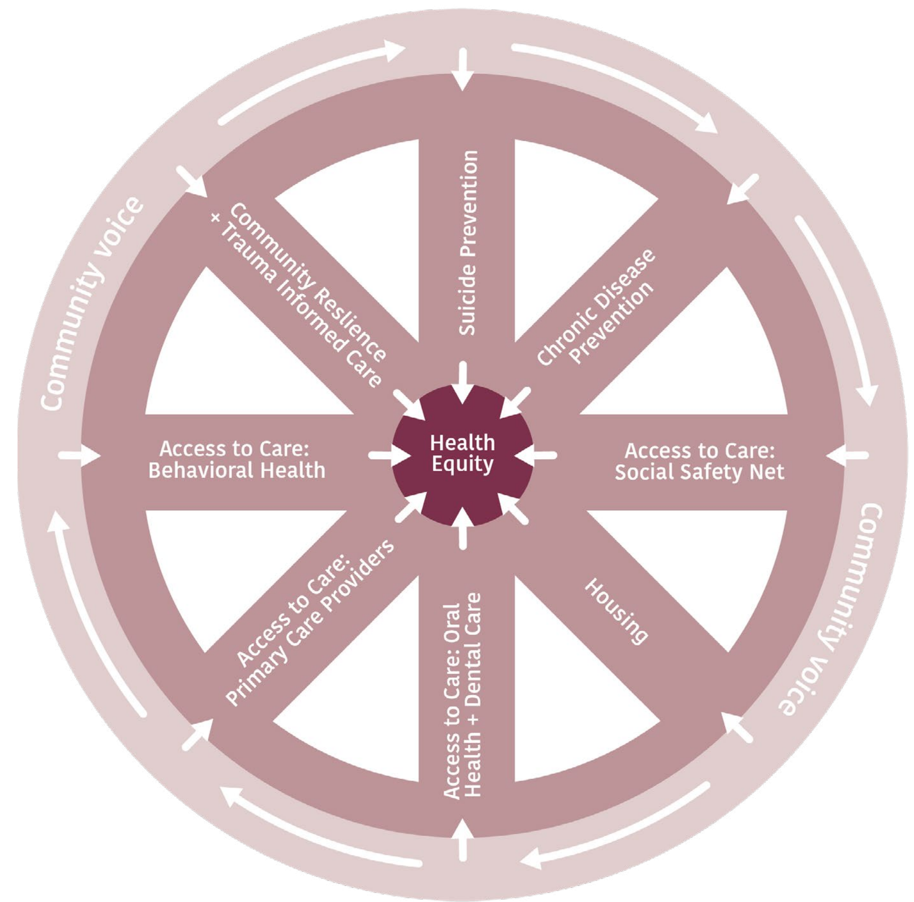
> "HEALTH EQUITY MEANS THAT EVERYONE HAS A FAIR AND JUST OPPORTUNITY TO BE AS HEALTHY AS POSSIBLE. FOR THE PURPOSES OF MEASUREMENT, HEALTH EQUITY MEANS REDUCING AND ULTIMATELY ELIMINATING DISPARITIES IN HEALTH AND ITS DETERMINANTS THAT ADVERSELY AFFECT EXCLUDED OR MARGINALIZED GROUPS" (RWJ, 2017).

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

## Purpose

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

Figure 1: Health equity wheel




notes:

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

## Regional health equity assessment

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

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

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

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

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

## Clatsop County COVID-19 Case Study

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

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

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

## BARHII toolkit

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

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

## LHD internal health equity capacity assessment: staff survey

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

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

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

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

## LHD internal health equity capacity assessment: leadership interviews

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

notes:

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

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

## Health Equity Planning

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

## Terminology + Acronyms

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

The following acronyms occur throughout this report:

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

# regional health equity assessment

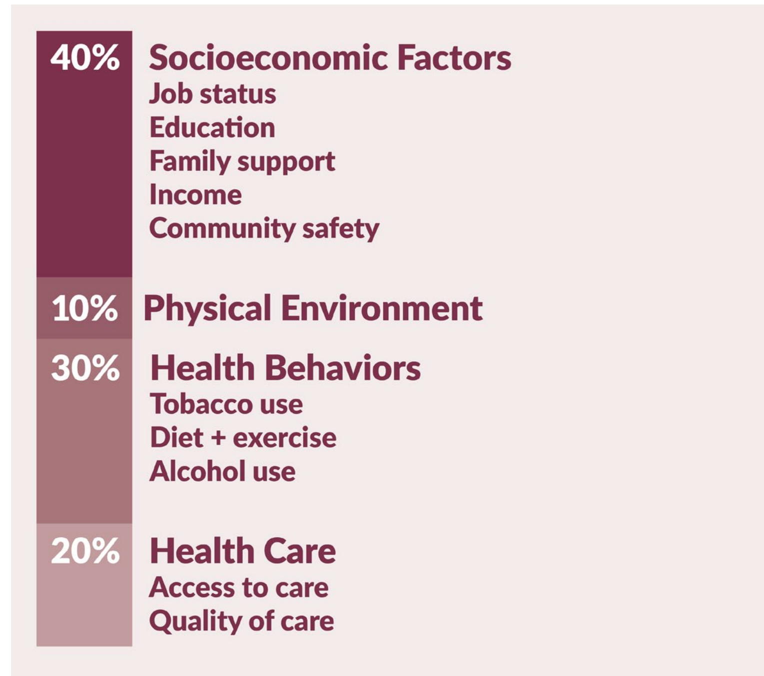
## Social determinants of health

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

The social determinants of health play a complex role in health outcomes and there is not consensus on how to precisely measure their overall impact on health. As seen in Figure 2, up to 50% of health determinants can be traced back to your zip code. Only 20% of health determinants involve the health care environment.

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

Figure 2: What goes into your health?[4]




notes:
4. Institute for Clinical Services Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014).

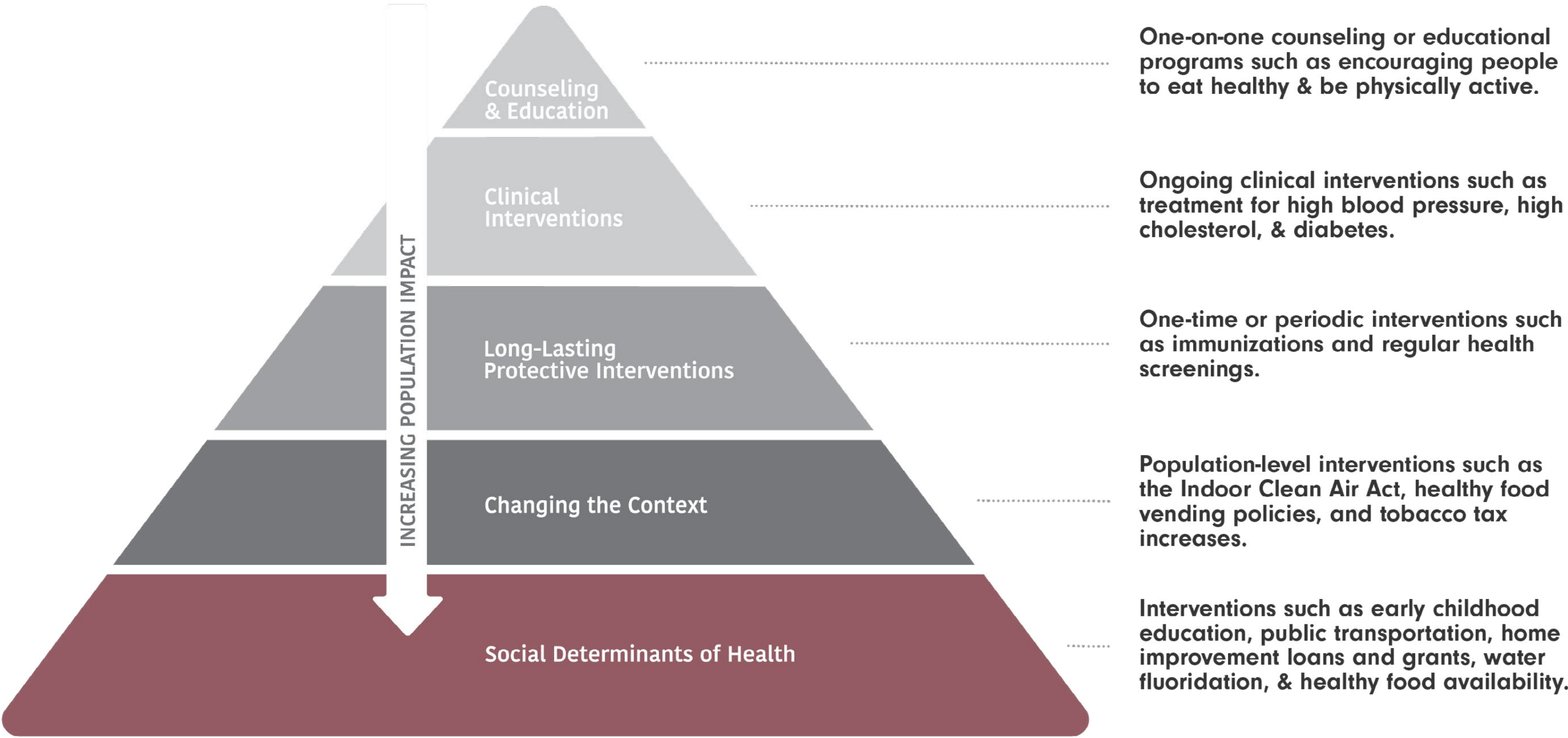
Table 1: Social Determinants of Health[5]

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

notes:

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

Figure 3: Health impact pyramid[6]




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

## Community health data

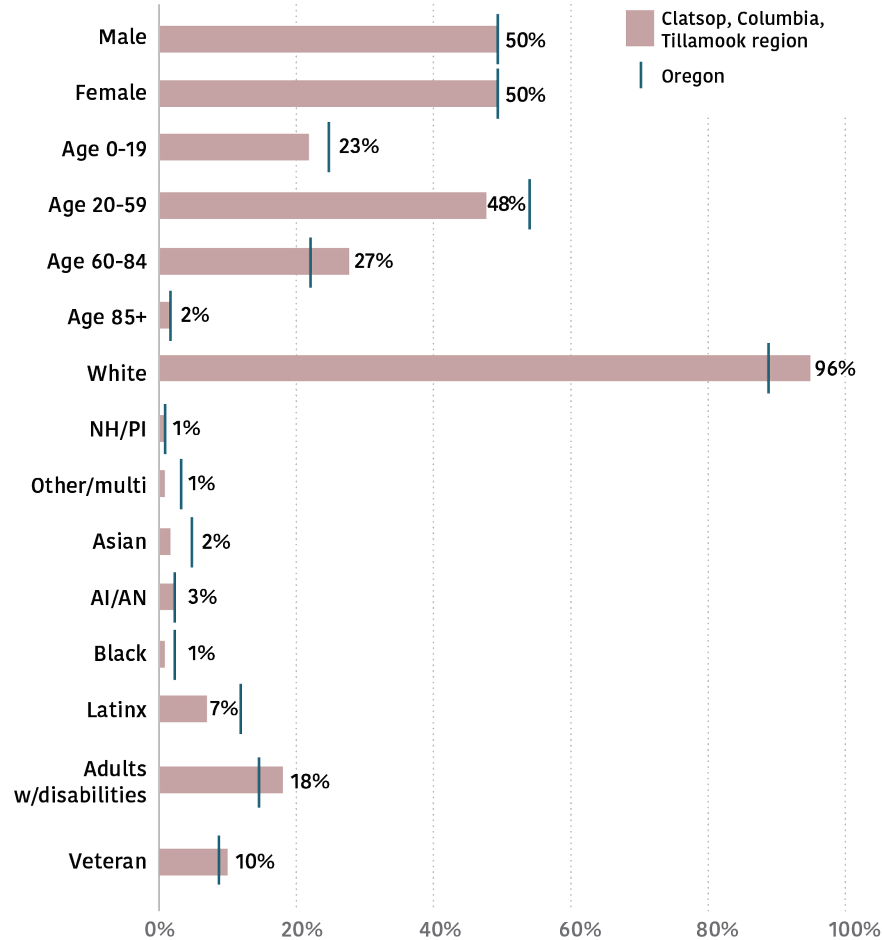
The community health data presented in this section were gathered from the 2019 Regional Health Assessment[7] and updated where available. Additional secondary data were incorporated as identified by the research team and regional collaborative.

### DEMOGRAPHICS

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

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

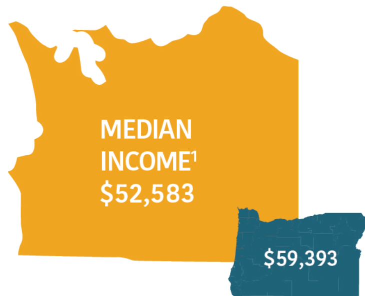
Figure 4: Population by gender, age, race, ethnicity, disability, and veteran status




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

notes:
7. Regional Health Assessment & Regional Improvement Plan 2019

Figure 5: Clatsop County overview




**Clatsop**

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

**Population...........38,562**

Race categories are not exclusive of Latinx ethnicity

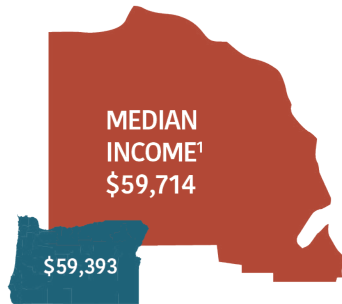
Sources:

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

| Category | Indicator | Clatsop |
| --- | --- | --- |
| POVERTY & FOOD INSECURITY | Living below the federal poverty level[2] | 12% |
| | Childhood poverty[3] | 17% |
| | Food insecurity[2] | 13% |
| | Childhood Food insecurity[2] | 21% |
| | 11th graders who ate less than they felt they should because there wasn't enough money for food[4] | 13% |
| | Percent of county population on SNAP[5] | 15% |
| HOUSING | Owner-occupied housing unit rate[1] | 62% |
| HEALTH INSURANCE | Percent of adult population who are uninsured[6] | 10% |
| | Percent of adult population on Medicare[6] | 19% |
| | Percent of adult population on OHP[6] | 27% |
| EDUCATION | Post-secondary degree among adults 25+[7] | 34% |
| | High school graduation rate 2018[8] | 78% |
| CHILDHOOD | Children in foster care[2] | 2% |
| | Children in single-parent households[2] | 30% |
| DISABILITY | Residents 18-64 with a disability[9] | 16% |
| | Residents 65+ with a disability[9] | 41% |

| Oregon (marker) | 0% | 20% | 40% | 60% | 80% | 100% |

### Figure 6: Columbia County overview




**Columbia**

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

**Population...........50,851**

Race categories are not exclusive of Latinx ethnicity

Sources:

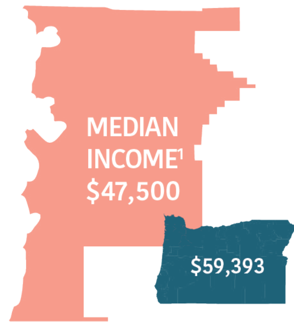
1. U.S. Census Bureau (2014-18)
2. OHA Population living below federal poverty level by county, Oregon, 2013-2017 and food insecurity by county, Oregon 2016
3. 2019 Children First for Oregon County Data Sheets
4. Oregon Healthy Teens Survey 2019
5. SNAP County Table by FIPS Jan2019-Dec2019
6. OHA, Oregon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

| Category | Indicator | Columbia |
|---|---|---|
| POVERTY & FOOD INSECURITY | Living below the federal poverty level[2] | 12% |
| | Childhood poverty[3] | 17% |
| | Food insecurity[2] | 13% |
| | Childhood Food insecurity[2] | 22% |
| | 11th graders who ate less than they felt they should because there wasn't enough money for food[4] | 13% |
| | Percent of county population on SNAP[5] | 14% |
| HOUSING | Owner-occupied housing unit rate[1] | 74% |
| HEALTH INSURANCE | Percent of adult population who are uninsured[6] | 8% |
| | Percent of adult population on Medicare[6] | 16% |
| | Percent of adult population on OHP[6] | 25% |
| EDUCATION | Post-secondary degree among adults 25+[7] | 28% |
| | High school graduation rate 2018[8] | 82% |
| CHILDHOOD | Children in foster care[2] | 2% |
| | Children in single-parent households[2] | 31% |
| DISABILITY | Residents 18-64 with a disability[9] | 16% |
| | Residents 65+ with a disability[9] | 39% |

| Oregon (marker)

0% 20% 40% 60% 80% 100%

Figure 7: Tillamook County overview




**Tillamook**

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

**Population...........26,076**

Race categories are not exclusive of Latinx ethnicity

Sources:

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

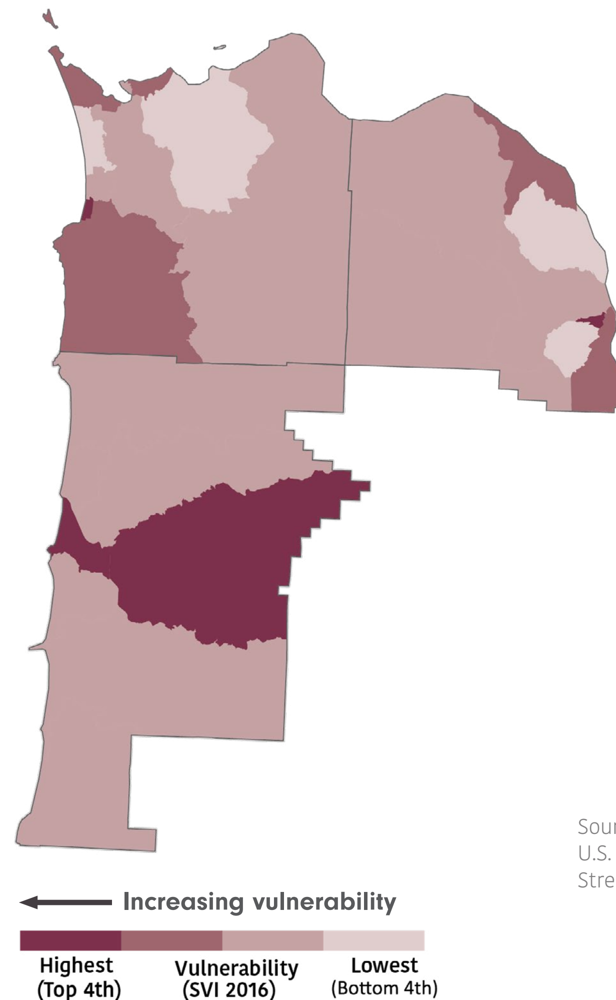
| Category | Measure | Tillamook |
|---|---|---|
| POVERTY & FOOD INSECURITY | Living below the federal poverty level[2] | 16% |
| | Childhood poverty[3] | 22% |
| | Food insecurity[2] | 13% |
| | Childhood Food insecurity[2] | 21% |
| | 11th graders who ate less than they felt they should because there wasn't enough money for food[4] | 11% |
| | Percent of county population on SNAP[5] | 15% |
| HOUSING | Owner-occupied housing unit rate[1] | 69% |
| HEALTH INSURANCE | Percent of adult population who are uninsured[6] | 10% |
| | Percent of adult population on Medicare[6] | 19% |
| | Percent of adult population on OHP[6] | 27% |
| EDUCATION | Post-secondary degree among adults 25+[7] | 28% |
| | High school graduation rate 2018[8] | 85% |
| CHILDHOOD | Children in foster care[2] | 1% |
| | Children in single-parent households[2] | 38% |
| DISABILITY | Residents 18-64 with a disability[9] | 18% |
| | Residents 65+ with a disability[9] | 37% |

| Oregon (marker) | 0% | 20% | 40% | 60% | 80% | 100% |
|---|---|---|---|---|---|---|

### OVERALL SOCIAL VULNERABILITY

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

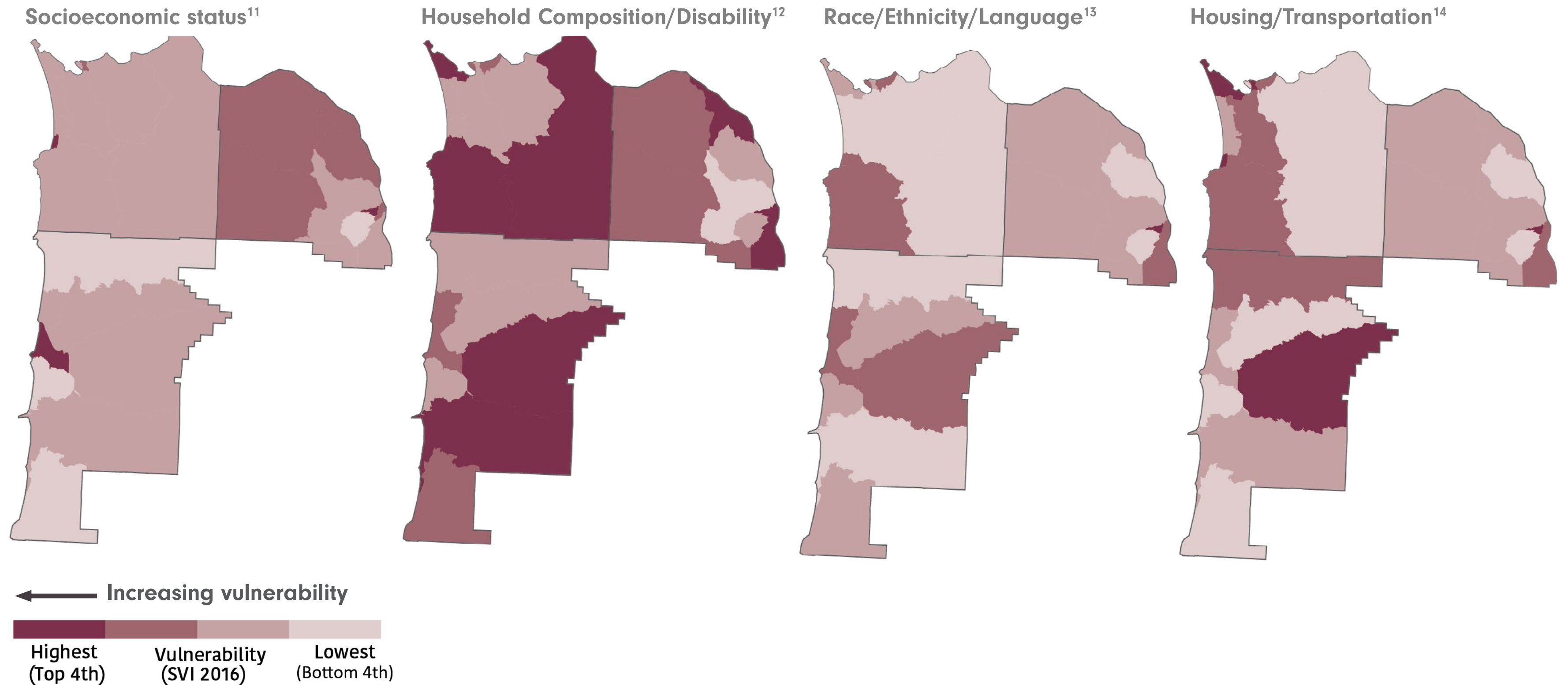
Figure 8: Regional Social Vulnerability (overall)[8]




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

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

Figure 9: Social Vulnerability Index Themes




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

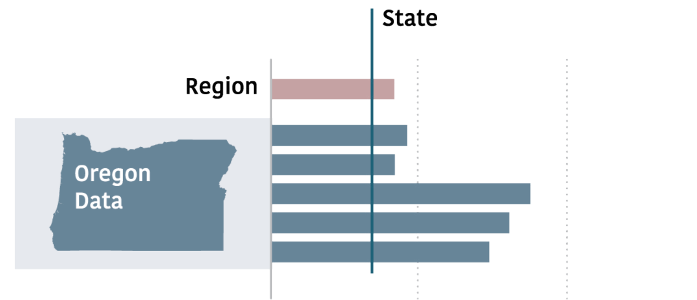
notes:
11. Socioeconomic Status: Poverty, Unemployed, Per Capita Income, No High School Diploma.
12. Household Composition/Disability: Aged 65 and Over, Aged 17 and Younger, Single-parent Household, Aged 5 and over with a Disability.
13. Race/Ethnicity/Language: Minority, English Language Ability.
14.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

### READING THE CHARTS IN THIS REPORT

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

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

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



## MEDIAN INCOME AND POVERTY

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

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

Figure 10: Median income by race/ethnicity

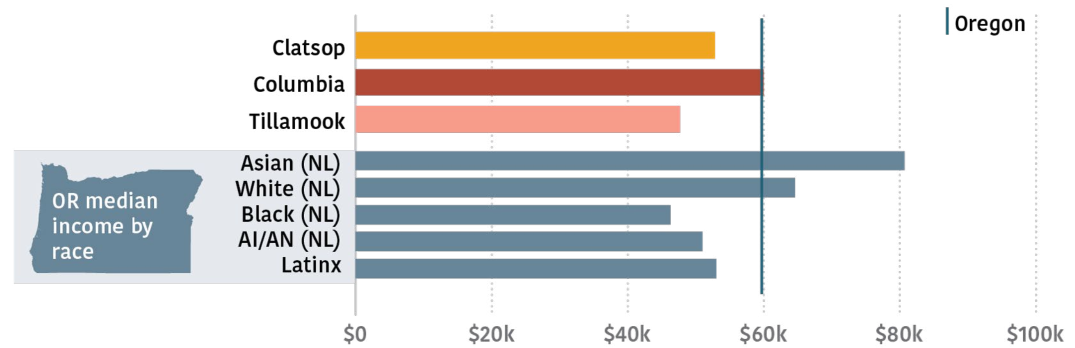
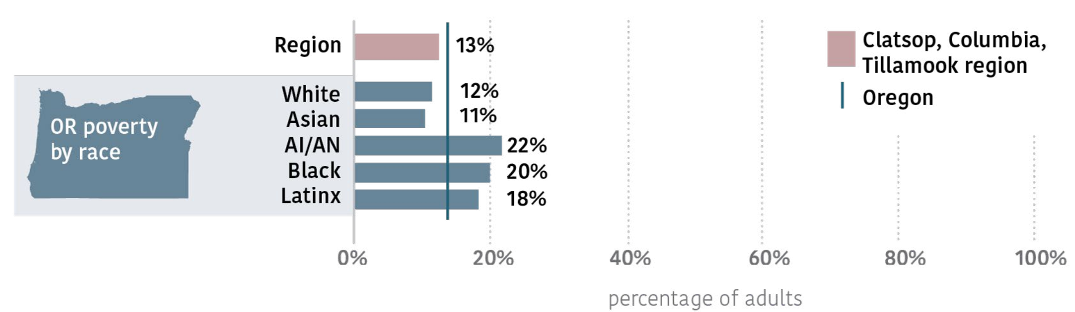



Figure 11: Poverty by race/ethnicity



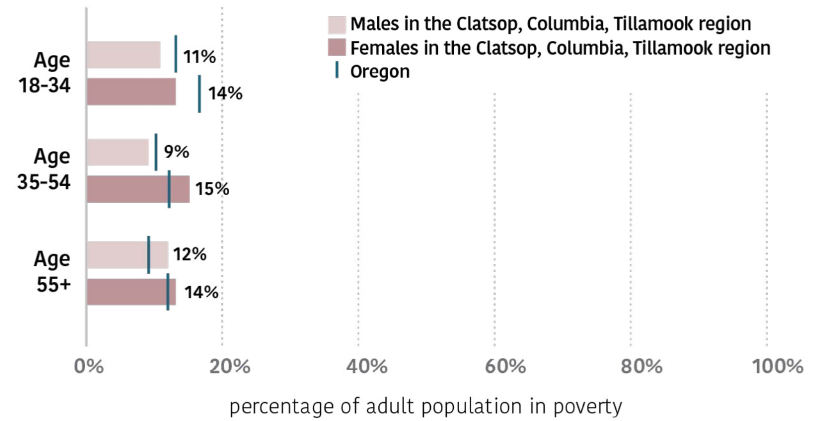

NL = non latinx

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

### POVERTY BY AGE AND SEX

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

Figure 12: Poverty by age and sex




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

## RATES OF HOMELESSNESS

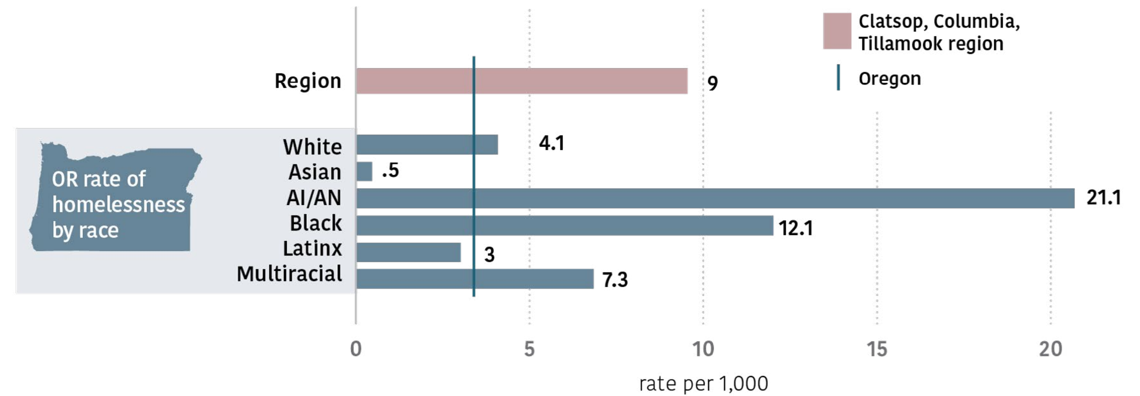
The Clatsop, Columbia, and Tillamook region has three times as many people experiencing homelessness in comparison to Oregon: 9 adults per 1,000 compared to 3 adults per 1,000 respectively.

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

## UNINSURED POPULATION

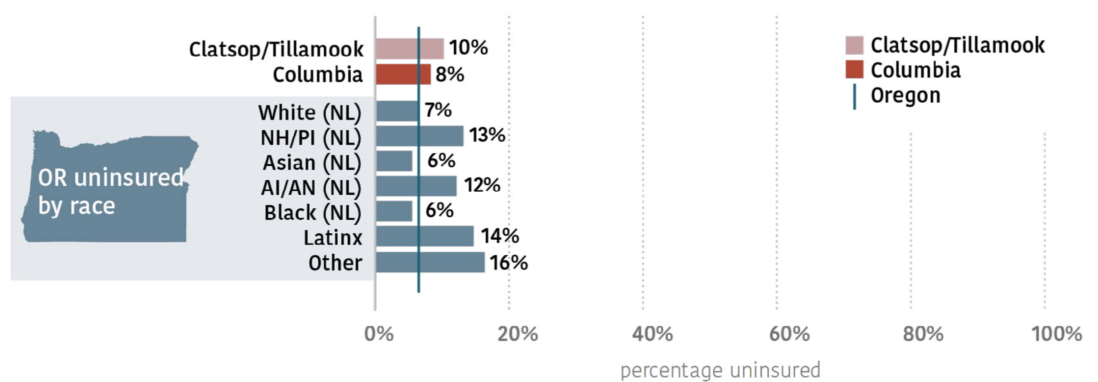
Clatsop, Tillamook and Columbia Counties have a slightly higher percentage of uninsured adults compared to the general population in Oregon (6%). As you can see by the state data, many communities of color experience a higher prevalence of being uninsured, including Native Hawaiian/ Pacific Islander,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

**Figure 13: Rates of homelessness by race/ethnicity**




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

**Figure 14: Uninsured population by race/ethnicity**

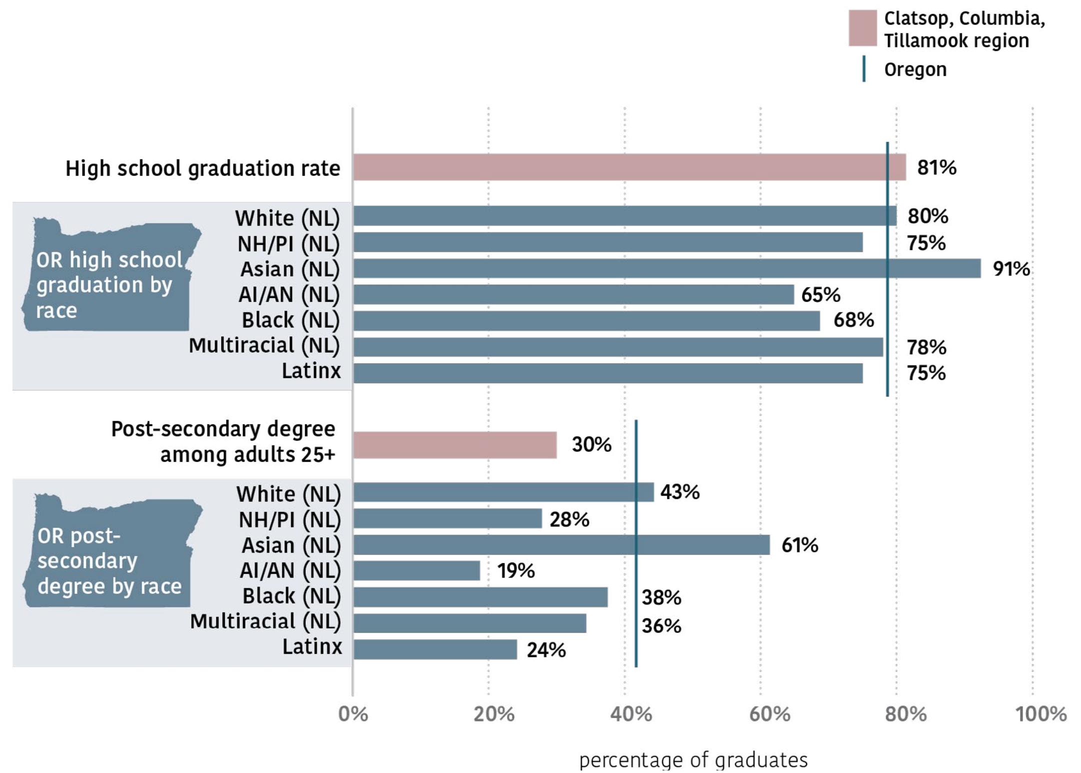



source: OHA, Oregon Health Insurance Survey, 2017
Race categories are exclusive of Latinx ethnicities

## EDUCATION

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

Figure 15: Educational attainment by race/ethnicity




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

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

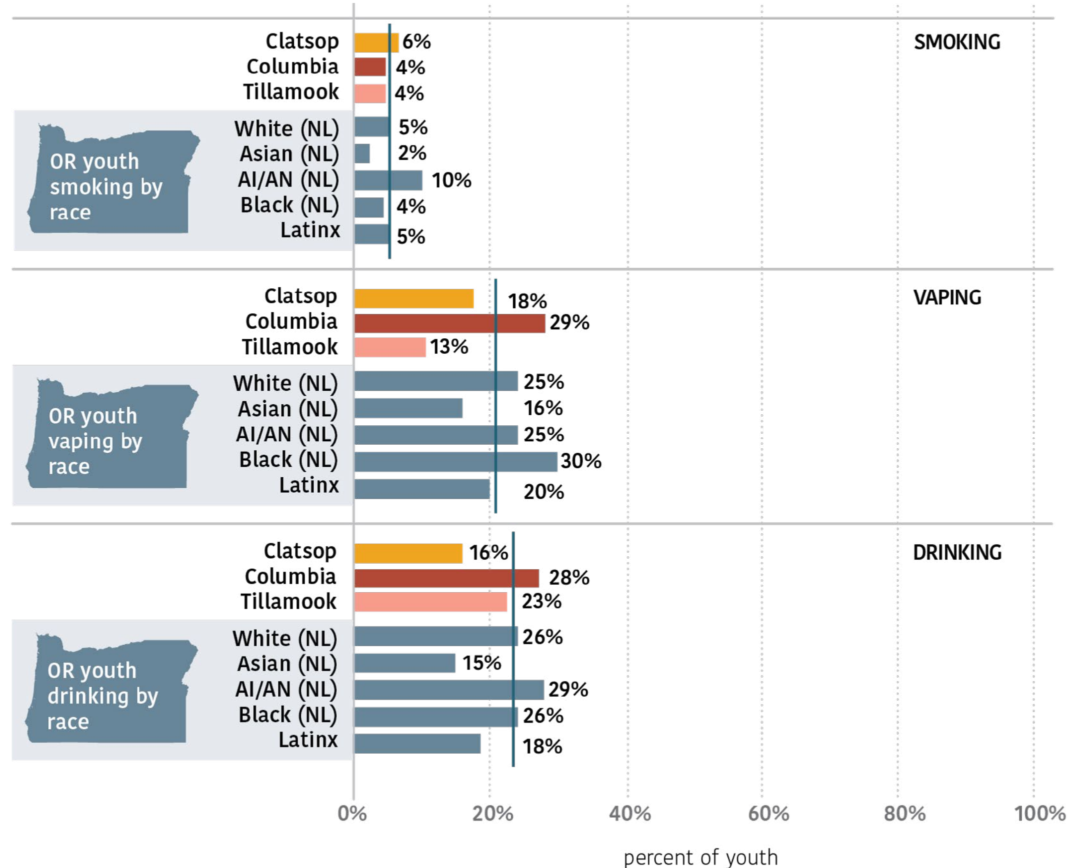
### YOUTH RISK FACTORS

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

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

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

Figure 16: Youth risk factors



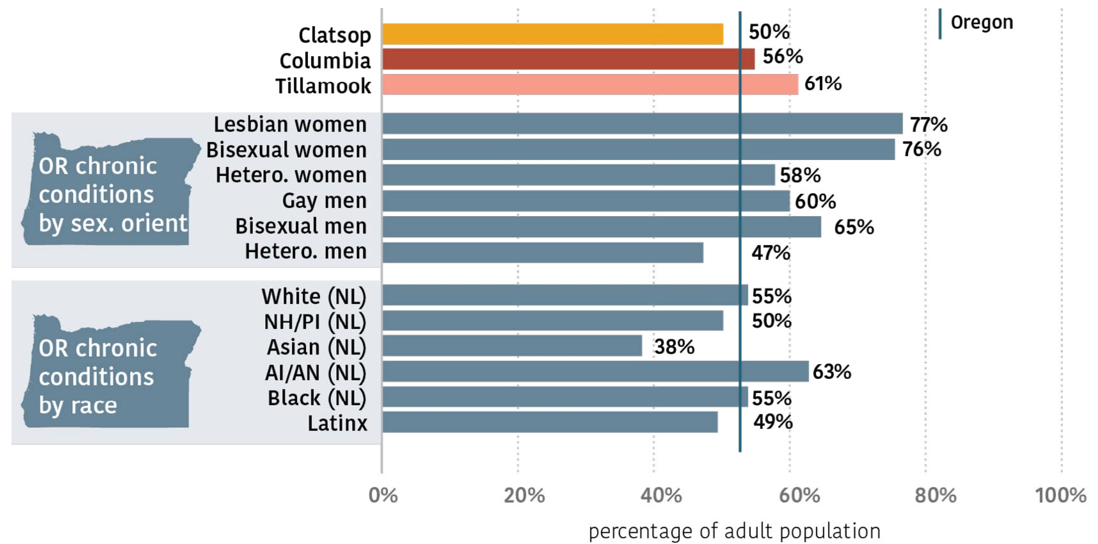

source: Oregon Healthy Teens Survey 2019
Race categories are exclusive of Latinx ethnicities

## CHRONIC CONDITIONS

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

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

Figure 17: Adults with one or more chronic condition

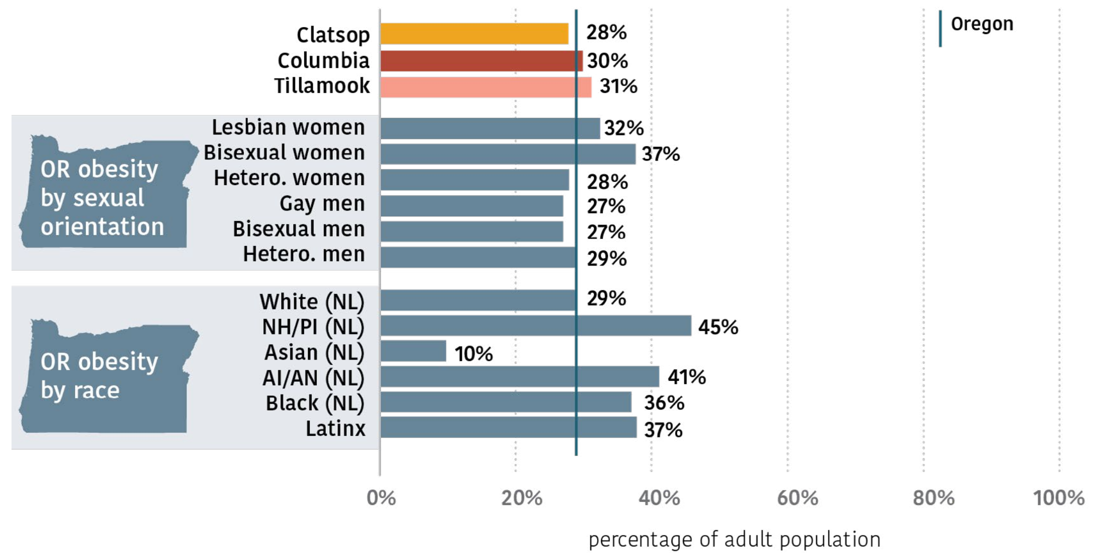



source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

### OBESITY AMONG ADULTS

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

Figure 18: Obesity among adults



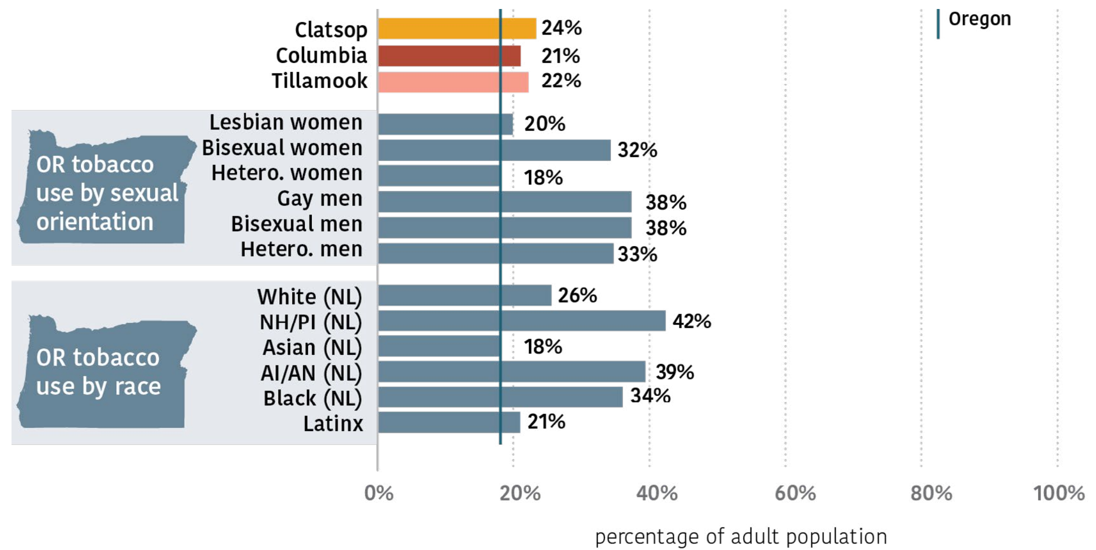

source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

## TOBACCO USE AMONG ADULTS

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

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

Figure 19: Tobacco use among adults

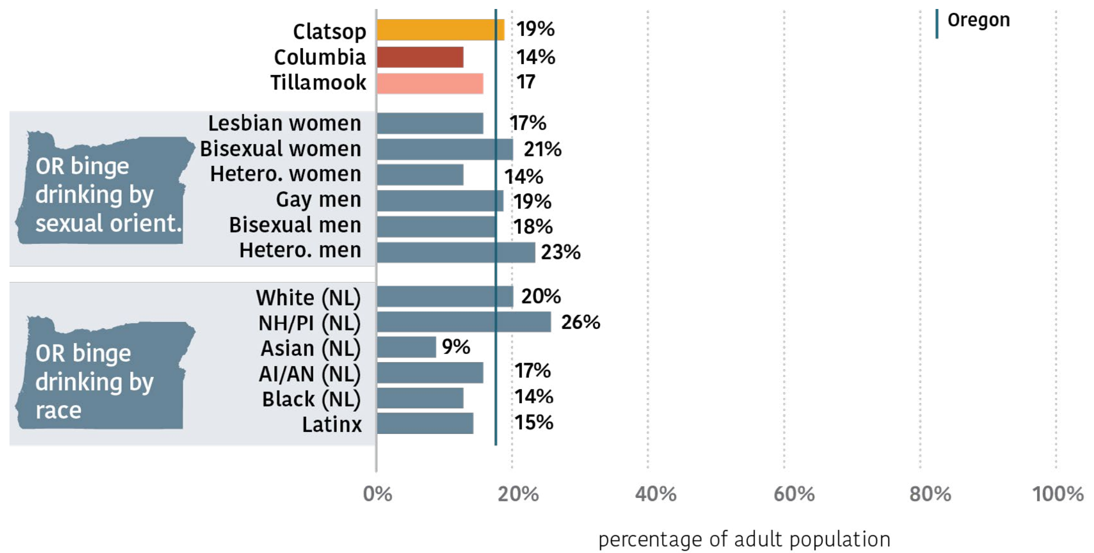



source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

### BINGE DRINKING AMONG ADULTS

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

Figure 20: Binge drinking among adults

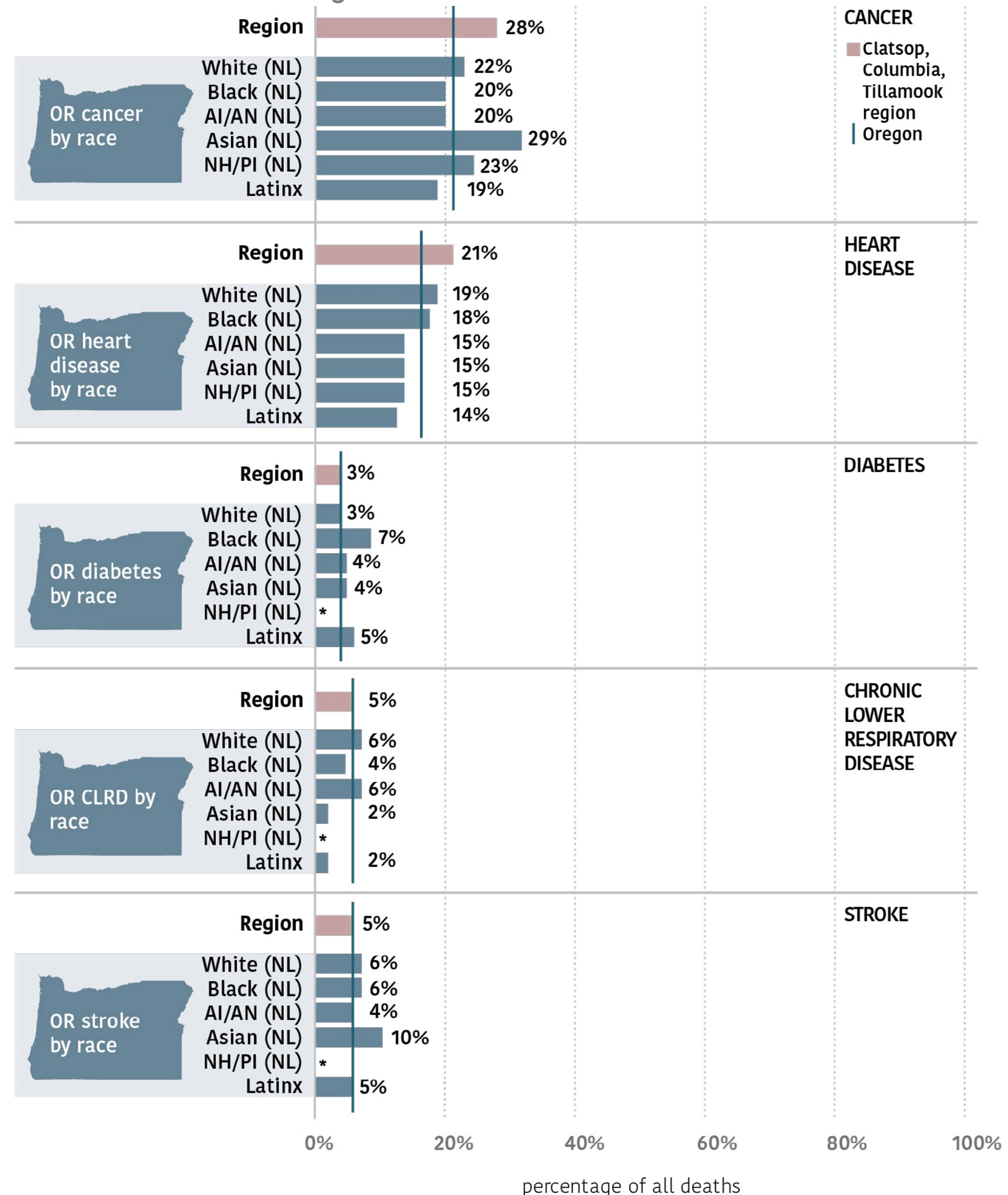



source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities

## PREVENTABLE CAUSES OF DEATH

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

Figure 21: Preventable causes of death



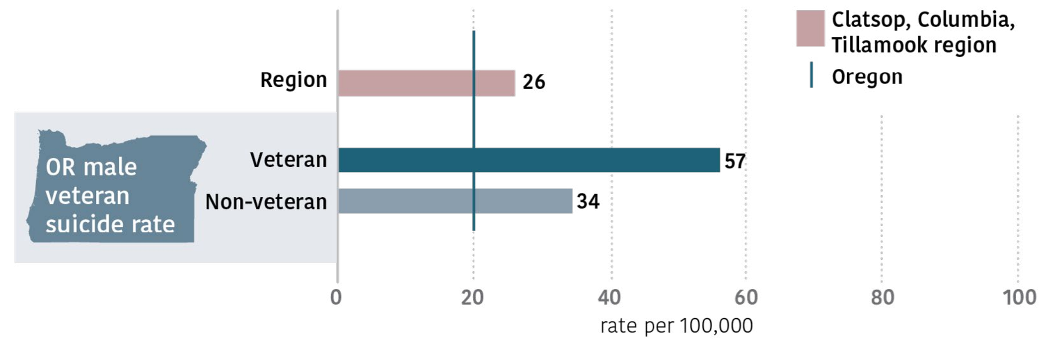

source: Oregon BRFSS 2015-2017; age-adjusted to the 2000 standard population
Race categories are exclusive of Latinx ethnicities
*numbers too small to be reliable

### SUICIDE RATES

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

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

Figure 22: Regional suicide rate




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

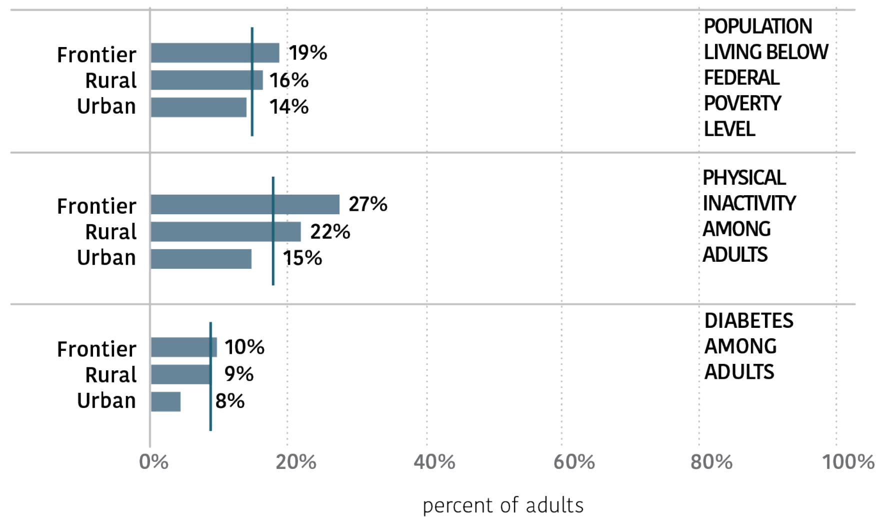
notes:
16. Oregon Vital Statistics Annual Reports (2013-2017).
17. https://onceasoldier.org/wp-content/uploads/2018/10/Oregon_2016.pdf

## GEOGRAPHIC DISPARITIES

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

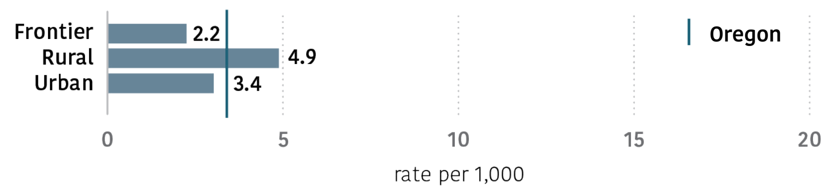
Figures 23 and 24 show examples of health disparities affecting people living in rural and frontier counties in Oregon.

Figure 23: Health disparities by geographic region




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

Figure 24: Estimates of homeless populations by geographic region




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

### 2019 NOVEL CORONAVIRUS (COVID-19)

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

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

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

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

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

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

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

# health equity case study

*Clatsop County COVID-19*

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

## Methods

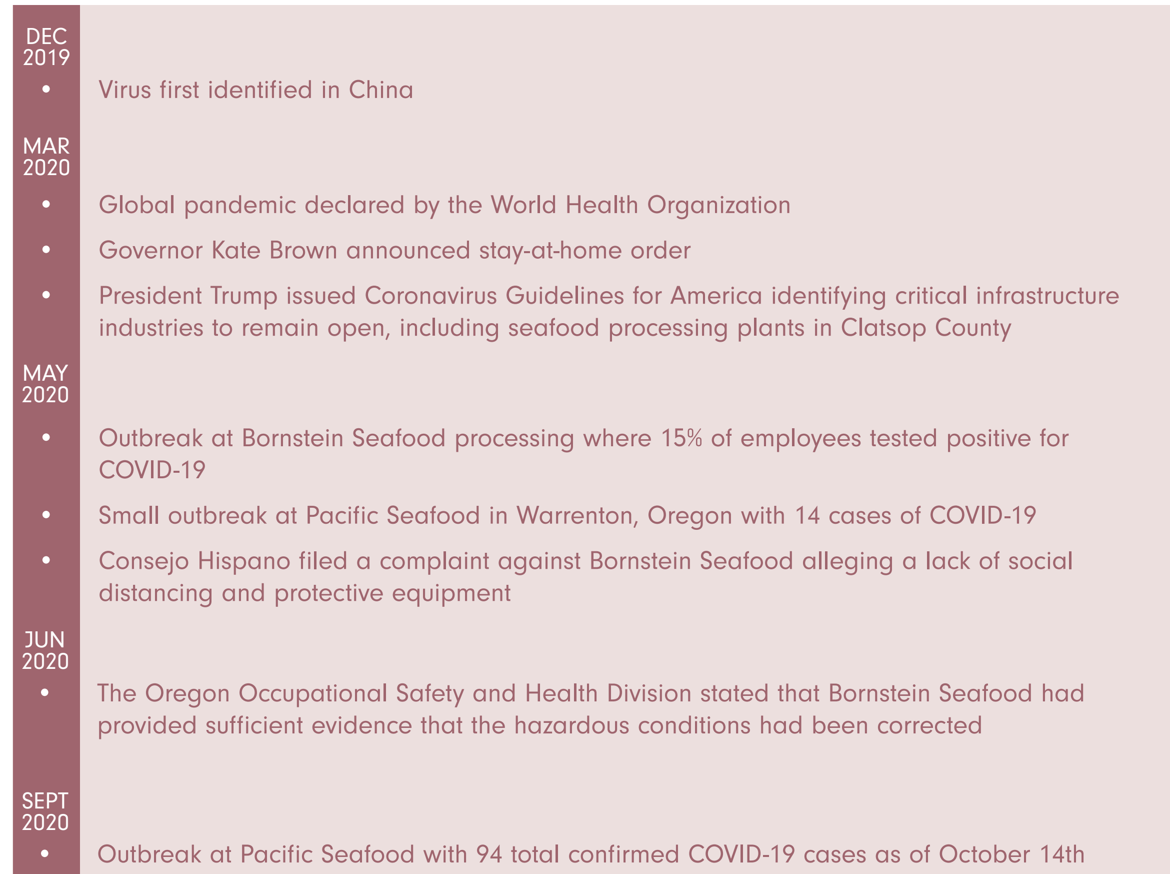
Semi-structured interviews were conducted by Consejo Hispano staff with ten community members who were diagnosed with COVID-19 to identify common themes and important narratives. Consejo Hispano is a community based organization that supports the equitable integration of Latinx residents in Oregon and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

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

## Overview of COVID-19 pandemic

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

Figure 25: COVID-19 timeline in Clatsop County



## National/state COVID-19 data

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

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

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

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

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

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

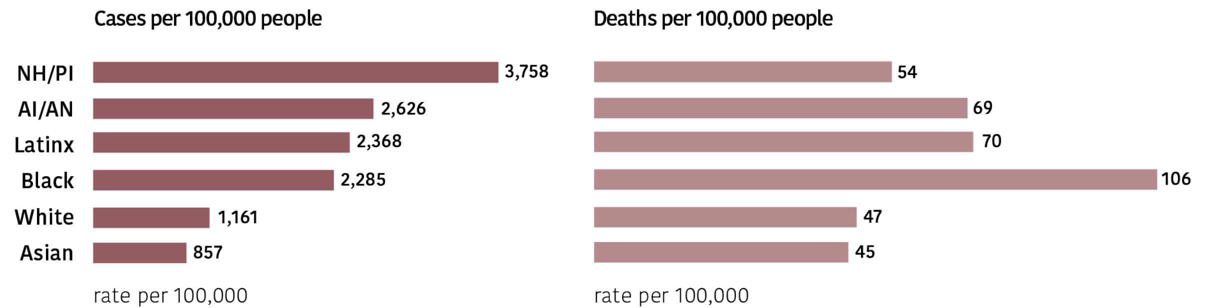
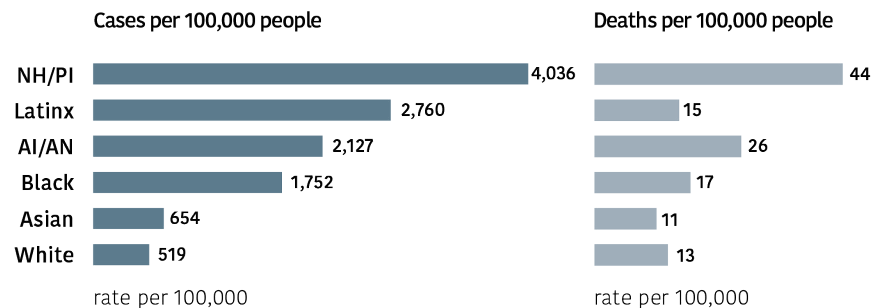



Figure 27: Oregon COVID-19 cases and deaths by race/ethnicity




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

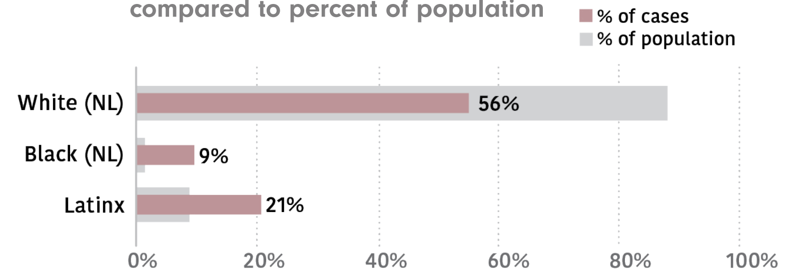
Oregon has reported race data for 86% of cases and 88% of deaths, and ethnicity data for 86% of cases and 82% of deaths. Graphic only includes demographic groups reported by the state. Race categories and mutually exclusive and include both Latinx and non-Latinx ethnicity.

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

## Clatsop COVID-19 data

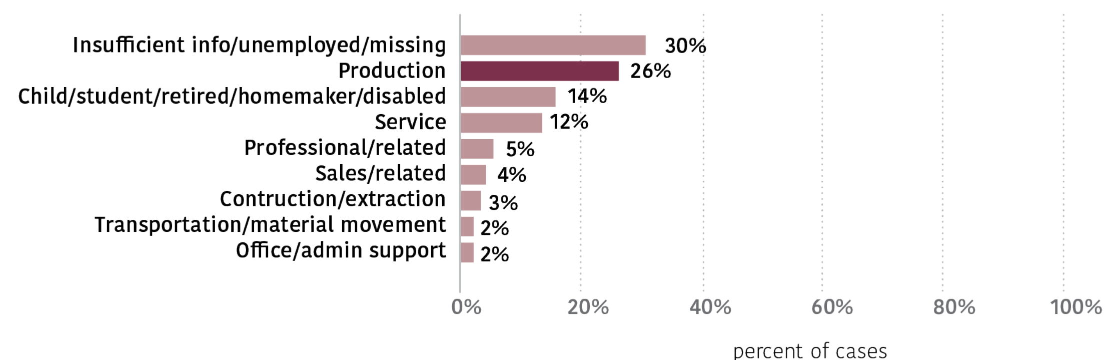
1. Clatsop County has a lower COVID-19 confirmed case rate in comparison with the rest of the state, at 545 per 100,000 as of 9/30/2020. There have been no deaths in Clatsop County due to COVID-19.
2. Data show that while the Latinx population in the Clatsop, Columbia, and Tillamook County region makes up less than 8% of the overall population, they represent 21% of COVID-19 confirmed cases.
    - 25-27% of COVID patients receiving services through the public health clinic are Latinx.
3. Type of occupation also carries different risks for contracting COVID-19. In the Clatsop, Columbia and Tillamook County region, of case information that exists by occupation, 26% of people who have had COVID-19 worked in production, which includes food processing plants.

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




source:

Figure 29: Regional COVID-19 cases by occupation




source:

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

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

**What leads to health inequities?**

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

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

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

notes:

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

## Workforce outbreaks

### BORNSTEIN SEAFOOD:

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

### PACIFIC SEAFOOD:

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

## Employee experiences

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

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

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

**—Community member**

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

**—Community member**

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

## Employee experiences continued

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

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

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

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

## Public health response

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

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

## Lessons learned

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

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

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

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

# LHD health equity capacity assessment

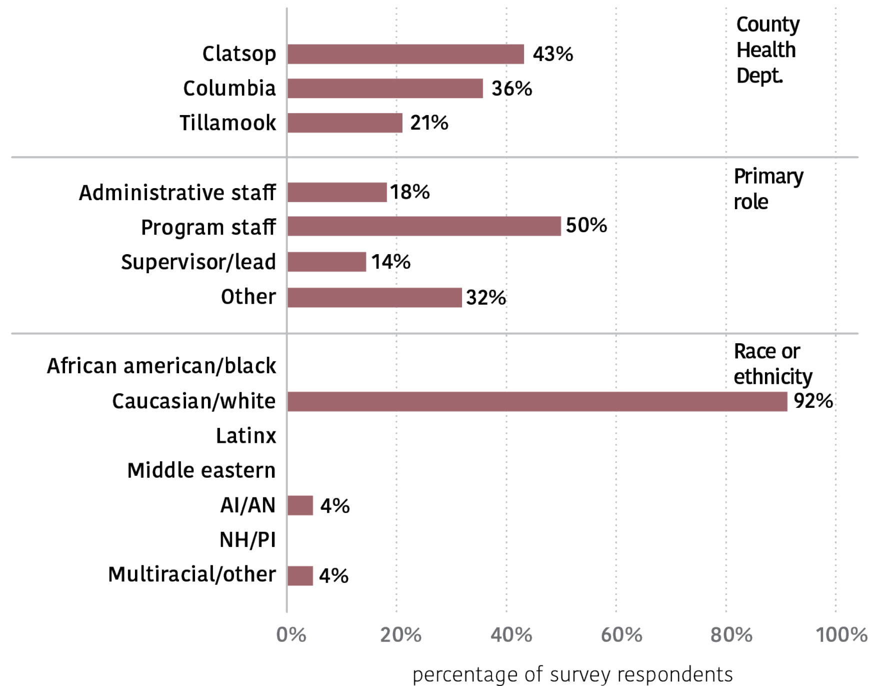
*staff survey results*

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

## Survey respondent demographics

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

Figure 30: Respondent demographics



## Community groups engaged to address the ESE conditions that impact health

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

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

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

Figure 31: Health department focus

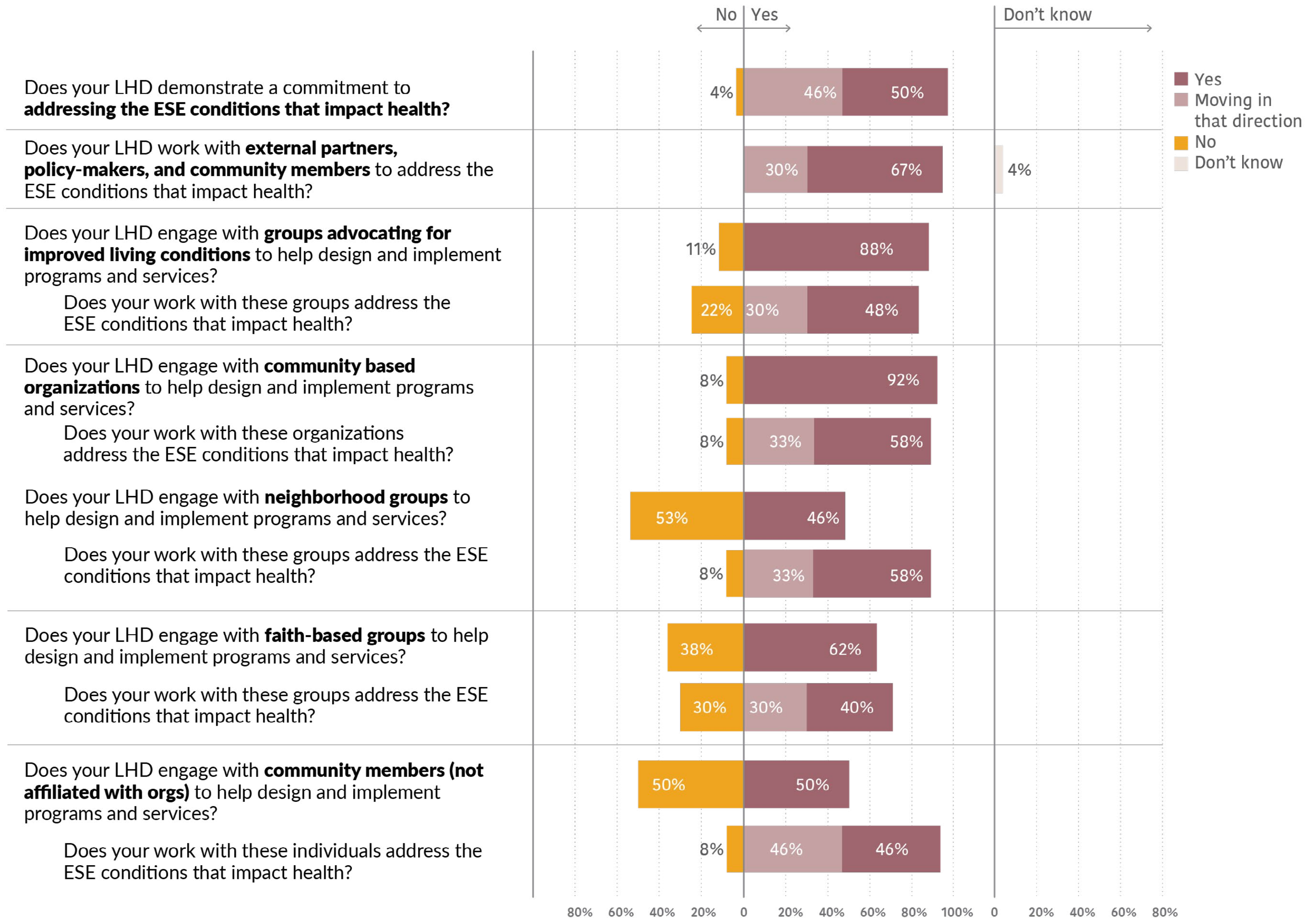


Figure 32: Community groups engaged to address the ESE conditions that impact health

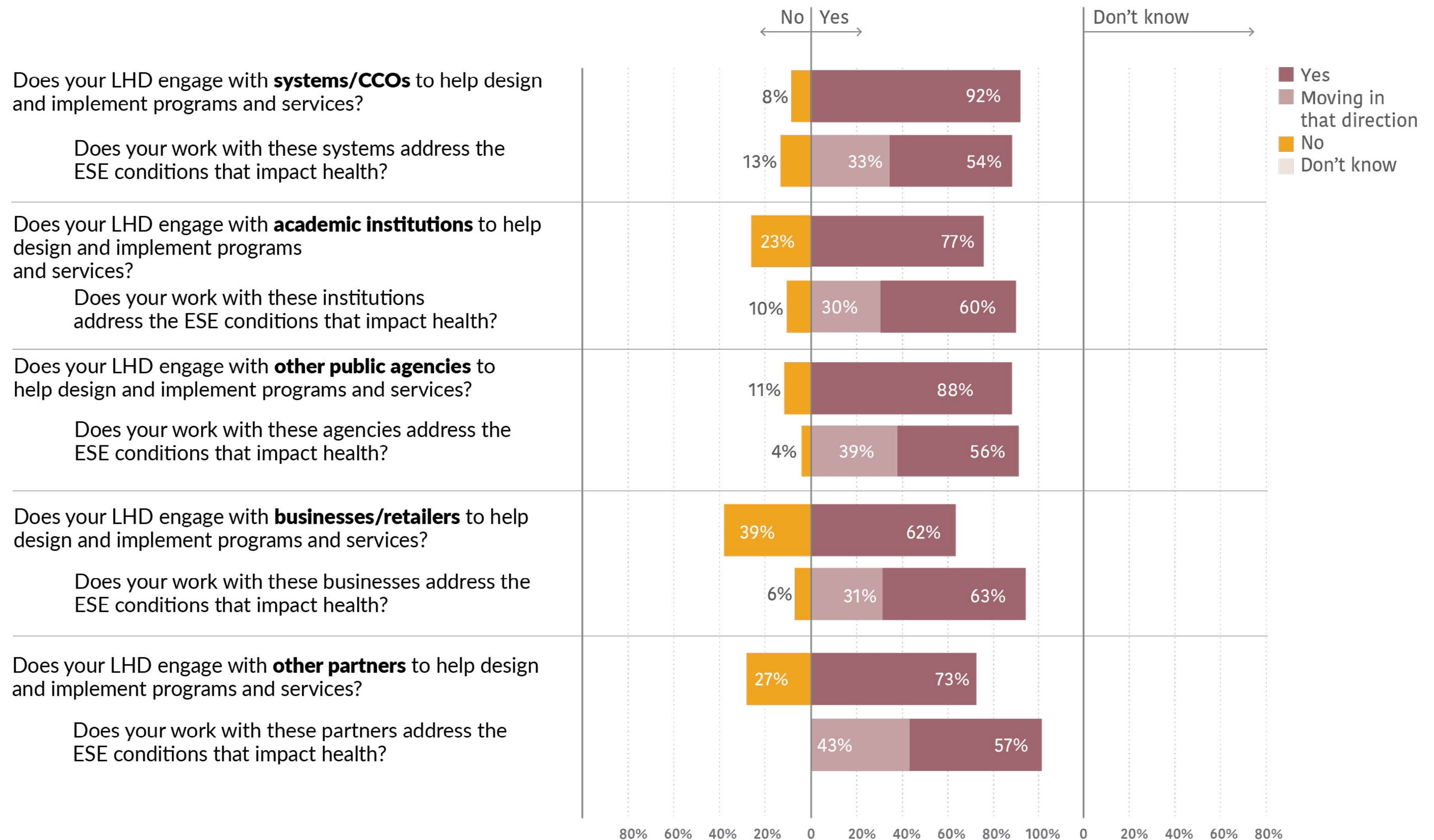


Figure 33: LHD collaborations to address ESE conditions that impact health

To what extent does your LHD **collaborate with public agencies** on the following issues?

Availability of quality affordable housing

Community safety and violence prevention

Community economic development

Racial justice

Transportation planning and availability

Food security

Early child development and education

To what extent does your LHD **collaborate with community-based organizations** on the following issues?

Availability of quality affordable housing

Community safety and violence prevention

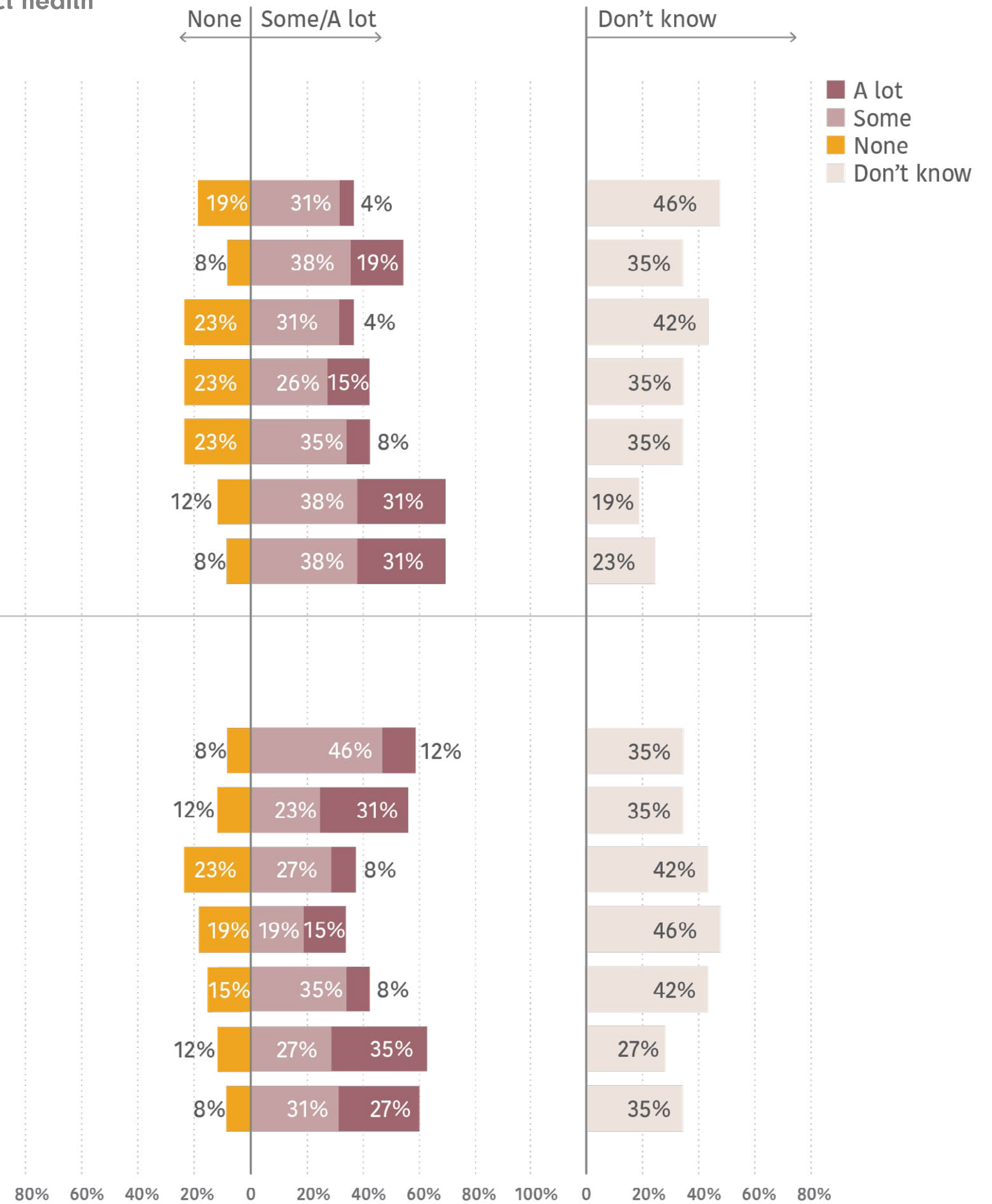
Community economic development

Racial justice

Transportation planning and availability

Food security

Early child development and education



## Addressing inequities

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

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

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

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

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

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

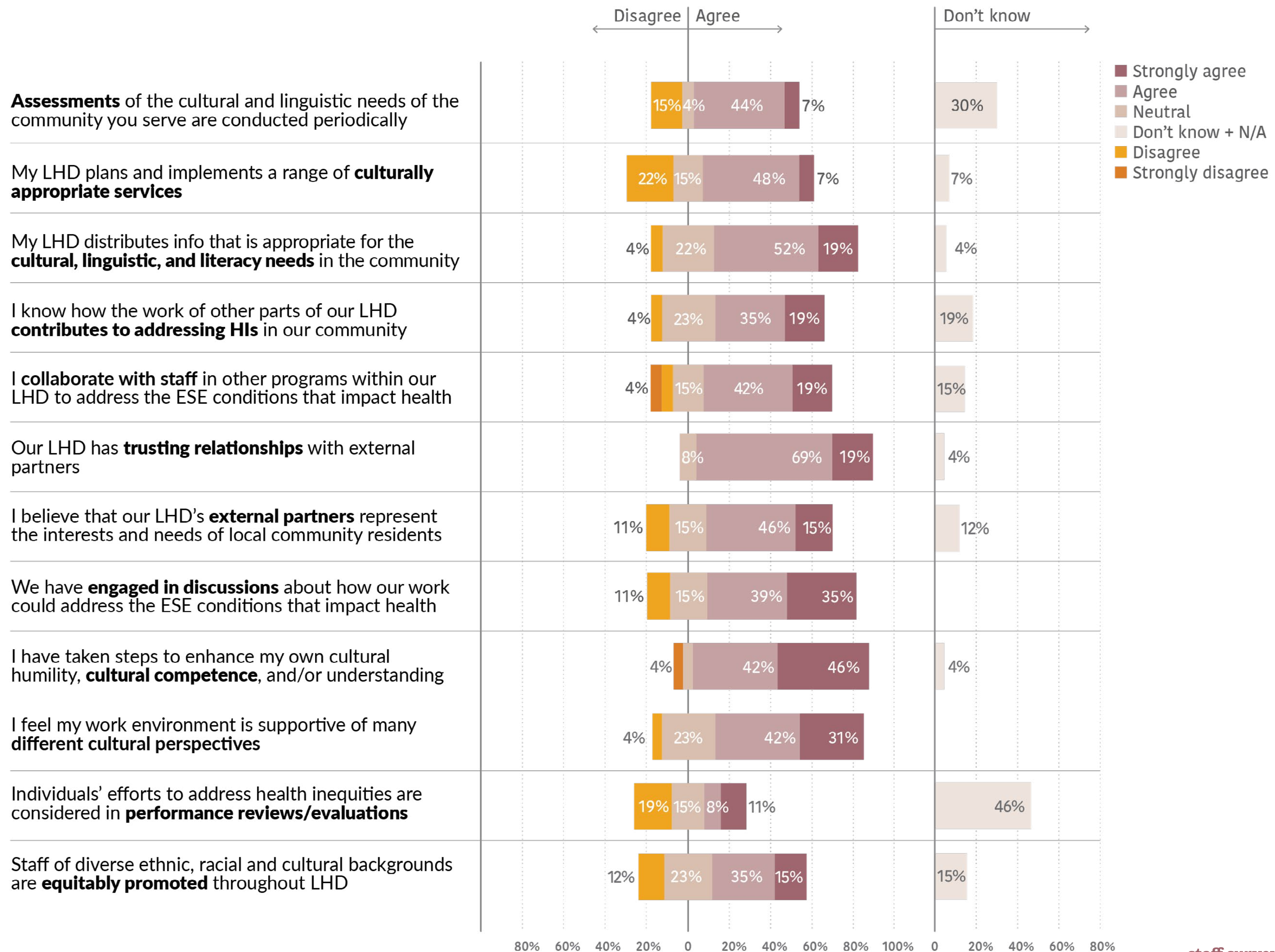
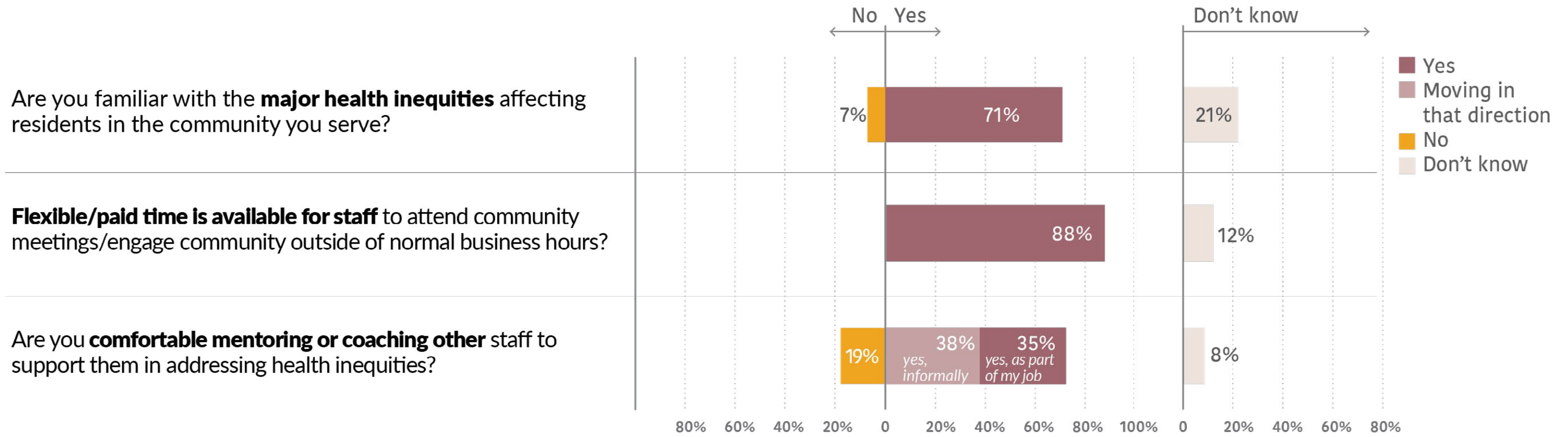


Figure 35: Supporting staff to address the ESE conditions that impact health continued



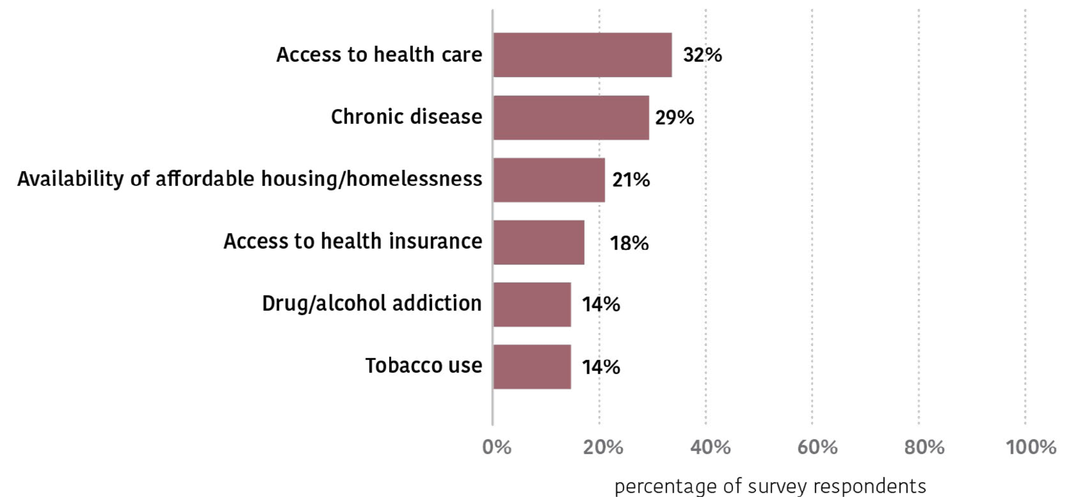
## staff survey results

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

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

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

Figure 36: Disproportionately and unfairly distributed health issues




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

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

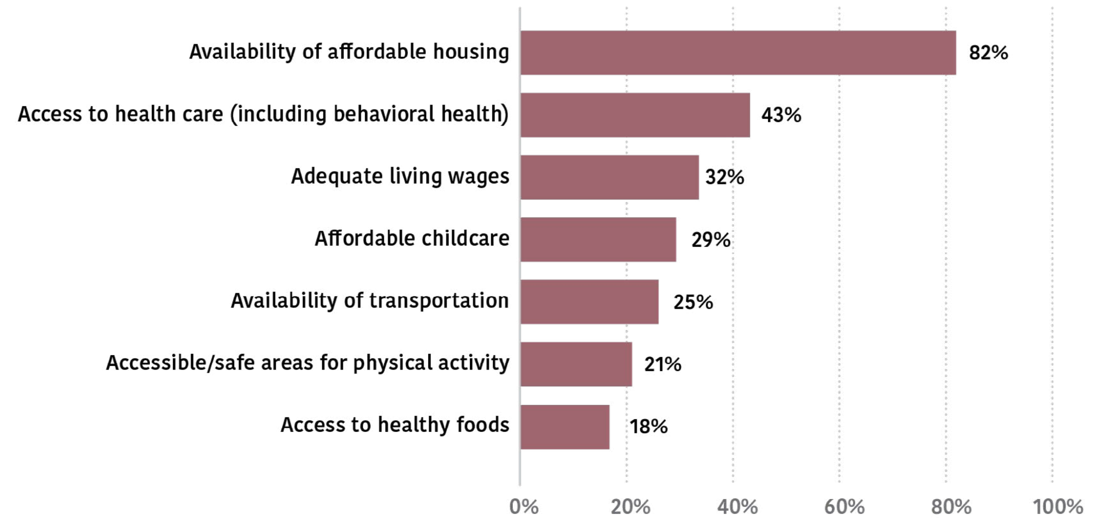
# staff survey results

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

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

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

Figure 37: ESE conditions that impact health




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

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

# LHD health equity capacity assessment

*leadership interview results*

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

## Organizational culture

### WORKFORCE DIVERSITY

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

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

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

**—LHD Leadership**

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

**—LHD Leadership**

### LEARNING CULTURE & WORKFORCE DEVELOPMENT

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

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

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

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

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

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

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

## Strategic planning

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

Participants in the strategic planning process include:

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

Input is gathered on strategic plans through:

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

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

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

**—LHD Leadership**

## Addressing inequities

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

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

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

—LHD Leadership

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

—LHD Leadership

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

—LHD Leadership

### CURRENT HEALTH EQUITY INTERVENTIONS

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

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

**—LHD Leadership**

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

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

### WORKING WITH COMMUNITY TO ADDRESS HEALTH INEQUITIES

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

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

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

Interviewees identified the following methods for building on community strengths:

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

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

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

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

**—LHD Leadership**

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

## leadership interview results

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

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

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

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

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

**—LHD Leadership**

# community feedback + key take-aways

## community feedback

A video summarizing the regional health equity data in this report was presented to community members and organizations from July 2nd through July 30th, 2021. Rede distributed the video and a brief survey, along with organizational presentation and open forum participation opportunities to a list of over 100 individuals, including people from:

- Coordinated care organizations
- Health coalitions
- Community-based organizations
- Health advisory committees
- Other organizations with ties to communities within each county

Through these efforts, Rede received feedback from 98 community members in the region. To start, community members were asked what they like best about living in their community. The top themes include the location, such as access to the outdoors, a sense of community, including feeling connected to friends and having social support, and living in a small and rural community. Community members were then asked questions about how their community could improve health equity. Table 4 compares the top conditions impacting health identified by community as well asLHD staff and leadership. Issues identified by community members tracked closely with the conditions identified by LHD staff and leadership.

Table 4: Top issues impacting health and representing economic inequities

| Stakeholder | Question | Results |
|---|---|---|
| Community feedback respondents | What would you want to improve about our community? | • More affordable housing (70%)<br>• More jobs/better wages (56%)<br>• Better access to healthcare (43%)<br>• Affordable childcare (35%) |
| | What do you believe is keeping our community from doing what needs to be done to improve health and quality of life? | • Availability of Services (27%)<br>• Poverty (25%)<br>• Housing Affordability (23%) |
| LHD staff survey respondents | What do you believe are the most important environmental, social, and economic conditions that impact health in your county? | • Affordable housing (82%)<br>• Access to health care (43%)<br>• Adequate living wages (32%)<br>• Affordable childcare (29%)<br>• Availability of transportation (25%) |
| LHD + Gov't leadership interviewees | What do you think are the most important environmental, social, and economic conditions that impact health in your county? | • Lack of hospitals and/or appropriate health care<br>• Having to travel long distances to access specialty health services<br>• Adequate paying jobs<br>• Affordable housing |

## key take-aways

To improve health and reduce disparities in Clatsop, Columbia, and Tillamook Counties, Rede

recommends that a regional health equity plan prioritize strategies related to increased affordable housing, increased access to health and social services, and addressing poverty. To identify where measurable change can take place, stakeholders may consider the following:

### INCREASED AFFORDABLE HOUSING

- Housing inventory: community members provided feedback about a general lack of available housing.
- Effects of short-term rentals on housing cost and inventory: community members noted the practice of keeping second homes by people who do not reside fulltime in the county, including those kept as vacation rentals, prevent locals from finding readily available and affordable housing, both when renting and buying.
- Equitable access to housing: in addition to a general lack of housing, community members noted that there is a lack of equitable access to housing among economic and racial groups.
- Lack of buildable land: due to zoning or other issues, community members have noticed decreased availability of affordable land, particularly community members looking to build houses on plots of land.

### LACK OF HEALTH AND SOCIAL SERVICES

- Health-related services like medical and emergency care, drug treatment, and mental health: many called out lack of access to appropriate health services, such as lack of timely care, delays in seeing a doctor, and a lack of medical facilities. Some urged prioritizing a hospital or 24-hour medical clinic, noting barriers to traveling for emergency or everyday medical care. Others called out a lack of drug treatment facilities and a lack of mental healthcare infrastructure.
- Family support and childcare: finding support for families and childcare repeatedly surfaced through conversations and in feedback from the community. Some called out childcare specifically, while others addressed that without familial support, it is difficult for parents to work and take care of other responsibilities.
- Transportation: Many noted that inadequate transportation infrastructure creates barriers accessing services or navigating the community. Specifically, community members called out the need for transportation to basic services like visiting the doctor, getting to the grocery store, or going to work.
- Food access: community members noted that it can be difficult in some counties to find healthy, culturally appropriate food, as well as finding adequate amounts of food. They said this can be because of a limited number of grocers, that food prices are expensive because of lack of competition among grocers, or there aren't markets that provide the kinds of food they want to eat. Some did highlight successful community efforts to provide food for houseless people and the presence of a food co-op, although this was not consistent among all counties.

### ADDRESSING POVERTY

- Income inequality: community members talked about gender and racial inequality as proponents of income inequality.
- Lack of job opportunities: respondents said that there is a lack of job opportunities for people of every skill level, including the working poor and houseless, perpetuating poverty cycles.
- Poor wages: respondents talked about poor wages compounding other issues, such as being able to access housing and food, ultimately contributing to a chronic state of poverty for some individuals and families.
- Low community engagement: participants noted that the community could be more deeply engaged to address poverty by providing resources to help raise people out of poverty.

Developing a plan to address these critical issues and further the connection between healthcare, social services, and other social factors that impact health is the crucial next step to increasing health equity in the northern coastal region.

See Appendix F for more detailed information about community feedback.

# appendix

## Appendix A: Clatsop County's COVID-19 Community Member Interview Questions

1. Tell me a little bit about what you know about COVID-19?
2. How have you or your family been affected by COVID -19 at work, at home, and in the community? (Please do not feel like you need to speak about diagnosis or anything related to your personal health)
3. How did you get information about COVID-19?
4. What was the most difficult thing about COVID-19 for you or your family?
5. Do you have any concerns about what will happen to you in the future because of COVID-19; if so, what are your concerns?
6. Is there anything that could have been done differently to make the COVID-19 situation better for you? (If you could change one thing other than having no-COVID, what would it be?)
7. What personal/family skill or strength did you use the most when dealing issues around COVID-19?
8. Is there anything else you would like us to know about your experience with COVID-19?

# Local Health Department Organizational Self-Assessment for Addressing Health Inequities

# TOOLKIT AND GUIDE TO IMPLEMENTATION

Bay Area Regional Health Inequities Initiative

## ACKNOWLEDGEMENTS

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## FOREWORD

The Bay Area Regional Health Inequities Initiative (BARHII) is pleased to offer this Organizational Self Assessment Toolkit for use in local health departments throughout the nation to assist in their development of a greater capacity to address health inequities.

The context for this toolkit might require some perspective. For starters, why "health inequities," when the term "health disparities" is used much more widely in the United States? The elimination of health disparities, for example, is one of two overarching goals of Healthy People 2010. The United States, however, appears to be alone in the use of the term "health disparities." The World Health Organization, using language more common in Europe, Canada and global public health organizations, has urged that all member states ". . . develop and implement goals and strategies to improve public health with a focus on health inequities . . . (and) to take into account health equity in all national policies that address social determinants of health."[1]

What is the difference, and why does it matter? The Oxford English Dictionary defines disparity as "the quality of being unlike or different," while inequity is "the lack of equity or justice; unfairness." What we see in the distribution of preventable illness and premature death is not mere difference, but rather patterns that reflect underlying social inequities. BARHII, for example, produced a report, *Health Inequities in the Bay Area*, documenting that people who live in poor neighborhoods in the nine-county San Francisco Bay Area can expect to live on average ten years less than people who live in affluent neighborhoods. These social inequities have been well documented in the United States and elsewhere, and explored in the award-winning Public Broadcasting System series, *Unnatural Causes: Is Inequality Making Us Sick?*[2]

Moreover, approaching "health disparities" one disease or population at a time, which characterizes much of public health funding and programs, restricts public health practice to clinical management and prevention or targeted health education. When public health practice focuses on social determinants of health, on the other hand, it ceases to be about one disease or one population. When trying to reduce asthma hospitalization rates among African American children, for example, providing improved clinical management, teaching children and parents about medications and avoiding triggers can be tailored; however, when the focus is on ports, trains, buses and trucks as sources of diesel air pollution, it is no longer specific to individuals with a health condition—it is about the people who live in the neighborhoods most subject to those conditions, and all the health problems that emerge from them.

The challenge of health inequities requires an understanding of how underlying social inequities shape the conditions that affect our health. Inequities based on class, race and gender in the distribution of power and resources, and in the priorities of institutional policies and practices, define the ways in which social determinants of health contribute to health inequities, and to the strategies local health departments would employ to confront them. The work of the Ingham County, Michigan, health department, which is particularly noteworthy in this regard, engages staff at all levels in constructive dialogue about how these larger social forces define the terrain in which public health must now negotiate.[3]

This is the direction in which BARHII and others are trying to move public health practice. A renewed understanding of the social etiology of disease, and how social determinants of health contribute to an inequitable distribution of the burden of disease, require a collective re-thinking of the mission and practice of public health. They also pose a major challenge to the public health workforce, often led by individuals trained in bio-medical

[1] Sixty-second World Health Assembly Recommendations, *Reducing Health Inequities Through Action on the Social Determinants of Health*, World Health Organization, May 22, 2009

[2] See, for example, Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health, World Health Organization, 2008; Richard Wilkinson and Kate Pickett, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, Penguin Books, 2009; John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health, *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S.*, www.macses.ucsf.edu ; Commission to Build A Healthier America, *Beyond Health Care: New Directions to a Healthier America*, The Robert Wood Johnson Foundation, www.commissionhealth.org/; California Newsreel, *Unnatural Causes: Is Inequality Making Us Sick?*, www.unnaturalcauses.org; Bay Area Regional Health Inequities Initiative, *Health Inequities in the Bay Area*, www.barhii.org ; Alameda County Public Health Department, *Life and Death from Unnatural Causes: Health and Social Inequality in Alameda County*, www.acphd.org.

[3] Doak Bloss, *Initiating Social Justice Action through Dialogue in a Local Health Department: The Ingham County Experience and Beyond* in Richard Hofrichter and Rajiv Bhatia (eds.), *Tackling Health Inequities Through Public Health Practice*, Oxford University Press ( Feb. 2010)

sciences, and to the financing, structure and culture of local health departments. This Toolkit is therefore intended not so much to provide measures along some arbitrary standards of progress, but rather to encourage a dialogue among senior managers and staff in local health departments to re-examine their collective understanding of and ability to address the underlying causes of health inequities.

We hope this Toolkit will contribute to the growing momentum urging public health toward a greater focus on social determinants of health and health inequities. On a global scale, the publications and pronouncements from the World Health Organization and important research and practice emerging from Canada and the European Community, and in the United States, the Health Equity and Social Justice Strategic Direction Team of the National Association of County and City Health Officials (NACCHO) and its Local Health Department National Coalition for Health Equity[4] and the powerful influence of *Unnatural Causes: Is Inequality Making Us Sick?* are important forces helping to shape this new direction for public health. This Toolkit coincides roughly with the launching of national public health improvement processes, including the credentialing of the workforce and accreditation of state and local health departments. Accordingly, we hope this Toolkit can contribute to the integration of the link between social justice and health into our mission, practice and forms of accountability. We understand that not all local health departments are in the same situation, or have equal resources to expand the scope of their work. The Toolkit should therefore be used in a manner that reflects local circumstances as the legitimate starting point for dialogue and change.

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Bay Area Regional Health Inequities Initiative (BARHII)
September, 2010

[4] Local Health Department National Coalition on Health Equity, National Association of County and City Health Officials, www.naccho.org/topics/justice/coalition.cfm

## EXECUTIVE SUMMARY

The mission of public health is to assure optimal health and wellness for all people. Within the current public health paradigm, we are doing our best to improve health overall and address health disparities. However, egregious gaps in health outcomes between populations persist. A growing body of evidence links significant differences in health outcomes to race, neighborhood of residency, educational attainment, income, and other social factors. Past and present policies and practices in each of these arenas play a critical role in people's lives and health outcomes, and often hamper public health efforts. How can a policy make people sick? What role do we have as local health departments (LHDs) in addressing issues such as racism and neighborhood conditions? How does our structure and workforce fit into the work that needs to be done in these arenas?

The prospect of addressing societal challenges may seem overwhelming for local health departments, yet the impact of these challenges on health is undeniable. Examples of these challenges include current and historical local, state, and national policies that have segregated communities based on race. As a result, people of color are more likely to live in lower income, less safe, inner-city neighborhoods that lack access to resources like high-quality public transportation, fresh fruits and vegetables, and safe places to walk and play. These neighborhoods tend to have schools with lower quality education for their children, resulting in fewer opportunities for advanced education and well-paying jobs. People with lower-paying jobs are less likely to have good health coverage or access to health promotion resources. The data consistently show that people who live in these conditions suffer worse health outcomes in chronic and infectious diseases, injury, and as a result of disasters and emergencies. Clearly, we must address these societal conditions if we are to reverse the trend of health inequities. This new paradigm of public health seeks to continue providing necessary individual services while also acknowledging and addressing these underlying causes that often stem from policy decisions. As this is a new direction for many LHDs, the Bay Area Regional Health Inequities Initiative (BARHII), a collaboration of eleven local health departments in the greater San Francisco Bay Area, developed the **Organizational Self-Assessment for Addressing Health Inequities Toolkit** (Toolkit). This Toolkit provides public health leaders with tools and guidelines that help identify the skills, organizational practices and infrastructure needed to address health equity and provide insights into steps LHDs can take to ensure their organization can have an impact on these negative policies. The **Organizational Self-Assessment for Addressing Health Inequities** (Self-Assessment) is intended to serve an LHD in the following ways:

- Serve as the baseline measure of capacity, skills and areas for improvement to support health equity-focused activities;
- Inventory the presence of a set of research-based organizational and individual traits that support the ability to perform effective health equity-focused work;
- Provide information to guide strategic planning processes and/or the process of developing and implementing strategies that improve capacities;
- Serve as an ongoing tool to assess progress towards identified goals developed though the assessment process.

To provide a framework for the Self-Assessment, a matrix of organizational and staff competencies needed to address health inequities was developed. This matrix identifies the skills and capacities at both the organizational and individual levels that support an LHD's ability to address health inequities. The Toolkit includes a compendium of instruments that address various elements of the matrix and the guidelines to help LHDs determine if, when, and how to carry out the Self-Assessment. Each tool is designed both to provide information for an assessment at an organizational level and to provide an opportunity for executives, staff, community agencies and other local partners to reflect upon their experiences in addressing health inequities in partnership with LHDs.

The Toolkit includes the following instruments:

1. **Staff Survey**—An online survey tool designed for LHD staff at all levels of the agency to complete. This tool addresses most of the elements included in the Matrix.
2. **Collaborating Partner Survey**—An online survey tool that provides an opportunity for other agencies, organizations and groups that work with the LHD to share feedback and insights regarding health equity work.

3. **Staff Focus Groups**—Facilitated group discussions that are designed for in-depth exploration of elements of the matrix and to gain further information on specific issues informed by the staff survey.
4. **Management Staff Interviews**—Individual interviews with members of an LHD's senior management/leadership team to allow an LHD to further develop an in-depth sense of its organizational strengths and areas for improvement related to addressing health inequities.
5. **Human Resources Data System Worksheet**—A worksheet that can be used to summarize important data gathered during the Internal Document Review and Discussion phase of the assessment. This sheet succinctly illustrates how responsive the HR system is to the diverse needs of the population served by the LHD.

These tools can be found in *Appendix I*.

The development of the self-assessment tools was informed by an extensive review of public health and organizational development literature, as well as a review of existing organizational and cultural competency assessment tools. Guided by the literature review, a team of consultants and BARHII's Internal Capacity Committee worked together to create indicators for each element of the matrix, and then created survey and qualitative instruments to measure these indicators systematically across an organization. Finally, the self-assessment was pilot tested at the City of Berkeley Public Health Division in 2008 and the tools were further refined based on the pilot experience and feedback from staff at that LHD.

In addition to the instruments themselves, the Toolkit contains an implementation guide with information, tools, resources, and bibliography to help LHDs:

- Assess whether they are ready to conduct the Self-Assessment;
- Prepare for the self-assessment;
- Complete the necessary steps for implementing the self-assessment; and
- Engage with the results of the self-assessment in an action-oriented way.

The Self-Assessment requires commitment on all levels of the LHD, dedicated staff, in-kind resources, and time. *Appendix V* provides information on time, resources and other investments required to implement the Self-Assessment. A summary of the key lessons learned from the piloting of the Self-Assessment can be found in *Appendix X*.

LHDs are increasingly seeking ways to do more to address health inequities. This self-assessment can be a key component in improving LHDs' capacity to partner with communities, agencies and organizations to achieve health for all.

# 1. BACKGROUND AND INTRODUCTION

- Background of BARHII's Organizational Self-Assessment
- Framework: Workforce Competencies and Organizational Characteristics for Addressing Health Inequities
- Purpose of the Self-Assessment
- Introduction to the Self-Assessment Tools
- Definitions of Key Terms and Concepts

## Background of BARHII'S Organizational Assessment

In the mid-1990s, the public health directors and health officers of several San Francisco Bay Area health departments gathered to determine whether the disparities in health outcomes among residents in their communities would better be addressed with a regional approach. Issues such as transportation, housing, air and water quality were readily identified as ideal issues that call for a regional solution. In reviewing the health outcomes of communities throughout the Bay Area, it became clear that specific communities appear to consistently experience health inequities based on social determinants such as race, educational attainment, neighborhood conditions, and other characteristics. Because contemporary public health programs were not designed to address social determinants, the public health officials decided to form the Bay Area Regional Health Inequities Initiative (BARHII).

BARHII is a collaboration of eleven local health departments (LHDs): Alameda, Berkeley, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma and Solano. The mission of BARHII is to transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities. Four committees (Internal Capacity, Community, Data, and Built Environment) were formed to begin to determine ways that individual health departments could work on a regional level to improve community health.

The Internal Capacity Committee (ICC), comprised of seasoned public health workers serving as administrators, managers and program coordinators/planners, was charged with identification of professional development and systems changes necessary to "transform" public health. The ICC's initial task in developing these strategies was to construct a matrix of organizational and staff competencies that LHDs need in order to adequately address health inequities (discussed in next section). Using this matrix, the ICC developed the **Organizational Self-Assessment for Addressing Health Inequities** (Self-Assessment). The Self-Assessment is a key initial step for health departments ready to engage in a critical review of their organizational ability to address health inequities.

The development of the Self-Assessment included the following phases:

1. Identification of skills and capacities at the organizational and individual levels that support an LHD's ability to address health inequities.
2. Verification and expansion of these skills and capacities through a review of available literature, as well as a review of existing organizational and cultural competency assessment tools.
3. Specification of each skill and capacity into a measurable indicator.
4. Development of a set of assessment tools to measure each indicator.
5. Pilot-testing and refining the tools at a member LHD.

## Framework: Workforce Competencies and Organizational Characteristics for Addressing Health Inequities

BARHII's Internal Capacity Committee (ICC) identified the skills and capacities at both the organizational and individual levels that support an LHD's ability to address health inequities. These indicators were grouped into domains and two matrices were developed: one for staff skills and competencies and a second for organizational competencies. (See *Appendix II*)

An extensive vetting process was conducted to finalize the matrices. This included clarification of each item, review of public health and organizational development literature to validate the item, and the creation of a glossary of definitions highlighting those indicators essential to address health equity. A "Roadmap" illustrating this process is included in *Appendix III*. See *Appendix XI* for an annotated bibliography of sources reviewed.

The Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities describes the nine domains of organizational characteristics, as well as nine domains of skills and abilities that LHD staff should possess to effectively address health inequities *(see Exhibit 1)*. The matrix, included in *Appendix II*, became the basis for the instruments and protocols contained in the Self-Assessment Toolkit.

EXHIBIT 1

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment to addressing health inequities<br>• Hiring to address health inequities<br>• Structure that supports true community partnerships<br>• Supporting staff to address health inequities<br>• Transparent and inclusive communication<br>• Institutional support for innovation<br>• Creative use of categorical funds<br>• Community-accessible data and planning<br>• Streamlined administrative process | • Personal attributes such as passion, self-reflection and listening skills<br>• Knowledge of public health framework (e.g. Ten Essential Services, public policy development, advocacy, data)<br>• Understanding of the social, environmental, and structural determinants of health<br>• Knowledge of affected community<br>• Leadership<br>• Collaboration skills<br>• Community organizing skills<br>• Problem solving ability<br>• Cultural competence and humility |

## Purpose of the Self-Assessment

The Self-Assessment is designed to:

- Provide LHDs with a comprehensive set of information from a variety of sources about strengths and areas for improvement with respect to skills and capacities that support institutional capacity to address health inequities;
- With results in hand, stimulate internal dialogue about how an LHD can build its capacity to address health inequities and optimally align its functioning with goals to reduce health inequities; and
- Guide strategic planning and other organizational development activities based on a broad set of information about current capacity to address health inequities.
- Provide ongoing measures to assess the LHD's progress towards identified goals developed during the assessment process.

The Self-Assessment is **not** designed to:

- Serve as a community needs assessment; or
- Evaluate cultural competency, quality of care or be used in a setting providing only clinical services with no community engagement component; or
- Plan or evaluate the effectiveness of health department programs (i.e. achievement of outcomes).

The Organizational Self-Assessment for Addressing Health Inequities is fundamentally designed *to provide information for reflection, discussion, planning, and organizational development*.

## Introduction to the Self-Assessment Toolkit

The Toolkit includes a compendium of instruments that address various elements of the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities. Where appropriate, different instruments are used to assess multiple dimensions of a single indicator. These instruments can found in *Appendix I*.

The Toolkit was pilot tested in 2008 at the City of Berkeley Public Health Division (BPHD). The 100 staff of BPHD and approximately 50 collaborating partners were invited to participate in the Self-Assessment. Because the process as well as the instruments were being pilot tested, it is not possible to provide an accurate estimate for the elapsed time for the implementation of the Self-Assessment and the analysis of the data. Rather, time estimates for each step in the Self-Assessment are provided in staff hours. The tools and guidelines were further refined based on the pilot experience and feedback from staff at BPHD. The important Lessons Learned from the BPHD are included in *Appendix X*.

Each instrument is designed both to provide information for an assessment at an organizational level and to provide an opportunity for executives, staff, community agencies and other local partners to reflect upon their experiences in addressing health inequities as a partnership.

The following summarizes the purpose, key elements and audience for each instrument included in the Toolkit.

### Staff Survey

The Staff Survey, designed for LHD staff at all levels of the agency to complete, is the most in-depth instrument in the Toolkit, addressing most of the elements included in the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities. This instrument is administered online to all staff of the LHD using a web-based survey, though it can be offered in hard copy to any staff without online access.

### Collaborating Partner Survey

This survey provides an opportunity for other agencies, organizations and groups that work with the LHD to share feedback and insights regarding their partnership with the LHD and the extent to which it facilitates efforts to address health inequities and the social determinants of health. This instrument is administered online using a web-based survey, though it can be offered in hard copy to any partners without online access.

### Staff Focus Groups

These focus groups are designed for in-depth exploration of elements of the Matrix that are informed by the Staff Survey and Collaborating Partner Survey results and are more suited to discussion and conversation, such as elements of the organizational culture that support skills and practices critical for addressing health inequities. To ensure inclusion of a breadth of perspectives, participants for the focus groups are randomly selected within various strata of the organization.

### Management Interviews

Individual interviews with members of an LHD's senior management/leadership team allow an LHD to further develop an in-depth sense of its organizational strengths and areas for improvement related to addressing health inequities.

### Internal Document Review and Discussion

This provides guidelines for extracting information from key internal documents, work products and data systems, and engaging in critical thinking about what those data sources indicate about existing capacity and action steps for improving capacity. Key data can be summarized using the Human Resources Data System Worksheet (see *Appendix I*).

## Glossary: Definitions of Key Terms and Concepts

A glossary containing definitions of key terms and concepts relevant to health inequities is provided as a background reference for this assessment, and represents the shared understanding of these terms by those that developed the assessment. It can be provided to all staff and collaborating partners participating in the assessment to minimize confusion about what is meant by these terms. In the online versions of the survey tools, the glossary can be accessed on every page. This was written as plainly as possible to address varying levels of education of LHD and collaborating partners' staff. For each term a definition is provided followed by a tangible example of each concept. The example is *italicized* to highlight the subtle differences between these terms. These can be found in *Appendix I*.

# 2. TOOLKIT CONTENTS

**This Toolkit contains information, tools and resources designed to:**

- Help LHD decision-makers assess whether their organizations are ready to conduct the Organizational Self-Assessment for Addressing Health Inequities and whether it will be useful to them;
- Enable executive staff to prepare their organizations for the Self-Assessment;
- Guide the implementation team at LHDs through the necessary steps for completing the Self-Assessment;
- Provide analysts and consultants with the tools to analyze the Self-Assessment findings; and
- Offer ways for leadership and staff to engage together with the results of the Self-Assessment in an action-oriented way.

**Section III** examines the capacity an LHD should have in place before beginning the Self-Assessment and provides recommendations on the preparation that will help the organization get the most out of the experience.

**Section IV** provides specific instructions and recommendations for implementing each of the five Toolkit components: the **Staff Survey,** the **Collaborating Partner Survey,** the **Staff Focus Groups**, the **Management Interviews** and the **Internal Document Review and Discussion**. For each component you will find:

- The purpose of the component, what information it will provide, the advantages and the challenges/limitations associated with it.
- The resources and estimated staff time necessary for completing the component;
- A step-by-step implementation checklist; and
- Information and guidelines to help make key logistical decisions about implementation.

This section also provides recommendations on the selection of components based on the individual needs of each LHD. Key tips from the Berkeley PHD pilot are also included.

**Section V** helps staff interpret the findings from the Self-Assessment and use the information to move the organization toward action that will increase capacity to address the root causes of health inequities in your community.

**Appendix I** contains all of the Self-Assessment instruments to be implemented at an agency.

**Appendix II** contains the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Heath Inequities, which forms the framework of the Self-Assessment.

**Appendix III** contains a "Roadmap" linking the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Heath Inequities to the Self-Assessment Toolkit instruments.

**Appendix IV** includes sample communications with Self-Assessment participants to serve as models for the LHD.

**Appendix V** includes a time and materials budget for an at-a-glance summary of the resources required for implementation of the Self-Assessment.

**Appendix VI** includes a worksheet to document actionable ideas that come out from reflection and discussions about the findings from the Self-Assessment.

**Appendix VII** offers guidelines for managing and analyzing the data yielded by each instrument in the Toolkit.

**Appendix VIII** provides a sample of tables for summarizing the data collected by the Toolkit instruments. While LHDs will likely want to customize how they present findings to staff and others, these tables provide an initial process to help organize and systematically view the Self-Assessment data.

**Appendix IX** provides details for copying, launching, and managing online surveys on Survey Monkey, as well as for downloading survey data once it is collected.

**Appendix X** includes the key lessons learned from the pilot implementation of the Organizational Self-Assessment for Addressing Health Inequities.

**Appendix XI** contains an annotated bibliography of the sources reviewed and utilized in the development of the Self-Assessment.

# 3. Getting Ready: Preparing Your Organization and Staff for the Self-Assessment

The process of Self-Assessment does not occur in isolation from the ongoing work of your agency, nor is it an end in and of itself. LHDs wishing to implement the instruments in this Toolkit must first prepare the organization and staff in a way that will allow the agency to get the most out of the Self-Assessment. The survey tools are designed to capture the depth and breadth of the LHD's experience, capacities and staff skills addressing health equity in the public health setting. The executive leadership and project team should have in mind a clear goal for implementing to the Self Assessment and how results will be used.

## Is your organization ready to take the Self-Assessment?

The following checklist is designed to help you judge whether you can benefit from the Self-Assessment and make use of its findings:

- ☐ You have begun to have conversations about health equity and root causes of health inequities across all the strata of your organization. Prior to involving community partners in the Self-Assessment, you should also have developed relationships and begun these conversations. *This Self-Assessment assumes that the participants of each instrument have had at least an introductory exposure to the key concepts and terms related to the social determinants of health. This Self-Assessment process should not be undertaken without first engaging staff and community partners in some preliminary conversations about these concepts.*
- ☐ The leadership of your LHD is committed to engaging in this comprehensive Self-Assessment exercise, is open to feedback from all levels of staff and of collaborating partners, and intends to translate the findings into action.
- ☐ Your LHD is prepared to invest the time required to complete the necessary steps of the Self-Assessment. The time that it takes an LHD to complete the self-assessment will vary depending on the scale of the assessment that the LHD chooses to undertake as well size of the LHD. Berkeley Public Health Department piloted the entire assessment process with its 100 staff and approximately 50 community partners.
- ☐ The self-assessment explores issues of social inequality and can bring to the surface tensions that may exist in an LHD or in a community. Exploring these issues can create expectations that LHD leadership will address the concerns that have been raised. LHD leadership is prepared to address this likelihood and will take the time to plan its response.
- ☐ You should be clear as an organization why you are undertaking this effort, how you plan on using the results, and how it fits in with other organizational initiatives.
- ☐ You have the staff capacity to manage the implementation of the Self-Assessment and the organizational capacity to communicate effectively with staff and community partners.
- ☐ You have the staff capacity and technological resources to administer an online survey and import the results.
- ☐ You have the staff capacity and technological resources to perform quantitative and qualitative data analysis of survey responses, or have the financial resources to engage a consultant/contractor to do so.
- ☐ You have a partner at a colleague organization or neighboring LHD who can facilitate focus groups, adapt focus group questions and conduct interviews with members of your staff, or you have the financial resources to hire a consultant/contractor to do so.

## Preparing for the Self-Assessment

Once you have determined you are ready to take on the Self-Assessment, the preparation you do with your staff will further influence the impact of the exercise. The following are recommendations for creating and maintaining a constructive context around the Self-Assessment:

- [ ] Lay the groundwork for the Self-Assessment by communicating clearly to all staff why your LHD is undertaking this effort, what it will entail from staff, and how you intend to use the results.
- [ ] Determine which components (or instruments) of the Self-Assessment you will undertake. A more thorough discussion of this is provided in the next section.
- [ ] The timing of the Self-Assessment should coincide with or follow a staff-wide event, such as screenings and discussions of the film series *Unnatural Causes*,[5] to garner momentum and help staff make connections between the Self-Assessment effort and other work of the agency. To avoid over-loading participants, be mindful of other large agency efforts such as other surveys in which staff or community partners are being asked to participate.
- [ ] Plan the implementation of the entire Self-Assessment; avoid large time lapses between activities and ensure that the logistics of the process run smoothly.
- [ ] Take advantage of the Self-Assessment's potential for sparking dialogue, and create opportunities for conversations about health equity and the assessment activity and results.
- [ ] Communicate Self-Assessment results and next steps back to staff and collaborating partners in a timely manner, and involve staff from all levels of the agency as well as collaborating partners in any action planning that follows the Self-Assessment.

[5] California Newsreel, *Unnatural Causes: Is Inequality Making Us Sick?*, www.unnaturalcauses.org

# 4. IMPLEMENTING THE SELF-ASSESSMENT TOOLKIT

- Important Implementation Considerations
- Staff Survey
- Collaborating Partner Survey
- Staff Focus Groups
- Management Interviews
- Internal Document Review and Discussion

## Important Implementation Considerations

The implementation of the self-assessment requires a committed effort of time and resources. A timeline and implementation plan need to be developed prior to the launching of the assessment. The plan should take into account all of the resources required to carry-out the necessary steps to successful completion of the assessment: review and refinement of the assessment tools, communication and promotion of the assessment process, implementation, and analysis of the assessment results. The following section outlines detailed implementation requirements and timelines for each assessment tool.

It is recommended that the LHD identify a project coordinator and organize one or more implementation teams to oversee and conduct the assessment exercise. The team should include staff members representing various functions and areas of the agency. The size of the team will vary with agency size, but 4–7 people should be large enough to share the workload and small enough to be nimble and responsive.

Suggested membership of the implementation team include:

- ☐ A member of the senior leadership team to expedite decision-making;
- ☐ Staff from different agency sites so that all areas of staff have a "personal ambassador" on the implementation team and have a familiar face to approach with questions;
- ☐ Someone whose position is integrally involved in other health equity activities and projects, providing continuity with related organizational efforts;
- ☐ Someone who is recognized agency-wide as a person who can help get things done, is persistent, and not easily ignored;
- ☐ A person with epidemiology or other analysis background who helps organize and guide the analysis of responses; and
- ☐ Someone with web/internet experience who can lead survey tool creation and manipulation.

The assessment tools are designed to capture the depth and breadth of the LHD's experience, capacities and staff skills addressing health equity. While the completion of all of the tools will provide your LHD with the most useful information for understanding and planning to build capacity to address health inequities, the unique circumstances of each LHD will dictate which instruments are most appropriate to implement. The *Staff Survey* will provide information with the most breadth about the organizational practices and culture. The *Collaborating Partners Survey* will provide your organization with the best information about your ability to work effectively with partners outside the organization to address health inequities. The remainder of the instruments deepen the understanding that the survey results can yield.

The implementation team may decide to eliminate, re-word or re-order questions to meet the LHD's situation. It is recommended that before selection of instruments and tailoring questions, the LHD project team identify the domains and indicators most relevant to the LHD's mission. The "Roadmap" in *Appendix III* can assist in selecting the instrument and editing the questions. Tailoring the self-assessment tools and questions may require additional time and resources, which should be added to the LHD's timeline and implementation plan.

## Staff Survey

### I. Purpose

The Staff Survey is administered to staff members to determine the LHD's capacity to address the root causes of health inequities from the perspectives of staff throughout the agency. In addition to providing information for an organizational assessment, the survey gives staff an opportunity to reflect on their own experiences in addressing health inequities through their work in the department. *The Staff Survey is the backbone of the Toolkit, and should be the first instrument administered*. The findings of the survey can stand alone to inform action planning, and can also be used to inform decisions on which elements of the Staff Focus Group and Management Interview protocols to prioritize for further investigation.

In order to streamline the survey distribution and data management processes, the instrument was designed using Survey Monkey, an online survey tool.

**Advantages:** The Staff Survey is inclusive of all staff levels and perspectives, is efficient to administer and monitor, and does not require data entry because the online survey responses can be automatically downloaded into a database. It is the best way to get a large amount of information from a large number of people. Responses can easily be tracked and reminders sent to participants who have not yet completed the survey. Another benefit of an online survey is that data are automatically collected and ready to be exported for data management and analysis without data entry.

**Challenges and Limitations:** As with any large survey, it is unable to capture contextual information for individual responses, and its one-size-fits-all approach may mean that across all agency sites and programs, not all staff will find all questions relevant or framed just right for the way they do their work. Additionally, the data management and analyses required for exploring the survey's findings require a skilled analyst and may be time consuming.

**Use the staff survey to:**

- Get an organization-wide picture of attitudes, practices, competencies and structures that indicate a capacity to address root causes of health inequities.
- Hear from all staff about what supports their ability to address health inequities and what makes it challenging to do so, including those staff that don't often have a voice in planning and organizational decision-making processes.
- Identify priority areas for developing staff capacity and improving organizational functioning to support health equity efforts.

The Staff Survey is the most in-depth instrument in the Toolkit and addresses most of the elements included in the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities. The specific domains addressed by the Staff Survey include:

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment<br>• Hiring to address health inequities<br>• Structure that supports true community partnerships<br>• Support staff to address health inequities<br>• Transparent and inclusive communication<br>• Institutional support for innovation<br>• Community accessible data & planning<br>• Streamlined administrative process | • Personal attributes<br>• Knowledge of public health framework (e.g. Ten Essential Services, public policy development, advocacy, data)<br>• Understand social determinants of health<br>• Community knowledge<br>• Leadership<br>• Collaboration skills<br>• Community organizing<br>• Problem solving<br>• Cultural competency/humility |

## II. Implementation

### Staff Time and Resources

The table below shows the estimated investment required for implementing the Staff Survey. Note that it may take 2-3 weeks from the time the survey link is distributed to get all staff to complete the survey and multiple reminders will likely be necessary.

| Survey Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Convening Implementation Team/Survey Preparation | Leadership and Selected Staff | 5-10 hours per person |
| Communicating with Staff | Leadership, Implementation Team and Managers | 5-10 hours per person |
| Managing Survey | Selected Implementation Team Member | 8-12 hours |
| Completing the Survey | All Staff | 20-45 minutes per person |
| Data Management and Analysis | Analyst | 10-15 hours for data management;<br>15-40 hours for data analysis, including qualitative analysis of open-ended survey items; this may vary depending on size of LHD |

**Additional Resources Needed:**

- Subscription to online survey tool
- Computer and Internet access for staff
- In-house expertise and resources or external consultant for survey administration and/or data analysis

### Implementation Plan

The checklist below provides recommended steps for implementing the Staff Survey:

☐ **Review and Preparation of the Staff Survey**

The Implementation Team should review the Staff Survey to modify as needed. It is recommended that you administer the entire Staff Survey instrument. However, if the circumstances of your LHD do not warrant using all the questions, the Roadmap in *Appendix III* provides guidelines to help you determine which questions would be most appropriate to the needs of your LHD. It suggests a set of core questions to include in the Staff Survey and illustrates how survey questions correspond to the

Matrix of Workforce competencies and Organizational Characteristics elements. Once the survey questions have been selected, the survey must be prepared in the online survey tool of choice. BARHII will proved a copy of a ready-to-use tool on *SurveyMonkey* which can be copied and edited. One Implementation Team member should be in charge of coordinating the survey.

☐ **Set Goals and Develop Implementation Plan**

The Implementation Team should set a response rate goal and develop an implementation plan to reach that goal. The implementation plan should include steps to inform all staff members of the Staff Survey and incentives to help encourage more staff members to participate in the survey.

It is important for LHD leadership to convey that this is a priority effort and that staff have explicit permission to spend time on the survey.

**Berkeley Pilot Experience: Ideas for Increasing Staff Survey Response Rates:**

**Staff Outreach Strategies:** The Berkeley Public Health Department (BPHD) Implementation Team facilitated meetings to inform staff members of the Staff Survey's purpose and significance.

**Incentives:** The BPHD also provided incentives for completing the Staff Surveys. Incentives were determined based on completion rates:

- 90% completion rate – All staff would receive a chocolate thank you and be entered in a raffle for ten $10 *Peet's Coffee* gift cards and five $10 *Target* gift cards.
- 85% completion rate – All staff would receive a chocolate thank you and be entered in a raffle for ten $10 *Peet's Coffee* gift cards.
- 80% completion rate – All staff would receive a chocolate thank you and be entered in a raffle for five $10 *Peet's Coffee* gift cards.

Using these strategies Berkeley Public Health Department had an 81% completion rate

☐ **Administration of the Staff Survey**

(Coordinated by one Implementation Team Member)

- Compile a list of all staff members and their email addresses.
- The lead executive or public health official sends an introductory email or letter before the online survey is administered to share the purpose of the assessment being undertaken and to convey the importance of staff participation. See *Appendix IV* for a sample introductory letter from a public health official inviting staff members to participate in the survey.
- External consultant or selected staff member administers the survey online. *SurveyMonkey* is one suggested current online survey provider that is easily accessible, user friendly, and inexpensive. *Appendix IX* provides an administration guide for *SurveyMonkey*.
- To maintain confidentiality if a unique link is used (see below for explanation), external consultant or selected staff member monitors the survey responses and sends reminders to staff members who have not completed the survey. LHD leadership and implementation teams should not be provided with the responses

**Recommendation**

If no external consultant will be contracted, choose one staff member that will administer and monitor all survey responses and keep responses confidential.

or response status of any individual staff member. If a generic link is used, all responses are anonymous.

- After reaching the completion rate goal, external consultant or selected staff member begin the data analysis and management. *SurveyMonkey* analysis offers the ability to provide summary reports, trend analysis, and basic visual formats to present data in a customized format. Further analysis may be required using another program. Also, qualitative data will require a more in-depth analysis than *SurveyMonkey* can provide. It is recommended that the response data be exported into SPSS (or other data analysis software package) for data management and analysis.

*See Appendix VII for technical guidelines on how to manage and analyze Staff Survey data.*

## III. Key Considerations

### Survey Links

When administering online surveys, there are generally two types of survey links that can be used: a generic link or a unique link.

**Generic Link:** When a generic link is provided, staff members will all receive the same link. Every time the link is clicked, a blank survey uploads no matter what computer or email account is being used.

**Advantage:** Using a generic link will allow staff members to forward the link along to other colleagues. With a generic link it would be impossible to enter a survey that has already been started by someone else. Generic links allow staff to be entirely anonymous, even to the survey administrator, so staff may be more forthcoming.

**Disadvantage:** Since a blank survey uploads when a generic link is clicked, staff members would not be able to revisit a survey they have already started. They would have to complete the whole survey in one sitting. Also, the person monitoring the survey will not be able to follow-up with non-responders since all responses received from the generic link will not be tied to individual email addresses. Thus, it will not be known who has and has not responded. Another disadvantage is that it possible for a single individual to answer the survey more than once, which could skew the results.

**Unique Link:** A unique link is provided to each staff member.

**Advantage:** Using a unique link, the person monitoring survey responses can track who has not yet responded and follow-up with them individually if necessary. Staff members will also be able to save their unfinished surveys and revisit their link later to finish.

**Disadvantage:** The unique link cannot be forwarded, as it corresponds only to the staff member it is sent to. With a unique link, there's a risk that some staff members will still forward their link even if instructed not to, and staff members using the same link could view and

**Red Flag**

If your department decides to use unique links to administer the survey, make sure to continue stressing that the unique link CANNOT be forwarded from person to person, even for purposes of promoting the survey. Instead, the implementation team could provide sample emails for supervisors and managers to send to their staff as reminders to follow their own link or how to get it if lost. Be aware of the survey management risks using the unique link option.

overwrite each other's responses. Survey information is not entirely anonymous, since the administrator can track responses tied to staff names.

**Berkeley Pilot Experience with Survey Links**

The BPHD chose to use unique links during the pilot assessment. They felt that concerns about confidentiality would be reduced by using an external, non-health department survey administrator and the ability to track individuals would help with response rates.

Staff appreciated being able to save unfinished surveys to be completed at their convenience. However, Berkeley did encounter significant problems with supervisors forwarding links to encourage staff to complete the survey. In spite of clear directions asking that links not be forwarded, this happened numerous times and caused confusion as previously completed surveys were overwritten and data lost.

### Staff Follow-up

After the survey is closed, staff should be notified of the final response rate, thanked for their time and participation, and informed about next steps in the Self-Assessment. If an incentive was offered, prizes should be awarded promptly. Timely follow-up is both respectful of staff input and encouraging of further dialogue and participation among staff.

## Collaborating Partner Survey

### I. Purpose

The Collaborating Partner Survey provides an opportunity for other agencies, organizations and groups that work with the LHD to share feedback and insights regarding their partnership with the LHD and how it facilitates public health approaches, strategies and activities that help address health inequities and the social determinants of health.

**Advantages:** This survey allows the LHD self-assessment to benefit from the perspectives of outside agencies and organizations. As with the Staff Survey tool, an online survey tool, such as *SurveyMonkey*, is an efficient way to reach many partners, and eliminates the need for data entry. Additionally, this survey includes many open-ended questions to allow partners to contextualize their responses and provide detailed information about how the LHD does or can address the root causes of health inequities.

**Challenges and Limitations:** Because some collaborating partners may not have access to the online survey format, be prepared to offer a paper version that you can mail to those participants, if you have the capacity to manually enter and analyze the data. Because of the rich information solicited by the open-ended questions integrated into this survey, a moderate amount of qualitative analysis will be required, which is more time consuming than an exclusively quantitative questionnaire.Moreover, keep in mind that some collaborating partners may not be comfortable with survey-taking and that a more open-ended discussion might be more productive.

Questions in this survey included the following elements of the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities:

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional Commitment<br>• Structure that supports True Community Partnerships<br>• Transparent and Inclusive Communication<br>• Community Accessible Data & Planning | • Community Knowledge<br>• Community Organizing<br>• Cultural Competency/Humility |

### II. Implementation

#### Staff and Community Partners' Time and Resources

The table below shows the estimated investment required for implementing the Collaborating Partner Survey.

| Survey Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Convening Implementation Team/ Survey Preparation | Leadership and Selected Staff | 2-5 hours per person |
| Identifying and Communicating with Partners | Leadership, Implementation Team and Managers | 2-8 hours per person |
| Managing Survey | Selected Implementation Team Member | 8-12 hours |
| Completing the Survey | Selected Partners | 15-25 minutes per person |
| Data Management and Analysis | Analyst | 6-8 hours for data management; 10-12 hours for data analysis, including qualitative analysis of open-ended survey items; this may vary depending on the number of participants |

**Additional Resources Needed:**

- Subscription to online survey tool
- In-house expertise and resources or external consultant for survey administration and/or data analysis

## Implementation Plan

The preceding table shows the estimated investment required for implementing the Collaborating Partner Survey:

☐ **Create an Implementation Team**

☐ **Review of the Collaborating Partner Survey**

The Implementation Team should review and tailor the Collaborating Partner Survey to modify any language that is not relevant or clear in the context of your community and your work with the partners receiving the survey. It may be useful for the team to consider the reading level of the potential respondents. While a glossary of key terms is available for survey participants, many of the questions are related to complex Public Health ideas and functions. BARHII will proved a copy of a ready-to-use tool on *SurveyMonkey* which can be copied and edited. See *Appendix IX* for guidelines on using *SurveyMonkey*.

☐ **Identifying Partners**

Management staff and the Implementation Team should select collaborating partners to participate in the survey. See Key Considerations below for identifying partners.

☐ **Administration of the Partner Survey**

- The public health official should send an introductory email or letter before the online survey is administered to share the purpose of the assessment and to convey the importance of the partner's participation. For a sample introductory letter from a public health official inviting collaborating partners to participate in the survey, see *Appendix IV*.
- An external consultant or selected staff member administers the online survey tool.
- To maintain confidentiality, an external consultant or selected staff member monitors the survey responses and sends weekly reminders to partner representatives who have not completed the survey.
- *SurveyMonkey* offers limited quantitative analysis. It is recommended that after reaching the completion rate goal, an external consultant or selected staff member exports all responses into SPSS for data management and analysis. Qualitative data will require additional analysis. See further discussion under Staff Survey section (page 20).
- After the survey is closed, community partners should be notified of the final response rate, thanked for their time and participation, and informed about next steps in the Self-Assessment.

**Recommendation**

If no external consultant will be contracted, choose one staff member that will administer and monitor all survey responses and keep responses confidential.

*See Appendix VII for technical guidelines on how to manage and analyze partner survey data.*

## III. Key Considerations

### Survey Modality

**Online Survey:** The survey can be created using an online survey provider such as *SurveyMonkey*. A link should be sent to each survey participant through an email distribution.

**Advantage:** Online surveys are easier to administer and monitor. Responses can easily be tracked and reminders sent to participants who have not yet completed the survey. Another benefit of an online survey is that the data are automatically collected and ready to be exported for data management and analysis without data entry.

**Recommendation**

After sending an email invitation for an online survey, closely monitor the response rate. If there's a low response rate, contact a sample of survey participants to see if the email with the survey link is being automatically filed as junk mail.

**Disadvantages:** The risk of sending an online survey with a large distribution list is that your email may be classified as junk mail and the recipient may never see the email. If you find that this is the case, try sending a generic link through a personal email or send a paper survey. Another disadvantage of the online method of survey administration is that those without regular, private access to a computer and the internet may not be able to respond to the survey and cannot have their perspectives heard. Based on your list of desired survey respondents, you may decide to make a paper survey available to mail to those who cannot participate online.

### Identifying Community Partner Organizations to Participate in the Survey

The following criteria for selecting community-based organizations, community groups and other public agencies to invite to participate in the Collaborating Partner Survey aim to ensure that a variety of external perspectives are included and that the responses are as relevant and useful as possible to the LHD.

All community partners included in the Self-Assessment should:

- Work with communities most affected by health inequities;
- Provide critical services or advocacy efforts for the LHD and/or the communities served by the LHD;
- Have a basic understanding of public health functions; and
- Have a pre-existing relationship with the LHD.

In considering the particular individuals who will complete the survey, include a relevant cross section of staff from organizations, from line staff to senior management as well as a set of individuals carrying out varying roles within organizations and groups with less formal structures.

Additionally, selected organizations and groups should represent a variety of:

- Sizes (large, medium, small)
- Populations served (consider race/ethnicity, geography, age spectrum, and other community characteristics)
- Issues addressed:
  - Health focused vs. non- health focused
  - Specific service/issue areas such as communicable disease, mental health, transportation, environmental justice, health care access, substance abuse, violence and injury, housing, etc.
- Sectors and organization types:
  - Academic
  - Advocacy
  - Direct service
  - Community-based
  - Public
  - Private/business
  - Neighborhood associations
- Levels of partnership with the LHD
  - Former (not collaborating with the LHD but has in the past)
  - Minimal (networking/information sharing only)
  - Some (activity coordination/cooperative)
  - Extensive (collaborative partnership, or funded by the LHD)

### Survey Links

When administering online surveys, there are generally two types of survey links that can be used: a generic link or a unique link. For more details, see discussion on page 20 in the Staff Survey section.

## Staff Focus Group

### I. Purpose

The Staff Focus Groups are designed to explore issues that are more suited to discussion and conversation than a survey, such as elements of organizational culture that support skills and practices critical for addressing health inequities. The focus groups also can be used to get deeper and more contextualized information about some of the same elements of the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities addressed or assessed in the Staff Survey.

**Use staff focus groups to:**

- Facilitate discussion about organizational culture and other matters difficult to capture in a survey.
- More deeply explore issues identified by the staff survey.
- Provide a safe space for staff to talk with each other about organizational factors affecting their ability to contribute to health equity work and elevate their feedback to the attention of LHD leadership.

**Advantages:** The focus groups offer a way to elicit in-depth information about staff perceptions, experiences, knowledge and ideas about the LHD's capacity to address the root causes of health inequities. The richness of this qualitative information adds depth, context and clarity to the Staff Survey findings and can be used to further explore issues raised in the survey.

**Challenges and Limitations:** Because focus groups are most effective with relatively small numbers of participants, some voices and perspectives may be missed. However, in combination with the Staff Survey, this is a minimal concern. The large amount of qualitative data generated by the focus groups is time-consuming to analyze and must be done by someone with experience and skill in synthesizing such content.

The specific elements addressed by the focus groups include:

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment<br>• Hiring to address health inequities<br>• Structure that supports true community partnerships<br>• Support staff to address health inequities<br>• Transparent and inclusive communication<br>• Institutional support for innovation | • Personal attributes<br>• Knowledge of public health framework (e.g. Ten Essential Services, public policy development, advocacy, data)<br>• Understand social determinants of health<br>• Community knowledge<br>• Leadership<br>• Collaboration skills<br>• Community organizing<br>• Problem solving<br>• Cultural competency/humility |

### II. Implementation

#### Staff Time and Resources

The table on the following page provides an estimate of the investment required for implementing the Staff Focus Groups.

| Focus Group Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Reviewing focus group protocol and customizing to reflect survey findings and LHD priorities | Facilitator, with assistance from Implementation Team member | 10 hours |
| Selecting and Scheduling Staff | Facilitator, with assistance from Implementation Team member | 1 hour to manage and randomize staff lists, 2 hours to schedule |
| Preparing for and Facilitating Focus Groups | Facilitator | 2 hours per focus group, plus travel time if necessary |
| Participating in the Focus Group | Selected Staff | 90 minutes |
| Qualitative Data Analysis | Analyst/Consultant | 15-20 hours; this will vary depending on the number of focus groups |

**Additional Resources Needed:**

- Private meeting room, possibly off-site (but nearby), in which to conduct the focus groups.
- *Optional:* Digital recorder to record interviews and funds for a professional transcription service.
- If not trading facilitation services with a colleague organization/neighboring LHD, funds to secure a consultant to facilitate the focus groups and analyze the data.
- Refreshments for participants.

*See below for additional discussion regarding third-party facilitation for staff focus groups and analysis of focus group data.*

## Implementation Plan

The checklist below provides recommended steps for convening Staff Focus Groups:

- [ ] **Determine an Appropriate Facilitator**

The facilitator chosen to implement this component of the Toolkit should have experience in leading focus groups, and should have knowledge of public health practice, social determinants of health and health inequities. To ensure a safe environment for staff participants, it is **strongly recommended** to have an individual external to the LHD facilitate the focus groups. If resources are not available to hire a consultant, one cost-saving solution is to partner with a neighboring LHD that would also like to engage in the Self-Assessment, and find an appropriate staff member in each LHD to facilitate the focus groups of the partnering LHD.

Another option for minimizing costs is to hire a consultant to facilitate the groups and provide transcripts of the focus groups with any identifying comments removed, so that the analysis of these qualitative data can be performed by internal LHD staff with the capacity and skills to do so.

- [ ] **Review and Customize the Focus Group Protocol**

The Implementation Team or a subset should review the protocol to ensure that the language and questions are relevant to the LHD, and to prioritize questions based on Staff Survey findings and other agency needs.  Use the Roadmap in *Appendix III* to help guide the customization.

- [ ] **Determine the Number of Focus Groups to be Held**

The number can vary with the size of your LHD. If possible, more than one focus group should be held to provide a broad set of perspectives. In the pilot, the City of Berkeley Public Health Division conducted one focus group with management level staff and two with program-level staff.

- [ ] **Designate a Coordinator/Liaison**

Select a member from the Implementation Team to serve as a coordinator and liaison to work with the facilitator.

This coordinator/liaison will be responsible for:

- Compiling a contact list of all staff with their name, email and phone contact information, job title, and agency site or division, as applicable.
- Creating stratified "pools" of staff from which the facilitator can randomly select focus group participants; each pool should be constructed based on similar staff level and include staff from a mix of program areas, sites, and racial/ethnic backgrounds to provide as diverse a voice as possible in each group.
- Providing the facilitator/consultant with contact and other relevant information about the staff in each pool so that the facilitator can directly select focus group participants without sharing identities with the Implementation Team.
- Assisting the facilitator with securing a focus group site as needed.
- Providing the facilitator with the focus group protocol and any background information about the LHD and the Self-Assessment that would be relevant to their role as facilitator.

- [ ] **Communicate with Staff about the Focus Groups**

As with the survey, it is important that staff understand this to be both an agency priority and an approved use of their time. After the facilitator is selected and the agency is ready to implement the focus groups, the the public health official or lead executive should send a communication to all staff announcing the focus groups, discussing their purpose and why they are important, and making explicit that staff members have permission to use work time to participate in the group if they are contacted by the facilitator, and in fact are strongly encouraged to do so. See *Appendix IV* for sample staff communications about the focus groups.

- [ ] **Select the Focus Group Participants**

To maintain confidentiality and a safe space for focus group participants to be candid, management and program-level staff should participate in different focus groups. In addition, the facilitator should be the one to select the actual staff members that will participate in the focus groups. From the stratified pools of potential staff, the facilitator will randomly select 8-10 people to make up each group. One easy way to do this is to assign each person in each pool a consecutive number, and then use an online random number generator, such as http://www.randomizer.org to randomly select 8-10 numbers from each pool.

- [ ] **Schedule and Conduct the Focus Groups**

The facilitator finds times that work for the selected participants, works with the Implementation Team Liaison to secure a site for the confirmed group time, and conducts the groups. The groups should be scheduled for 90 minute sessions and refreshments should be provided.

- [ ] **Thank the Staff for their Participation**
  The facilitator should follow up with participants to let them know their time and participation was appreciated. See *Appendix IV* for sample thank you letters to email the participants after the focus groups.

*See Appendix VII for technical guidelines on managing and analyzing Staff Focus Group data.*

## III. Key Considerations

### Selecting Staff

The Staff Focus Groups are important not only in their ability to capture rich, contextual qualitative data beyond the capabilities of a survey, but also it is an opportunity to give direct meaningful voice to those with the least power in the organization. Random selection of participants by a neutral facilitator helps protect against selection bias. It can also facilitate inclusion of a more diverse set of views from across the department that can help produce a more accurate assessment. Ensuring that the levels of staff that are least often involved in decision-making are most represented in the focus groups is a way to increase equity of participation in the Self-Assessment and elevate the insights and experiences of these staff in a way that might not otherwise happen.

### Emphasize Confidentiality

Because the issues and experiences discussed by staff in the focus groups are often sensitive and personal, it is of utmost importance to establish clear confidentiality guidelines and communicate them clearly to the staff participating. Let them know all the ways that their identities will be protected, from the random selection by an external facilitator to the anonymous nature of the notes captured in the groups.

It is also important for staff to know who else is in the room with them. Especially in larger LHDs, staff may not all know each other and may assume that management level staff members are in the room with them. Start by asking people to introduce themselves and their positions so that a tone of equality can be established in the room and people can feel more comfortable sharing information that they may not normally share at work.

## Management Interviews

### I. Purpose

The interviews with senior management staff members provide another opportunity to collect in-depth information about an LHD's organizational strengths and areas for improvement related to addressing health inequities, this time from the perspective of those in leadership and decision-making positions.

**Advantages:** The interviews provide an opportunity to explore with management and leadership staff how the LHD's processes, structures, and culture influence its capacity to address the root causes of health inequities. As with the focus groups, this qualitative information adds depth, context and clarity to the Staff Survey findings and can be used to further explore issues raised in the survey.

**Challenges and Limitations:** Because the interviews will be conducted with a relatively small numbers of staff, some voices and perspectives may be missed. However, in combination with the Staff Survey and focus groups, this is of minimal concern. The large amount of qualitative data generated by the interviews is time-consuming to analyze and must be done by someone with experience and skill in synthesizing such content.

**Use management interviews to:**

- Collect information about organizational culture, institutional commitment, and decision-making processes directly from the perspective of organizational leaders.
- Explore issues identified by the staff survey and focus groups with senior managers and leaders of the LHD.
- Provide a dedicated time and space for management staff to reflect individually on the LHD's work to address the root causes of health inequities.

Questions in the interview protocol are intended to measure the following elements of the Matrix of Organizational Characteristics and Workforce Competencies for Addressing Health Inequities:

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment<br>• Hiring to address health inequities<br>• Structure that supports true community partnerships<br>• Transparent and inclusive communication<br>• Institutional support for innovation<br>• Community accessible data & planning<br>• Streamlined administrative process | • Personal attributes<br>• Knowledge of public health framework (e.g. Ten Essential Services, public policy development, advocacy, data)<br>• Community knowledge<br>• Collaboration skills<br>• Cultural competency & humility |

### II. Implementation

#### Staff Time and Resources

The table on the following page shows the estimated investment required for implementing the Management Interviews.

| Management Interviews Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Reviewing focus group protocol and customizing to reflect survey findings and LHD priorities | Leadership and Implementation Team | 5 hours |
| Selecting and Scheduling Staff | Facilitator, with assistance from Implementation Team member | 1 hour to manage and randomize staff lists, 2 hours to schedule |
| Preparing for and Conducting Interviews | Facilitator | 1 hour per interview, plus travel time if interviews are in-person |
| Participating in the Interview | Selected Management Staff | 1 hour |
| Qualitative Data Analysis | Analyst/Consultant | 10-12 hours |

**Additional Resources Needed:**

- Private meeting room/office, possibly off-site (but nearby), in which to conduct the interviews. Interviews can also be conducted over the phone.
- *Optional:* Digital recorder to record interviews and funds for a professional transcription service.
- If not trading interview services with a colleague organization/neighboring LHD, funds will be needed to secure a consultant to conduct the interviews and analyze the data.

*See below for additional discussion regarding third-party interviewing and analysis of interview data.*

## Implementation Plan

The checklist below provides recommended steps for conducting the Management Interviews:

☐ **Determine an Appropriate Facilitator**

As with the Staff Focus Groups, the individual chosen to implement this component of the Toolkit should have experience conducting interviews, and should have knowledge of public health practice, social determinants of health and health inequities. It is strongly recommended to have an individual external to the LHD conduct the interviews, either in person or by phone. If resources are not available to hire a consultant, one cost-saving solution is to partner with a neighboring LHD that would also like to engage in the Self-Assessment, and find an appropriate staff member in each LHD to interview staff from the partnering LHD.

Another option for minimizing costs is to hire a consultant to conduct the interviews and provide transcripts of the focus groups with identifying information and comments removed so that the analysis of these qualitative data can be performed by internal LHD staff with the capacity and skills to do so.

☐ **Review and Customize the Interview Protocol**

The Implementation Team or a subset should review the protocol to ensure that the language and questions are relevant to the LHD, and to prioritize questions based on Staff Survey findings, focus group themes and concerns, and other agency needs. The Roadmap in *Appendix III* can assist in customization.

☐ **Determine the Number of Interviews to be Conducted**

The number can vary with the size of your LHD and leadership team. Staff members with the administrative and budgetary authority to make changes in your LHD should all be considered. In general, it is not necessary to conduct more than 10-12 interviews; if this number represents an overwhelming proportion of your LHD's senior management staff, then fewer may be selected. If your leadership team is extremely small, on the other hand, the Implementation Team may choose to add additional staff with management responsibilities to the list of potential interviewees.

☐ **Designate a Coordinator/Liaison**

Select a member from the Implementation Team to serve as a coordinator and liaison to work with the interviewer.

This coordinator/liaison will be responsible for:

- Compiling a contact list of all senior management staff with names, email and phone contact information, job titles, and division, as applicable, from which the interviewer can randomly select interview participants.
- Assisting the interviewer with securing interview locations as needed.
- Providing the interviewer with the interview protocol and any background information about the LHD and the Self-Assessment that would be relevant to their role as interviewer.

☐ **Communicate with Staff about the Interviews**

Although management staff members are likely to be highly aware of the ongoing Self-Assessment, it may still be helpful for the public health official or lead executive to communicate that their participation in the interviews should be prioritized. This communication can also alert staff of the individual that will be contacting them to schedule the interviews.

☐ **Select the Interview Participants**

To maintain confidentiality and a safe space for interviewees to be candid, the interviewer should be the one to select the actual staff members that will participate in the interviews. One easy way to randomly select interviewees is to assign each person from the pre-screened list of potential participants a consecutive number, and then use an online random number generator, such as http://www.randomizer.org to randomly select the appropriate number of participants from the list provided.

☐ **Schedule and Conduct the Interviews**

The interviewer finds times that work for the selected participants, decides with the interviewee if a phone or in-person meeting would be best, and conducts the interviews as arranged. Staff should allow one hour for the interview. The interviewer should record the interviews with a digital recorder, if possible, or take notes as close to verbatim as possible during the interview.

☐ **Transcribe the Interviews**

A professional transcription service is the easiest way to obtain a full transcript of each interview. If costs are prohibitive, then the external partner who conducted the interviews should transcribe the responses from the taped interviews.

*See Appendix VII for technical guidelines on managing and analyzing the interview data.*

## III. Key Considerations

### Strategic Selection of Questions

The interview protocol included in *Appendix I* contains more questions than can be discussed within the suggested interview length of one hour. Before conducting the interviews at your LHD, it is important to prioritize the questions that will add the most value to your Self-Assessment given your own needs and context, and communicate clearly to the consultant or partner who will conduct the interviews about your goals for the interviews.

## Internal Document Review and Discussion

### I. Purpose

Although much of the Self-Assessment is dedicated to generating new information from staff and partners about the LHD's capacity to address health inequities, the LHD's internal documents, work products, and data systems contain rich information about many aspects of the LHD's capacity. Compiling key data from a selective, strategic review of these materials can help the LHD further identify areas of particular strength, identify where to focus on building capacity and provide benchmarks for future assessments. *Some of the most salient data gathered during this phase can be summarized using the Human Resources Data System Worksheet included in Appendix I.*

**Use document review and discussion to:**

- Answer key questions about institutional commitment and capacity to address health inequities.
- Provide a venue for various staff from across the agency to engage in critical thinking about how organizational documents and work products might show evidence of addressing the root causes of health inequities.

**Advantages:** A systematic review of internal documents and data provides concrete evidence of an LHD's institutional commitment. Discussions of the data and observations yielded by this review offer an opportunity to invite critical thinking from a variety of staff about existing capacity and action steps for improving capacity.

**Challenges and Limitations:** Compiling all materials and information listed in this section is time-consuming and may not yield consistently relevant or useful information. This process is best completed with strategic modifications and selectivity to ensure that your LHD's priorities are served.

This tool addresses the following domains of the Matrix of Organizational Characteristics and Workforce Competencies for Addressing Health Inequities:

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment to address health inequities<br>• Hiring to address health inequities<br>• Structure that supports true community partnerships<br>• Support staff to address health inequities<br>• Creative use of categorical funds<br>• Community accessible data & planning | • Personal attributes (reflecting diversity of community)<br>• Knowledge of public health framework<br>• Understands the social, environmental and structural determinants of health<br>• Community knowledge<br>• Leadership<br>• Cultural competency and humility |

### II. Implementation

#### Staff Time and Resources

Staff time required to review existing documents and data depends significantly on the items chosen and prioritized by the LHD, as well as on the number and groupings of staff convened to discuss the information compiled in such reviews.

#### Implementation Plan

Implementation of the Internal Document Review and Discussion can vary greatly based on LHD priorities and, therefore, has the most room for customization. The steps suggested here provide a broad framework for engaging in a review and discussion of existing internal materials and should be modified to fit the needs of your LHD.

☐ **Internal Document Review Guidelines**

The following questions are meant to identify priority areas of your inquiry into existing documents and materials at your LHD. Because time and staff resource constraints likely will not allow for full review of all possible materials, a deliberate prioritization of the following lines of inquiry will help narrow the review activities. The following questions explore the institutional commitment to addressing health inequities. Select the questions that are the most timely, relevant, and useful to your agency.

### Guiding Principles Address Health Inequities

1. Do the mission, vision and values reflect an institutional commitment to addressing health inequities?
2. Do the LHD goals, strategies, plans and benchmarks support the concept of health equity as a goal of public health practice and a basic social right?
3. Does the LHD integrate addressing root causes of health inequities into the institution's employee orientation, workforce development, program development and performance monitoring activities?
4. Does the LHD integrate the public health framework (e.g. essential services, strategic partnership development, policy-development, policy advocacy and community organizing) into the institution's employee orientation, workforce development, program development and performance monitoring activities?

### Budgetary practices reflect commitment to address health inequities

5. Do budget allocations reflect commitment to address health inequities?
6. Does the LHD make efforts to cross-fund and use categorical funding creatively to address health inequities?
7. Does the LHD have sources of stable funding that are not "siloed" or issue-area-specific?

### Plans and procedures are in place to assure culturally competent service delivery

8. Does the LHD integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, client satisfaction assessments, and outcomes-based evaluations?
9. Are conflict and grievance resolution processes culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts?
10. Is an ongoing cultural competency training program established and promoted for the workforce at all levels to enhance self-awareness, cultural awareness, knowledge, and skills?

### Program planning and service delivery prioritize needs of the community

11. Does LHD communicate health information and data effectively and respectfully to the public, combining technical accuracy with community accessibility, taking into consideration health literacy levels, language, and cultural norms of the community?
12. Do internal program plans and LHD-funded projects:
    a. Use approaches that focus on the strengths and assets of community residents rather than just on their needs and issues?
    b. Seem responsive to changing demographics and emerging community health issues?
13. Are flexible work hours options provided to allow employees to work with communities at times that are convenient for community members?

**Human Resources policies and practices demonstrate that the LHD values a culturally and socio-economically diverse workforce and recruits, hires, and retains employees with the appropriate qualifications from a variety of disciplines for addressing the root causes of health inequities**

14. Job Descriptions
    a. Are County Classifications written so that the educational requirements do not eliminate candidates with the experience, skills and qualities needed to do health equity work in a local health department?
    b. Is there a process in place to review job descriptions through a health equity lens? Is there language in all job descriptions that addresses experience working with people who are culturally different from the applicant?
    c. Do job specifications include individual skills and competencies for addressing health inequities?
    d. Do job requirements reflect experience working with communities most affected by health inequities and appropriate language capacity?
15. Testing Procedures
    a. Are multiple choice tests used? (If so, re-evaluate the use of multiple choice testing as it may disproportionately disadvantage certain groups from being hired. Work with Human Resources to collect data on the people who pass or do not pass multiple choice tests in the County by race/ethnicity and possibly income and educational level.)
    b. If multiple choice testing is used, who develops the questions? (Counties should look critically before purchasing questions from testing services. If there is bias built into the structure of the testing service and its writers, the questions will invariably be biased as well. This will result in the elimination of individuals who may actually be the right fit for health equity work.)
16. Do Recruitment Procedures reflect the following?
    a. Recruit for competencies appropriate to addressing the root causes of health inequities?
    b. Recruit for multi-disciplinary expertise?
    c. Have formal and open processes to recruit prospective employees?
    d. Have application procedures that are easy to understand and accessible to a broad range of people?
    e. Routinely advertise when their examinations are open? If so, are diverse and accessible forms of media used to notify the public?
    f. Are "informal" recruitment strategies used within LHDs to recruit prospective employees? (Are these informal channels likely to generate the broadest range of applicants or are they mirrors of the individuals who are doing the recruiting?)
    g. Are educational pipelines used for recruitment? (If so, do these pipelines produce the types of individuals who have the characteristics needed for health equity work?)
    h. Does LHD have formal practices established to "grow its own" workforce? Some of those practices might include:
        - Formal internship opportunities;
        - Partnerships with community-based youth development programs to establish mentoring opportunities; and
        - Recruiting and training people from within the client/community population.

17. Do Retention Practices reflect the need to achieve the following?
    a. Retain staff that reflects the diversity of the population served by the LHD.
    b. Ensure that all staff members are compensated in a fair and equitable fashion based on experience and responsibility, and that all staff earn a living wage.
    c. Leadership positions reflect the diversity of the population served by the LHD.
    d. Have procedures to help staff that reflect the diversity of the population served by the LHD gain the experience needed for promotional opportunities.

☐ **Identify Sources of Data**

Informed discussions of most of these questions will require an examination of existing hard copy documents such as reports, research findings, strategic plans, proposals, written polices and protocols as well as publications, and community planning and public education materials. Investigating some of these questions may require the extraction of data from financial systems, human resources/payroll systems, client indexes and other electronic applications. While some documents and data systems identified below may not deal explicitly with health inequities, all of them contain important information about the overall capacity of an LHD to address the underlying factors that influence community health and wellbeing.

In this step, identify which internal documents and data sources will contain the most relevant information for answering the questions you have prioritized. The documents and data sources that may be reviewed in the Internal Document Review and Discussion include, but are not limited to:

1. Strategic Plan/Organizational Statements
2. Budget Documents
3. Human Resource Policies/Practices
4. Job Specifications/Classification/Recruitment Materials
5. Research/Briefings
6. Public Information/Education Materials
7. Orientation and Training Materials
8. Performance Plans
9. Communication Plans
10. Proposals
11. Program Reports

☐ **Designate Reviewers**

After identifying the types of documents and data to prioritize for review, designate the person or group of people who are best positioned to investigate each. For example, Program Managers may be best positioned to evaluate the relationship of their budgets to activities that address root causes of health inequities, while Human Resources staff may be able to most easily extract data about workforce diversity.

☐ **Create Timeline for Review**

In order to keep the review activities aligned with the other instruments of the Toolkit and to preserve momentum and relevance, develop a timeline for reviewers to complete their assigned activities that is coordinated with other Toolkit activities and that will allow for timely discussions that can inform the processing of other Toolkit findings.

☐ **Conduct the Review**

As you review each data source, identify the ways in which the reviewed material answers the question at hand, as well as observations about the information for group discussion.

☐ **Convene Discussion Groups**

The information gained by the Internal Document Review and Discussion is meant to provide the basis for rich discussion. Form one or more groups of no more than 10 staff members to discuss and analyze the the results of the Internal Document Review. Including relevant staff from all levels of the organization in these discussions will provide an opportunity for a broad set of perspectives, including those not always heard in strategic discussions, to inform the interpretation of these findings. Use the findings along with the other information obtained through the Self-Assessment to develop priority areas for action.

# 5. AFTER THE SELF-ASSESSMENT: Reflecting on the Results for Action

Once all Self-Assessment data have been analyzed and formatted into tables (see *Appendix VIII*), they should be used to inform action-oriented discussions within your LHD. After carefully reviewing all findings, the executive leadership team should engage in a discussion about the results and their implications. Then, further discussions and action planning should include staff representing a variety of levels and locations within the organization. The process considerations and discussion questions below are suggested to help LHD staff stimulate dialogue, reflect on Self-Assessment findings, and make actionable next steps for how the organization can do more in the future. (See *Appendix VI* for an action planning worksheet).

There are many ways to meaningfully involve staff in the reflection and action planning process. Including staff members who represent a cross-section of the organization allows you to:

- Maintain the participatory momentum of the Self-Assessment;
- Benefit from the diversity of wisdom and experience that staff from all over the organization bring to the table;
- Create buy-in for organizational change or new initiatives with a wider base of champions; and
- Establish new relationships and communication channels within the organization.

**Berkeley Pilot Experience: Using the Results for Action**

A subcommittee of three staff representing a range of classifications reviewed the data and, using the Action Planning Worksheet (*Appendix VI*), developed a number of possible Actions that needed to be addressed given the findings. The relevant Workforce Competencies and Organizational Characteristics were identified for each Action (Berkeley added in a separate column to the Worksheet to track this). The collective set of recommended Actions was presented to Berkeley's Leadership Team and a workgroup focused on addressing the "ISMS". Those presentations resulted in a shortened list of short-term and long-term Actions that Berkeley is currently working from to guide the division's work in addressing health inequities. To date these have informed the Public Health 101 Training for staff, hiring and promotional practices, and a recent reorganization.

In creating opportunities for staff other than the executive leadership team to reflect on the Self-Assessment results and consider potential action for the LHD to take, keep the following considerations in mind:

- All staff can be leaders.
- Be mindful of organizational hierarchies and power dynamics, and create safe spaces for authentic discussions and ideas to emerge.
- Communicate clearly to staff that you convene for reflection and planning so that the context, scope and purpose of their discussions are understood. It is important that people are not given a false sense of authority over decisions that are not within their control.

The following is a list of reflection questions to help your LHD make meaning out of the Self-Assessment results and translate them into action:

- What surprised you?
- What confirmed what you already suspected?
- What challenged your perceptions of your LHD?
- What do you want to know more about, where could your understanding go deeper?
- What was glaringly missing that you had expected to see?

- Given these findings, what do you see as your role in the process of making change?
- What additional support or resources might you need to successfully fulfill your role in the change process?
- When reviewing the results, did you find any of your personal values supported or challenged?
- Who else should be brought into the review and discussion process about how to make change in your LHD based on these results?
- What implications do you see these results having for how your LHD could do its work in a way that more effectively addresses social determinants of health/root causes of inequity?
- Based on these results, what opportunities exist to build upon for action?
- What potential barriers do you foresee to undertaking change? What are some strategies to address these barriers?
- What is your communication strategy for sharing the results, implications and plans for next steps?
- What is the scale, pace, and sequencing of action steps that the department could undertake to make change?
- What conversations do you want to have with:
  - each other;
  - other members of the department; and
  - people outside the department.
- *For non-management staff:* Are there any questions or considerations you would like to direct to the executive or management team?

Appendices

## APPENDIX I: The Self-Assessment Toolkit


- Glossary of Key Terms .......... 44
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## Glossary of Key Terms

Many of these terms represent related ideas. The terms are often used interchangeably and it can be difficult to know when to use each one. To assist you in completing the survey, we have provided the definitions below. The *italicized* sections contain examples that highlight the subtle differences between these terms.

### Health Disparities

Health disparities are "...differences in the ... burden of diseases and other adverse health conditions ... that exist among specific population groups in the United States."[6] The United States is perhaps the only country that uses the term health disparities. Its emphasis is on differences—it does not consider the relationship to patterns of social inequalities. The term health disparities will not be used in this survey.

> *A local health department that addresses health disparities focuses on specific diseases and populations, such as high asthma rates among African Americans. Interventions focusing on this would be culturally competent clinical care, health education and case management. This approach does not address the underlying causes of poor air quality and sub-standard housing conditions in neighborhoods. It also ignores the effect of the history of housing segregation by race in which people of color were forbidden from living in the same neighborhoods as whites and how being forced to live in lower income areas of the community also may have exposed children and community members to poor air quality and other neighborhood conditions that contributed to the community's high asthma rates.*

### Health Inequities

Health inequities are differences in health status and death rates across population groups that are systemic, avoidable, unfair, and unjust.[7] These differences are sustained over time and generations, and are beyond the control of individuals. These differences follow the larger patterns of inequality that exist in society. This is different from the term **health disparities**, which emphasizes that differences exist, but does not consider their relationship to patterns of social inequalities. The term **health inequities** will be used throughout this survey.

> *A local health department addressing health inequities targets the health issues facing the community it serves, while at the same time working to address the inequities in the social and environmental conditions that contribute to the differences in illness and injury. For example, in addition to providing individuals with WIC vouchers, a local health department also works with a coalition to advocate for equal access to affordable, healthy food in low-income neighborhoods.*

### Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age[8] (e.g. air quality, schools, parks, job and housing conditions, etc.). This term does not address how or why these conditions are inequitably distributed throughout society.

> *A local health department can address the social determinants of health by collaborating with community partners and other public agencies to influence decisions governing land use, transportation, education, housing, employment and other social factors that affect health. An example of this would be to work with land use planners to create a new walking path. The path will provide an attractive opportunity to be physically active. However, if the underlying social conditions that have led to segregated neighborhoods or poverty are not addressed, this path may not be used by members of the community equally and health inequities could continue.*

[6] National Association of Chronic Disease Directors, http://www.chronicdisease.org/i4a/pages/index.cfm?pageid=3447).

[7] World Health Organization, *Concepts and Principles for Tackling Social Inequities in Health,* prepared by Margaret Whitehead and Goran Dahlgren, 2006.

[8] World Health Organization, Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health,* 2008.

## Root Causes of Health Inequities

The root causes of health inequities are the underlying social inequalities that create different living conditions. Discrimination based on class, race/ethnicity, immigration status, gender, sexual orientation, disability and other "isms" influence the distribution of resources and power. Past discriminatory practices are reinforced in the policies and practices of institutions that define the context of our daily lives. This in turn creates an unequal distribution of beneficial opportunities and negative exposures, resulting in health inequities.

*A local health department can address the root causes of health inequities by working to identify and change its own policies and practices that contribute to inequitable social and environmental conditions. It can also challenge other institutions to do the same by demonstrating how their policies and practices advantage or disadvantage particular populations. Examples of this include funding practices in public education and public transportation that unfairly advantage residents living in higher income neighborhoods. A local health department can also build the ability of its service population to challenge unfair institutional policies and practices.*

**Institutional or Structural Racism** is a root cause of health inequities. It is a system of power that has created widespread historical and persistent barriers that keep people of color from having equal access to opportunity, information, resources, and power. This system is maintained and preserved by formal and informal practices and policies that benefit some groups of people while disadvantaging others.[9]

*An example of this would be the long-term effects of racist institutional policies such as federal housing and bank-lending policies and practices that denied people of color homeownership opportunities while at the same time expanding them for lower income whites. In the US, home ownership has been a primary method for creating wealth and expanding opportunities, such as affording college education, that increase the potential to secure higher paying jobs. Institutions, policies and structures in society decrease the odds for people of color to have long, healthy lives. Local health departments can identify and address the ways they and other institutions may be maintaining institutionalized racism.*

*LHDs can ensure that people of color in the community they serve have the opportunity to influence the department's planning and decision-making. Local health departments can also recruit and retain staff with ethnic backgrounds representative of the communities they serve at all levels, and particularly in management positions.*

**Class** refers to the level of wealth, power, and status of a person or group. A root cause of health inequities is the persistent inequality between different classes. Some people do not have the same access to resources important for good health as others, such as well-paying jobs, health insurance, safe and healthy home and work environments, quality housing, healthy food, and educational opportunities.

*A local health department can intentionally recruit and retain staff from poorer class backgrounds. It can consider life experience as well as education level in the hiring process and support these staff to develop the professional qualifications that are needed to advance within the organization. It can work with community partners to advocate for employment with a living wage, benefits, and health insurance, and for universal health care coverage. It can also produce data that show the link between income and wealth on health status.*

[9] Camara Phyllis Jones MD, MPH, PhD, Levels of Racism: A Theoretic Framework and a Gardener's Tale, *American Journal of Public Health* Vol 90 (2000) :1212-1215.

**Social Justice**

Social Justice refers to social, economic, and democratic fairness and equality. All people are able to participate fully in society; have equal access to resources, public goods and life opportunities; and are free from discrimination on the basis of race, gender, class, sexual orientation, and other factors.

> *A local health department can address its own policies and practices that contribute to unfair social and environmental conditions as well as challenging other institutions to do the same. Local health departments can also prepare and share data that demonstrate unfairness in exposures and opportunities, which builds the case for needed change. They can also build the ability of the affected group to challenge unfair institutional policies and practices.*

*(These definitions of key terms and concepts should be distributed with each instrument.)*

## Staff Survey

This survey is to help our Local Health Department (LHD) assess our overall capacity for addressing health inequities. While some questions do not deal explicitly with health inequities, all questions contain important information about our overall capacity as an organization to impact the factors that influence community health and well being, including institutionalized racism and social and environmental factors.

This survey is anonymous—your responses will never be linked to you individually. This is not a test, and no survey response will be used against individuals, programs or departments.

**Your honest responses on this survey are truly valuable.**
**Thank you for your time!**

Please refer to the definitions of key terms and concepts relevant to this survey with which you were supplied. While these terms may be familiar to you, we ask that you read the definitions provided so that all staff have a common understanding of the major concepts underlying this assessment.

*(In the online version, there will also be a link to these definitions at the top of each page of the survey so that the participants can reference them at any time during the survey if needed.)*

**There are six sections of this survey:**

- **A. Introductory Questions**
- **B. Health Department Planning And Policies**
- **C. Collaboration Within Your Local Health Department**
- **D. Collaboration With External Partners & Policy-Makers To Address the Environmental, Social, and Economic Conditions that Impact Health**
- **E. Collaboration With Community Groups to Address the Environmental, Social, and Economic Conditions that Impact Health**
- **F. Supporting Staff to Address the Environmental, Social, and Economic Conditions that Impact Health**

The questions in each of these sections help build a picture of how our LHD is doing in the five key areas in order to effectively address the environmental, social, and economic conditions that impact health.

## Section A. 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 our Local Health Department (LHD).

1. Which best describes your position in the LHD?
   - ☐ Administrative staff
   - ☐ Front line staff
   - ☐ Supervisor (not senior management)
   - ☐ Senior management level/unit or program lead
   - ☐ Leadership team
   - ☐ Other (please describe): ______________________________

2. What program unit do you work in?

   ______________________________

3. How long have you been working in the public health field?
   *(Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)*

   ____ Years ____ Months

4. How long have you been at [LHD]?
   *(Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)*

   ____ Years ____ Months

5. 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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

8. In the populations served by [LHD] what are the top 5 disproportionately and unjustly distributed health issues?

   ______________________________
   ______________________________
   ______________________________
   ______________________________
   ______________________________

9. Please list what you think are the most important environmental, social, and economic conditions that impact health among the populations that the LHD serves.

10. In your opinion, how much does [LHD] focus on addressing health inequities? *(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.

## Section B. Health Department Planning and Policies

We would like to know whether your LHD's mission, vision and values clearly communicate an organizational commitment to addressing health inequities.

Please answer the following questions based on your own impressions of your LHD's organizational principles, even if you don't know exactly what they say.

### Mission, Vision and Values

11. Does the [LHD]'s **vision statement** demonstrate a commitment to addressing health inequities? *(Check only one box.)*
    - ☐ Yes
    - ☐ No
    - ☐ I don't know whether the vision statement addresses health inequities
    - ☐ I don't know whether [LHD] has a vision statement

12. Does [LHD]'s mission statement express a commitment to addressing health inequities? *(Check only one box.)*
    - ☐ Yes
    - ☐ No
    - ☐ I don't know whether the mission statement addresses health inequities
    - ☐ I don't know whether [LHD] has a mission statement

13. If [LHD] has an organizational statement of values or principles, does it contain a commitment to addressing health inequities? *(Check only one box.)*
    - ☐ Yes
    - ☐ No
    - ☐ I don't know whether the organizational statement of values addresses health inequities
    - ☐ I don't know whether [LHD] has an organizational statement of values

For each of the following statements, please indicate the response that most closely describes your LHD:

14. I think [LHD] 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

15. I think [LHD] as an organization demonstrates a commitment to working with external partners, policy-makers, and community members to address the environmental, social, and economic conditions that impact health inequities.

☐ No ☐ Moving in that Direction ☐ Yes ☐ Don't know

16. To the best of my knowledge, there are program units within [LHD] whose work plans explicitly have strategies that address environmental, social and/or economic conditions that impact health inequities.

☐ No ☐ Moving in that Direction ☐ Yes ☐ Don't know

17. I think we have strategies in place in [LHD] to advocate for public policies that address environmental, social and/or economic conditions that impact health inequities.

☐ No ☐ Moving in that Direction ☐ Yes ☐ Don't know

18. I think most staff members at [LHD] demonstrate a commitment to addressing the environmental, social, and economic conditions that impact health.

☐ No ☐ Moving in that Direction ☐ Yes ☐ Don't know

### Strategic Planning

The next section of questions relates to strategic planning documents and processes at your Local Health Department. We are interested in knowing whether the strategic planning documents explicitly address issues related to health inequities, and whether strategic planning processes deliberately include a variety of community or staff perspectives.

19. Does [LHD]'s strategic plan include an explicit commitment to addressing health inequities?

☐ Yes
☐ No
☐ I don't know whether the strategic plan addresses health inequities
☐ I don't know whether there is a strategic plan for the whole LHD
☐ Not applicable: There is not a strategic plan for the whole LHD

20. If your program unit has its own strategic plan, does it specifically describe efforts to address health inequities?

☐ Yes, it does ☐ No, it doesn't ☐ No strategic plan ☐ I don't know

Please indicate the degree of community and staff input into strategic planning at your LHD:

21. In your experience, what role(s) do community leaders, residents and community based organizations play in strategic planning? *(Check all that apply.)*

- ☐ Contribute input in the beginning of the strategic planning process
- ☐ Review strategic planning documents and give feedback
- ☐ Maintain active involvement throughout the strategic planning process
- ☐ Participate in the decision-making of the strategic planning process
- ☐ Collect feedback from larger groups of community members and communicate the feedback to [LHD]
- ☐ None
- ☐ Don't know
- ☐ Other (please describe) ____________________

22. In your experience, what role(s) do community leaders play in program planning and delivery? *(Check all that apply.)*

- ☐ Contribute input in the beginning of the planning process
- ☐ Review program planning documents and give feedback
- ☐ Maintain active involvement throughout the planning process
- ☐ Collect feedback from larger groups of community members and communicate the feedback to [LHD]
- ☐ Participate in the decision-making of the strategic planning process
- ☐ Other (please describe) ____________________

## Program Planning

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

23. How much does program design reflect a general understanding of the environmental, social, and economic conditions that impact health?

☐ None ☐ Some ☐ A lot ☐ Don't Know

24. How much are all levels of staff involved in program planning?

☐ None ☐ Some ☐ A lot ☐ Don't Know

25. What groups outside of [LHD], if any, are usually involved in program planning processes? *(Check all that apply.)*

- ☐ Community members/residents
- ☐ Community-based organizations
- ☐ Faith-based organizations
- ☐ Academic institutions
- ☐ Other public agencies
- ☐ Other private institutions
- ☐ Other non-profit organizations
- ☐ Businesses
- ☐ None
- ☐ Don't know
- ☐ Other (please specify) ____________________

The Ten Essential Services of Public Health provide a guiding framework for the responsibilities of local public health systems. The following set of questions focus on how each of the essential services can contribute to addressing health inequities experienced by residents of your health department's community. For example, health status monitoring could be used to document health inequities and track progress in closing health gaps among different groups in the community.

*Your response should indicate the extent to which you think that your work in each area contributes to addressing health inequities. For those that do not describe any part of your job, please choose "N/A."*

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

| | N/A: this component is not relevant to my job | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|---|
| 26. My work has a role in monitoring health status and tracking the conditions that influence health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27. My work contributes to diagnosing, investigating and protecting people from health problems and health hazards that disproportionately impact vulnerable populations. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28. My work has a role in informing, educating and empowering people from populations that disproportionately experience poor health outcomes to act collectively in improving their health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. My work has a role in mobilizing community partnerships and action to identify and address the conditions that influence health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 30. My work contributes to developing policies and plans that support individual and community health efforts to address the conditions that affect health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31. My work has a role in applying the enforcement of laws and regulations that protect health and ensure safety in order to reduce health inequities (e.g. environmental justice). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32. My work has a role in linking people from populations disproportionately experiencing poor health outcomes to needed personal health services and assuring the provision of health care when otherwise unavailable. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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

| | N/A: this component is not relevant to my job | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|---|
| 33. My work has a role in assuring a competent, culturally sensitive and diverse public health workforce that can effectively address health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 34. My work has a role in evaluating the effectiveness, accessibility, and quality of health services provided to populations experiencing disproportionately poor health outcomes. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35. My work contributes to and applies new insights, innovative solutions, and the evidence base to address health inequities and community conditions that influence health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Section C. Collaboration within your Local Health Department

The purpose of this section of the survey is to better understand what aspects of your LHD make internal collaboration possible and how different kinds of collaboration within the organization function.

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

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 36. I know how the work of other parts of [LHD] contributes to addressing health inequities in our community. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37. I collaborate with staff in other programs within [LHD] to address the the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38. There is support from management within [LHD] for collaborations between programs addressing health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 39. Staff at all levels have the opportunity to become leaders in the work [LHD] is doing to address health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

40. What role do you have in making decisions that affect your program unit's efforts to address health inequities? *(Check only one box.)*

- ☐ I have no decision-making role.
- ☐ There are opportunities for me to give input, but I don't have a role in seeing that my input is incorporated into the decision.
- ☐ I have an active role in major decisions affecting my program unit's efforts to address health inequities.
- ☐ I have primary decision-making power for my program unit.
- ☐ Addressing health inequities is not a focus of my program unit.
- ☐ Other: ________________________________________

41. What role do you have in making decisions that affect department-wide efforts to address health inequities? *(Check only one box.)*

- ☐ I have no decision-making role.
- ☐ There are opportunities for me to give input, but I don't have a role in seeing that my input is incorporated into the decision.
- ☐ I have an active role in major decisions affecting [LHD']s efforts to address health inequities.
- ☐ I have primary decision-making power for [LHD].
- ☐ Addressing health inequities is not a focus of [LHD].
- ☐ Other: ________________________________________

Please indicate the response that best describes your experience regarding the transparency of decision-making at your LHD:

42. When a program level decision is made that affects you and your job tasks, do you know why it was made?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

43. When a department level decision is made that affects you and your job tasks, do you know why it was made?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

The next set of questions is about the culture of your LHD with respect to learning.

**In my experience ...**

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 44. Staff are encouraged to learn about ways to address the environmental, social, and economic conditions that impact health from one another. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 45. Staff are encouraged to learn about ways to address the environmental, social, and economic conditions that impact health from external sources. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 46. Staff are encouraged to be creative in addressing new challenges. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Section D. Collaboration with External Partners & Policy-makers to Address the Environmental, Social, and Economic Conditions that Impact Health

The questions in this section are to help us learn about the extent that your LHD collaborates with other public agencies, institutions and with community-based organizations on the underlying conditions that impact health inequities. **Section E** will ask questions about your work with community groups and community residents.

**To what extent does your LHD collaborate with public agencies, institutions or community-based organizations on the following issues?**

| | Public Agencies | Community-Based Organizations |
|---|---|---|
| 47. Availability of quality affordable housing | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 48. Community safety and violence prevention | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 49. Recreation opportunities, parks and open space | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 50. Land-use planning | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 51. Quality public education | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 52. Community economic development (e.g. job creation, business development, etc.) | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 53. Racial justice | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |

**To what extent does your LHD collaborate with public agencies, institutions or community-based organizations on the following issues?**

| | Public Agencies | Community-Based Organizations |
|---|---|---|
| 54. Arts and culture | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 55. Transportation planning and availability | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 56. Environmental justice | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 57. Food security | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 58. Early childhood development and education | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |
| 59. Youth development and leadership | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know | ☐ None<br>☐ Some<br>☐ A lot<br>☐ Don't know |

The following questions are about your work with external partners (e.g., other public agencies, institutions and community-based organizations)

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

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 60. [LHD] has trusting relationships with external partners. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61. I believe that [LHD]'s external partners really represent the interests and needs of local community residents. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Section E. Working with Communities to Address the Environmental, Social, and Economic Conditions that Impact Health

This section focuses on [LHD]'s collaboration with residents of [LHD's jurisdiction]. 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 [LHD]. We also want to learn how collaboration with community groups and residents takes place in the everyday work of staff in your LHD and how this work addresses the environmental, social, and economic conditions that impact health.

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

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 62. I am familiar with information sources that can help me identify and learn about major concerns in the community I serve. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 63. I am familiar with the major health inequities affecting residents in the community we serve. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 64. I am familiar with the strengths and resources of the community we serve. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 65. I am familiar with the demographic composition of the community we serve. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 66. Part of my job is to bring the community's voice into the LHD decision-making processes. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 67. Part of my job is to bring the LHD messages to the community. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 68. I have influenced how [LHD] has provided resources to community residents and groups to address the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 69. When LHD's priorities don't match the priorities of a community group we're working with, I know how to resolve such a conflict. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

The following questions are about your work with community-based groups.

70. Do you work with community groups (e.g. groups made up of community members rather than institutions or agencies within the community) as part of your job at [LHD]?

   ☐ Yes *(If yes, respondent answers questions 71–76.)*

   ☐ No *(If no, respondent skips to question 77.)*

71. For each of the following questions, please answer section b for each type of community group that you mark in section a.

**What types of community groups do you work with as part of your job at [LHD]?**

| a. *(Check all that apply.)* | b. Does your work with this community group address the environmental, social, and economic conditions that impact health? |
|---|---|
| ☐ Groups that advocate for improved living conditions | ☐ No<br>☐ Moving in that direction<br>☐ Yes |
| ☐ Neighborhood groups | ☐ No<br>☐ Moving in that direction<br>☐ Yes |
| ☐ Faith-based groups | ☐ No<br>☐ Moving in that direction<br>☐ Yes |
| ☐ Youth development/leadership groups | ☐ No<br>☐ Moving in that direction<br>☐ Yes |
| ☐ Community members not affiliated with an organization or group | ☐ No<br>☐ Moving in that direction<br>☐ Yes |
| ☐ Other (please specify) ______________________ | ☐ No<br>☐ Moving in that direction<br>☐ Yes |

72. If you checked that you worked with “other” community groups in the matrix above, please specify:

______________________________________________

______________________________________________

______________________________________________

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

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 73. I have trusting relationships with my community partners. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74. I believe that my community partners really represent the interests and needs of local community residents. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Please indicate the response that most accurately describes your LHD:**

| | No | Moving in that Direction | Yes | Don't Know |
|---|---|---|---|---|
| 75. We have strategies in place to mobilize community groups to address health inequities. | ☐ | ☐ | ☐ | ☐ |
| 76. We have strategies in place to support the work of community groups advocating for public policies that address health inequities. | ☐ | ☐ | ☐ | ☐ |
| 77. 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.) | ☐ | ☐ | ☐ | ☐ |
| 78. [LHD] 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. | ☐ | ☐ | ☐ | ☐ |
| 79. [LHD] is open and responsive to community stakeholders' feedback on its work. | ☐ | ☐ | ☐ | ☐ |
| 80. [LHD] 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. | ☐ | ☐ | ☐ | ☐ |

**Please indicate the response that most accurately describes your LHD:**

| | No | Moving in that Direction | Yes | Don't Know |
|---|---|---|---|---|
| 81. [LHD] sets standards and expectations for how we work with the community. | ☐ | ☐ | ☐ | ☐ |
| 82. [LHD] assesses its work against benchmarks that are set for how we work with the community. | ☐ | ☐ | ☐ | ☐ |
| 83. [LHD] plays an active role in developing, maintaining and supporting networks in the community. | ☐ | ☐ | ☐ | ☐ |
| 84. [LHD] creates and distributes oral and written information that is appropriate for the cultural, linguistic and literacy needs in the community. | ☐ | ☐ | ☐ | ☐ |
| 85. [LHD] collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community. | ☐ | ☐ | ☐ | ☐ |
| 86. [LHD] is able to adapt to new communities and changes within the populations we serve. | ☐ | ☐ | ☐ | ☐ |

87. Does [LHD] provide trainings to build the capacity of community leaders to address the environmental, social, and economic conditions that impact health? *(Check only one box.)*

- ☐ Yes
- ☐ No
- ☐ I don't know

## Section F. Supporting Staff to Address the Environmental, Social, and Economic Conditions that Impact Health

In this final section of the survey, we'd like to know about how you are supported as a staff member of [LHD], and how you could be more supported in addressing health inequities in your work here.

### Supporting Staff in Addressing Health Inequities through Training

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

- ☐ Yes
- ☐ No
- ☐ I don't remember

89. Since you have been working at [LHD], have you ever received training or any mentoring or guidance on any of the following topics? *(Please check all that apply.)*

- ☐ Ten Essential Services of Public Health
- ☐ How to evaluate the work you do
- ☐ How to understand and use data to further your work
- ☐ Program planning
- ☐ How to conduct assessments of community needs and strengths
- ☐ How to research, understand and develop policies that impact the social, economic, and physical conditions that impact health
- ☐ How to advocate for and/or support external partners and community groups advocating for policies that address the social, economic, and physical conditions that impact health
- ☐ How to organize communities to advocate on their own behalf to improve the social, economic and physical conditions of their neighborhoods.

90. Is flexible and/or paid time available to allow staff to attend community meetings and otherwise engage with community residents outside normal business hours?

- ☐ Yes
- ☐ No
- ☐ I don't know

## Supporting Staff in Addressing Health Inequities through Professional Development Opportunities

**Have you been encouraged to use the following professional development opportunities to FURTHER YOUR UNDERSTANDING OF HEALTH INEQUITIES?**

| | *(Check only one.)* | If *Yes*, have you used this type of opportunity to BETTER UNDERSTAND HEALTH INEQUITIES? |
|---|---|---|
| 91. Mentoring/coaching | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |
| 92. Tuition reimbursement for a relevant class or certification | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |
| 93. A formal professional development or training program on the topic of the environmental, social, and economic conditions that impact health | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |
| 94. Professional membership or journal subscription | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |
| 95. Conferences, trainings, workshops | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |
| 96. Other (please specify) ______________ | ☐ Yes<br>☐ No<br>☐ Don't Know<br>☐ Not Available to Me<br>☐ Not Applicable/LHD does not offer this | ☐ Yes<br>☐ No<br>☐ Not yet, but I plan to |

97. If you checked "other" for the previous question, please specify what other professional development opportunities you have been encouraged to use:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

98. Have you provided mentoring or coaching to other staff to support them in addressing health inequities? *(Check only one box.)*

- ☐ Yes, as part of my job
- ☐ Yes, informally
- ☐ No
- ☐ I don't remember

## Supporting Staff in Addressing Health Inequities through Time for Reflection

**Please indicate how much you agree or disagree with the following statements about the opportunities you have to reflect on addressing health inequities in your work:**

| | Not Applicable to My Job Function | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|---|
| 99. I have opportunities to talk with my supervisor(s) about the impact of our work on the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 100. Within my unit we have engaged in group discussions about how our work could address one or more of the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 101. I subscribe to a listserv, online discussion group, e-mail list, or other web-based source for learning about developments on the topic of health inequities on an ongoing basis. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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.

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

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 102. I understand what the environmental, social, and economic conditions that impact health are. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 103. I could explain the environmental, social, and economic conditions that impact health to my co-workers. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 104. Being aware of my own beliefs, values and privilege helps me understand others' perspectives. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 105. I believe it is important to understand the beliefs and values of the residents and community members served by [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 106. 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). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 107. I regularly have personally meaningful interactions and have learned from people of different cultures and backgrounds from my own. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 108. I feel my work environment is supportive of many different cultural perspectives. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 109. In general, [LHD] programs are structured to address the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 110. Staff I interact with at [LHD] are comfortable talking about race and racism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 111. Senior management at [LHD] is comfortable talking about race and racism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 112. Staff I interact with at [LHD] are comfortable talking about class and classism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 113. Senior management at [LHD] are comfortable talking about class and classism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 114. I work with a culturally diverse staff. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

For the set of questions below, we are interested in knowing how you think your LHD is doing with respect to hiring and keeping a diverse staff at all levels of the organization.

**Please indicate how much you agree or disagree with the following statements regarding the recruitment, hiring, and retention of diverse staff at your LHD:**

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 115. [LHD] actively recruits culturally diverse management and leadership staff members. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 116. Culturally diverse management and leadership staff members remain long-term employees of [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 117. Culturally diverse administrative staff members are actively recruited. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 118. Culturally diverse administrative staff members remain long-term employees of [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 119. [LHD] actively recruits culturally diverse staff to provide direct client services. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 120. Culturally diverse direct service staff members remain long-term employees of [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 121. When appropriate, minimum requirements for positions are flexible, allowing for relevant community experience in place of educational degrees. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 122. Individual staff members' efforts to address health inequities are considered in performance reviews/evaluations. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 123. When forming interview panels for the hiring of new staff, attention is paid to how the make up of the panel could enhance the recruitment of a more diverse workforce. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 124. Interview questions are designed to gain insight into an applicant's capability to address health inequities in the performance of their program responsibilities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 125. Staff of diverse ethnic, racial and cultural backgrounds are equitably promoted throughout [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Please indicate how much you agree or disagree with the following statements about the cultural relevance of public health programming at your LHD:**

| | Strongly Disagree 1 | Disagree 2 | Neutral 3 | Agree 4 | Strongly Agree 5 | Don't Know |
|---|---|---|---|---|---|---|
| 126. A range of culturally appropriate program delivery models are planned and implemented at [LHD]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 127. Assessments of the cultural and linguistic needs of the community we serve are conducted periodically. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## You're almost done!

This information is optional, but will help us understand more about the distribution of experiences and attitudes across your LHD with respect to health inequities work. Your responses are anonymous and confidential.

128. What is the race or ethnicity that you primarily identify with? *(Please check only one.)*

- ☐ African American/Black
- ☐ Asian
- ☐ Caucasian/White
- ☐ Latino/Hispanic
- ☐ Middle Eastern
- ☐ Native American/Alaska Native
- ☐ Pacific Islander/Native Hawaiian
- ☐ Biracial/Multiracial/Other (please specify): ____________________

## Thank you!

## Collaborating Partner Survey

This survey is to help the [LHD] to assess our 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 [LHD]'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 [LHD] is interested in getting your perspective as a community resident, representative of a community organization, community group or other public or private agency serving the community about our capacity to address the underlying conditions that impact health inequities.

A glossary of key terms has been made available to you to review before and during the survey. 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 the LHD is prepared to address the underlying causes of health inequities, and therefore, will deal with many topics that are not always associated with public health. When you are answering the questions in this survey, please keep that in mind.

This survey is anonymous; your responses will never be linked to you individually. No survey response will be used against individuals, groups and organizations. Findings will have no effect on any contract, staff resources or other relationship you have with the [LHD] 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 [name, phone and email.]

**There are 57 questions; the survey should take between 20 and 30 minutes.**

**Your honest responses on this survey are truly valuable.**
**Thank you for your time!**

### About You

First, please tell us a little about yourself as well as your work with [LHD] and in the community.

1. Which of the following best describes your organization, group, or institution?
   - ☐ Academic institution/school
   - ☐ Community-based organization *(Please answer question 2, below)*
   - ☐ Community group/coalition *(Please answer question 2, below)*
   - ☐ Public agency
   - ☐ Faith-based organization
   - ☐ Private sector business
   - ☐ I am a community member/resident unaffiliated with an organization
   - ☐ Other (please specify) ______________________________

*If you selected CBO or community group/coalition above, please also answer question 2.*
*If not, please skip to question 3.*

2. What does the agency you work/volunteer with primarily do? *(Check all that apply.)*
   - ☐ Health advocacy/policy
   - ☐ Other advocacy/policy
   - ☐ Research
   - ☐ Private business
   - ☐ Direct health care/social services
   - ☐ Other direct services
   - ☐ Other (please specify) ______________________________

As a reminder, neither your name nor your organization will be associated with your responses, and nothing you share in this survey will impact your current or future contracts or MOUs with [LHD].

3. How long has your organization/group worked with [LHD]? *(Check all that apply)*
   - ☐ Not currently working with [LHD]

   We have worked with [LHD]:
   - ☐ 1 year or less
   - ☐ 1–5 years
   - ☐ 5 years and above

4. Our relationship with [LHD] has been primarily one of:
   - ☐ Not currently working with [LHD]
   - ☐ Networking or sharing information
   - ☐ Coordinating activities
   - ☐ Cooperating with/assisting [LHD]
   - ☐ Other

5. If other, please describe: ______________________________

6. In your community, what are the top 5 unevenly and unfairly distributed health issues?

7. What would you describe as the leading environmental, social, and economic conditions that impact the health issues you identified above?

*Remember, the glossary of terms is available for you to refer to throughout the survey.*

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

| | Strongly Agree 5 | Agree 4 | Neutral 3 | Disagree 2 | Strongly Disagree 1 | Don't Know |
|---|---|---|---|---|---|---|
| 8. My organization's/group's work with [LHD] addresses the environmental, social, and economic conditions that impact health in some way. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Please indicate the response that most accurately describes the awareness in [locale/community name] with respect to health inequities. *(Check only one box per statement.)***

| | Yes | Moving in that Direction | No | Don't Know |
|---|---|---|---|---|
| 9. I think there is a general awareness of the environmental, social, and economic conditions that impact health among organizations or groups like mine in [locale]. | ☐ | ☐ | ☐ | ☐ |
| 10. Addressing the environmental, social, and economic conditions that impact health in [locale]'s communities is a high priority among organizations or groups like mine in [locale]. | ☐ | ☐ | ☐ | ☐ |

Has your organization or group been a part of collaborations with [LHD] to address any of the following issues?

**My organization's / group's work with [LHD] addresses…**

| | Yes | Moving in that Direction | No | Don't Know |
|---|---|---|---|---|
| 11. Availability of quality affordable housing. | ☐ | ☐ | ☐ | ☐ |
| 12. Community safety and violence prevention. | ☐ | ☐ | ☐ | ☐ |

**My organization's / group's work with [LHD] addresses…**

| | Yes | Moving in that Direction | No | Don't Know |
|---|---|---|---|---|
| 13. Recreation opportunities, parks and open space. | ☐ | ☐ | ☐ | ☐ |
| 14. Land-use planning. | ☐ | ☐ | ☐ | ☐ |
| 15. Quality public education. | ☐ | ☐ | ☐ | ☐ |
| 16. Community economic development (e.g. job creation, business development, etc.). | ☐ | ☐ | ☐ | ☐ |
| 17. Racial justice. | ☐ | ☐ | ☐ | ☐ |
| 18. Arts and culture. | ☐ | ☐ | ☐ | ☐ |
| 19. Transportation planning and availability. | ☐ | ☐ | ☐ | ☐ |
| 20. Environmental justice. | ☐ | ☐ | ☐ | ☐ |
| 21. Food security. | ☐ | ☐ | ☐ | ☐ |
| 22. Early childhood development and education. | ☐ | ☐ | ☐ | ☐ |
| 23. Youth development and leadership. | ☐ | ☐ | ☐ | ☐ |
| 24. Please list or specify focus area: ______________________________ | | | | |

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

| | Strongly Agree 5 | Agree 4 | Neutral 3 | Disagree 2 | Strongly Disagree 1 | Don't Know |
|---|---|---|---|---|---|---|
| 25. [LHD] should play a significant role in addressing the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26. I think [LHD], as an organization, demonstrates a commitment to addressing the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27. [LHD] staff members that I have worked with demonstrate a commitment to addressing the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28. [LHD] staff I interact with understand residents' major concerns in our community. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. [LHD] staff I interact with understand the major causes of health inequities in [locale]. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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

| | Strongly Agree 5 | Agree 4 | Neutral 3 | Disagree 2 | Strongly Disagree 1 | Don't Know |
|---|---|---|---|---|---|---|
| 30. [LHD] staff I have interacted with are familiar with the strengths and resources of residents and community institutions. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31. [LHD] staff I have interacted with advocate on behalf of the community within [locale] and have influenced how resources have been made available to support community residents and/or community institutions in addressing community concerns. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32. I have trusting relationships with the [LHD] staff I work(ed) with. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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

| | Always | Sometimes | Never | Don't Know |
|---|---|---|---|---|
| 33. [LHD] holds community meetings that are welcoming, comfortable and familiar to community members. | ☐ | ☐ | ☐ | ☐ |
| 34. [LHD] provides food and childcare at the community meetings it holds. | ☐ | ☐ | ☐ | ☐ |
| 35. The community meetings that [LHD] holds are scheduled at times that are generally convenient for community members (meetings are held in the evenings, on weekends, etc.). | ☐ | ☐ | ☐ | ☐ |

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

| | Strongly Agree 5 | Agree 4 | Neutral 3 | Disagree 2 | Strongly Disagree 1 | Don't Know |
|---|---|---|---|---|---|---|
| 36. [LHD] values input from community residents. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37. [LHD] values input from organizations like mine. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38. [LHD] is responsive to the priorities of the community. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 39. [LHD] communicates openly and honestly with community members and partners. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 40. When [LHD] program decisions do not reflect community input, it is clear why those decisions were made. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 41. [LHD] has provided resources to community residents and partners to support their concerns and needs for addressing health inequities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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

| | Always | Sometimes | Never | Don't Know |
|---|---|---|---|---|
| 42. Organizations like mine are invited to participate in the [LHD] planning processes. | ☐ | ☐ | ☐ | ☐ |
| 43. Organizations like mine are meaningfully involved in the [LHD] planning processes. | ☐ | ☐ | ☐ | ☐ |
| 44. [LHD] informs the people and groups it works with about the results of community input into planning. | ☐ | ☐ | ☐ | ☐ |

45. In your experience, what role(s) do leaders from the community in [locale] play in [LHD] 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 [LHD]
- ☐ Maintain active involvement throughout the planning process as appropriate
- ☐ Participate in the decision-making of program planning and delivery
- ☐ Other (please describe) ______________________________

46. In your experience, what role(s) do other governmental/public agencies in [locale] play in [LHD] 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 [LHD]
- ☐ Maintain active involvement throughout the planning process as appropriate
- ☐ Participate in the decision-making of program planning and delivery
- ☐ Other (please describe) ______________________________

**Please indicate the response that most accurately describes the [LHD].** ***(Check only one box per statement.)***

| | Yes | Moving in that Direction | No | Don't Know |
|---|---|---|---|---|
| 47. [LHD] creates and distributes oral and written materials that are appropriate for the cultural, linguistic, and literacy needs of the community. | ☐ | ☐ | ☐ | ☐ |
| 48. [LHD] collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community. | ☐ | ☐ | ☐ | ☐ |
| 49. [LHD] provides trainings to increase the knowledge and skills of community leaders to address the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ |

**Please indicate the response that most accurately describes the [LHD].** ***(Check only one box per statement.)***

| | Yes | Moving in that Direction | No | Don't Know |
|---|---|---|---|---|
| 50. [LHD] plays an active role in developing, maintaining and supporting networks in the community. | ☐ | ☐ | ☐ | ☐ |
| 51. [LHD] builds the leadership capacity of community members to advocate on issues affecting the environmental, social, and economic conditions that impact health. | ☐ | ☐ | ☐ | ☐ |
| 52. [LHD] helps community members and community-based organizations assume leadership roles. | ☐ | ☐ | ☐ | ☐ |
| 53. [LHD] is able to adapt to new communities and changes within the populations living within [locale]. | ☐ | ☐ | ☐ | ☐ |
| 54. [LHD] works with non-health-focused networks in the community to address issues that can impact health. | ☐ | ☐ | ☐ | ☐ |

**You are almost done; hang in there!**

Because you may have worked with multiple areas of the [LHD], please be as specific as possible in this section.

55. What has been positive about the collaboration between [LHD] and organizations/groups like yours?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

56. What has been challenging about the collaboration between [LHD] and organizations/groups like yours?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

57. What do you think should change about the way [LHD] collaborates with organizations/groups like yours?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

**Thank you for your time and feedback!**

## Staff Focus Group Protocol

*(Prior to participating in a focus group, staff members should be provided with the list of key terms on page 44 in order to be able to ground the focus group discussion in these shared meanings relevant to health inequities.)*

### Introduction and Overview

Thanks for coming today to talk with us about various aspects of the [LHD] related to health inequities. We really appreciate your willingness to give your time. My name is ______. This is ______. We are with [organization], 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.

As you know, [LHD] is undergoing an assessment process to determine its ability to successfully reduce health inequities in our community. Our main purpose today in this group is to learn from you about the elements of the 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 personal characteristics you think people at [LHD] need in order to enable the organization to address the environmental, social, and economic conditions that impact health.

- <u>Role of facilitator and note taker</u>. I will be leading the conversation today and my colleague [*name*] will be taking notes during the conversation. We'll get into a few guidelines for how you can help us to do our jobs in just a moment.
- <u>Confidentiality</u>. Everything you tell us today will be kept strictly confidential. Your answers will not be linked to your names when we provide information to the leadership here at [LHD]. In our report of these focus groups, some quotes will be used, but we will never link those quotes to individuals.

### Ground Rules for the Group

I'd like to outline a few ground rules for the conversation:

- There are no right or wrong answers. We want to hear what each of you think and feel about your experience doing the work of the [LHD].
- Please speak one at a time—this will help the note taker capture everyone's thoughts and opinions.
- If you agree with what someone says, speak up, rather than nodding your head or gesturing in some other way. This helps [name] capture agreement in her notes.
- We would like to record this session so that your thoughts can be accurately captured. If you have a concern about this, please say so now.

Please take a minute now to review your handout that gives definitions of health inequities and related terms.

Do you have any questions before we begin?

1. To start, can everyone go around and share with us your name and what you do here at [LHD]?

2. Today we're meeting to discuss [LHD]'s capacity to address health inequities. Why do you believe that health inequities should be an area of concern for your health department?

*Transition Statement:*
First, let's talk some about how [LHD] supports staff to be involved in addressing health inequities:

3. What has [LHD] done to help staff at various levels learn about and develop skills to address the environmental, social, and economic conditions that impact health?

   *Probes:*
   a. Can you describe formal orientation, training, workshops or conferences you have received at [LHD] or externally at other agencies or associations that [LHD] has sent you to?
   b. Discuss whether [LHD] has a regular discussion or work group addressing health inequities and what role you and other staff have played in it.

4. How well-equipped are you and other staff to address the environmental, social, and economic conditions that impact health?

   *Probes:*
   a. What are some key skills and characteristics needed in staff and [LHD] to address the environmental, social, and economic conditions that impact health?

      *(If not mentioned)* Some of the <u>skills</u> that have been identified are in relation to <u>community organizing, developing strategic partnerships, developing and advocating for public policies to address the environmental, social, and economic conditions that impact health, compiling and sharing data, evaluation, assessment</u>, etc.

      *(If not mentioned)* Some of the characteristics identified as important for addressing health inequities are <u>listening, humility, creativity, the ability to be a team player and understands power dynamics</u>, etc.
   b. Can you share whether and how 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. Do you think most people really understand what the environmental, social, and economic conditions that impact health are? Give more detail.
   d. What other training and help from [LHD] do you think is needed for staff to be more effective in addressing the environmental, social, and economic conditions that impact health?
   e. What more could be done in your work to address the environmental, social, and economic conditions that impact health if you had the support of [LHD]?
   f. How well did [LHD] training and discussions help you in the work you and other staff do to address the environmental, social, and economic conditions that impact health? How has your work been impacted as a result?

5. How do you feel about the work [LHD] and you do to address the environmental, social, and economic conditions that impact health?

   *Probes:*
   a. How important do you feel this work is? What priority does it take over other work [LHD] does?
   b. How do you think other staff feel about the importance of this work?

6. When you or other staff have ideas about improving the [LHD]'s mission and work, what processes are in place to bring them to the attention of decision-makers?

    *Probes:*
    a. Give an example of how, when and how often [LHD] includes staff input and feedback on planning activities.

7. How welcoming and supportive is [LHD] to new ideas and programs to address root causes of health inequities?

    *Probes:*
    a. Give an example of LHD's response to a new idea.
    b. Can you describe the attitude that [LHD] and the leadership have toward trying new things?
    c. How does [LHD], leadership and staff cope with projects that fail?
    d. How does LHD and leadership handle differences in opinion?
    e. How do the reactions and attitudes of leadership staff members impact staff performance?

*Transition statement:*
Let's move to talking about some of the work that [LHD] is doing around health inequities:

8. Can you describe any [LHD] work toward addressing the environmental, social, and economic conditions that impact health that has been successful?

    *Probes:*
    a. What challenges, barriers and strengths and resources led to success? How has the work addressing the environmental, social, and economic conditions that impact health been enriched by that experience?

9. Can you describe any [LHD] work toward addressing the environmental, social, and economic conditions that impact health that has failed?

    *Probes:*
    a. What challenges, barriers and strengths and resources led to failure? How has the work addressing the environmental, social, and economic conditions that impact health been enriched by that experience?

*Transition Statement:*
Now let's talk about how [LHD] culture is in relation to issues of diversity:

10. Can you describe the diversity in [LHD]? Be sure to include all levels of staff.

    *Probes:*
    a. By diversity, we generally mean people of different genders, religious, national, cultural, ethnic and racial backgrounds. In [locale], what might be other groups that should be considered?
    b. Does [LHD] staff and decision makers reflect the diversity of the people in [locale],? Can you describe how this is so?
    c. Describe how [LHD]'s recruitment, hiring and promotion practices promote or discourage diversity.

11. Are there serious internal discussions of the impact of racism, classism, sexism and other "isms" on health inequities at [LHD]?

    *Probes:*
    a. Describe the comfort level of staff with these discussions.
    b. If these types of discussions have not occurred, why is that?

*Transition Statement:*
Lastly, let's talk some about [LHD]'s work with the community:

12. Describe how [LHD] works with community residents, community organizations and groups in addressing the environmental, social, and economic conditions that impact health.

    *Probes:*
    a. In what ways do you build on community strengths in your work with the community? *(For probes, keep in mind that asset-based approaches include considering the strengths of individuals, associations and institutions in the community, and adding resources and support where needed to bolster these strengths.)*
    b. What type of community organizations does [LHD] work with? What do they do?
    c. What role does the community play in addressing the environmental, social, and economic conditions that impact health?
    d. How valuable are these roles in the work to address the environmental, social, and economic conditions that impact health?
    e. In what other ways do you think that community residents, organizations and groups should be involved in this work?
    f. Has [LHD] provided resources and training to build the capacity of these partners to do this work? Please describe what has been done and whether it had a positive impact on community residents, organizations and groups' performance in addressing the environmental, social, and economic conditions that impact health.
    g. What is challenging about working with community residents, organizations and groups?

*Transition Statement:*
As we're wrapping up our discussion, let's hear any remaining ideas you may have about [LHD]'s work to address health inequities:

13. Given your knowledge of current and future program areas, do you have any suggestions for [LHD] to improve and expand its work toward addressing the environmental, social, and economic conditions that impact health?

14. What more can [LHD] do to improve its ability to address the environmental, social, and economic conditions that impact health?

**Thank you so much for your time today.**

## Management Interview Protocol

*(Interviewer: Prior to each scheduled interview, interviewees should be provided with the list of key terms [can be found on page 44] as well as the interview questions in order to give them time to reflect on questions and find answers.)*

Thank you so much for taking the time to speak with me today. As you know, these interviews are part of an organizational Self-Assessment that [LHD] is undertaking to assess its capacity to address the environmental, social, and economic conditions that impact health in [locale]. The interviews will help us get a more complete, in-depth sense of [LHD]'s strengths and areas for improvement related to addressing health inequities.

Before we get started, I want to assure your confidentiality in this process. I will be reporting feedback only as overall themes and insights that emerged from all our interviews. Nothing you say in this interview will be attributed to you personally, and nothing you tell us would be used against any person or program. The purpose of the assessment is to help [LHD] define areas of particular strength, identify where to focus on building capacity and provide benchmarks for future assessments. So, I hope you will feel free to be honest and candid in this conversation. The interview should take about 60 minutes. Do you have any questions for me before we begin?

First, please tell me a little about yourself.

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

   ____ Years and ____ Months

2. How long have you been at [LHD name]?

   ____ Years and ____ Months

3. How long have you been working in the public health field?

   ____ Years and ____ Months

*(Give a copy of the vision, mission, values and/or statement of principles to interviewee.)*

*Transition Statement:*
We're going to begin by talking about the overarching guiding principles and planning processes for the department. This includes things like the mission, vision, and values statements, strategic planning, succession planning, and program planning.

### Mission, Vision, and Values

*(Read aloud the agency's mission statement, vision and values. If they already do include health inequities, then focus the questions/probes on how it was entered in discussion.)*

4. Based on [LHD]'s vision, mission and values statements, do you think there is a commitment to address health inequities? How is this commitment demonstrated?

**Goals, Strategies and Benchmarks / Strategic and Succession Plans /Accessible Data and Informed Planning**

5. Does [LHD] engage in department-wide strategic planning?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. *(If not mentioned in previous answer)* Are staff at all levels involved in the process?
    d. *(If not mentioned in previous answer)* Are community representatives formally involved in planning? (*Probe:* What segments of the community are involved? (CBOs, residents, etc.) How are they involved?)
    e. *(If a strategic plan is in place)* Does the strategic plan discuss health inequities explicitly? Are there specific strategies and objectives for addressing health inequities? What are those?
    f. *(If not mentioned in previous answer)* Are there specific strategies and objectives for addressing the social, economic, and environmental conditions that influence health—areas that public health hasn't been traditionally involved in such as public education, land-use, and economic development? Can you describe those strategies?

6. Do individual programs or units 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 not mentioned in previous answer)* Are staff at all levels in the program or unit involved in the process?
    d. *(If not mentioned in previous answer)* Are community representatives formally involved in the program or unit planning? (*Probe:* What segments of the community are involved? (CBOs, residents, etc.) How are they involved?)
    e. *(If a strategic plan is in place)* Does the strategic plan discuss health inequities explicitly? Are there specific strategies and objectives for addressing health inequities? What are those?
    f. *(If not mentioned in previous answer)* Are there specific strategies and objectives for addressing the social, economic, and environmental conditions that influence health—areas that public health hasn't been traditionally involved in such as public education, land-use, and economic development? Can you describe those strategies?

7. How does [LHD] manage community input into planning processes?
    a. How does the department get community input?
    b. Who from the community is asked for input?
    c. At what point(s) in planning processes does the department seek community input?
    d. What impact on the final planning products does it have?
    e. Do community leaders have opportunities to give feedback on, or influence changes to existing programs and planning?
    f. How is community input communicated to [LHD] staff?
    g. How does [LHD] communicate back to the community how their input was used?

8. Does [LHD] conduct assessments on the conditions that influence health (such as housing, education, economic opportunity, or parks and recreation opportunities)?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. Is the assessment conducted internally or externally (through a third-party evaluator/consultant)? (*Probe:* How do you decide which data you can use for planning purposes? How do you decide on the appropriate uses and limitations of data for planning purposes?)
    d. Does [LHD] link data on these social, economic, and environmental conditions to health outcomes or use these data to make the case for their importance in public health?
    e. Does [LHD] collect specific data on health inequities in the populations its serves?
    f. How is this data shared with the community? How do you assure that the data-sharing is appropriate for the cultural, linguistic and literacy needs of the community?

9. Is there a process for regularly assessing [LHD]'s strengths and areas for improvement in its work to address health 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 other consultant?

10. Does [LHD] 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.

11. Does [LHD] have a written succession plan for its leadership?
    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 [LHD] leadership?
    c. How is the succession plan shared? How is it implemented?

*Transition Statement:*
Now, I'd like to ask you some questions about the organizational culture of [LHD].

### Cultivating Organizational Culture of Learning/Professional Development

12. Would you say [LHD] has a culture that encourages learning, growth, and change?
    a. (*Probe:* How are staff encouraged to challenge assumptions and the status quo? How does [LHD] give positive incentives for feedback? Are there repercussions if staff make a mistake, etc.?)
    b. What types of risk-taking does [LHD] successfully encourage? (i.e. hiring people without traditional qualifications, advocating for public policies that address the determinants of health, etc.)?
    c. Are there any other examples of how it does/does not foster a learning culture?

13.
    a. Would you say the attitudes and expectations within [LHD] encourage diversity (*Probe:* Consider multiple types of diversity such as class/class identity, gender, etc.). How is this evident?
    b. What types of diversity does [LHD] successfully encourage?
    c. What could [LHD] do to change the attitudes and expectations it conveys to encourage other types of diversity?

14. a. Does [LHD] intentionally recruit employees with class or racial/ethnic backgrounds reflective of the communities it serves?
    b. Do managers receive training in managing a diverse workforce?
    c. Do human resources staff receive training relevant it hiring diverse staff?
    d. How are staff members who reflect the community supported to gain the qualifications necessary to advance in [LHD]?

15. Does [LHD] provide opportunities for staff feedback about strategies and efforts to address health 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? *(Ask as a theoretical if it hasn't happened 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

16. 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?
       - *(Probe:)* In what ways do you validate or include these strengths? How are resources directed to build on those strengths?)
       - *(If answer only refers to this in terms of program planning and service delivery, Probe:)* How is this integrated into department-wide strategic planning and initiatives?

*Transition Statement:*
These next few questions are about decision-making at [LHD].

### Participatory and Transparent Decision-making Process

17. How are staff from multiple levels of the department involved in making major decisions? (*Probe:* Please think about different types of decisions: strategic, programmatic, structural, etc. In what ways are staff involved in decision-making?)

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

19. a. Do you think [LHD]'s values are consciously brought into decision-making processes? Can you give an example?
    b. When this happens—when the [LHD]'s values are intentionally applied to decisions—what is the impact on work addressing health inequities?

*Transition Statement:*
Now we're going to move on to questions about how [LHD] works with communities to address health inequities.

### Community Capacity Building

20. Does [LHD] have strategies to help community members and CBOs assume leadership roles, advocate for public health concerns, and influence the local health department? (*Probes:* What strategies does [LHD] use to build the capacity of community members and CBOs? What does community leadership look like? How has this led to community-driven advocacy? What has changed as a result?)

21. Has [LHD] established alliances with community groups that are working to improve conditions that influence health status such as housing, economic development, or living wages? (*Probe:* Please describe [LHD]'s alliances with formal and informal community groups. *Regarding whatever is mentioned:* What is the desired impact of this work on health inequities?)

22. What strategies does [LHD] have to increase community awareness about health inequities and their root causes in [locale]?

### Streamlined Administrative Processes and Funding

23. a. How does [LHD] 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.
    b. What barriers make it difficult for community members to participate in [LHD] decisions? What can [LHD] do to address these?
    c. How does [LHD] 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.)?

24. a. Does [LHD] have flexible processes for acquiring funds and services to work with community members (including stipends and sub-contracts)? Please give an example [of this flexibility *if "yes,"* or of when this would have been helpful *if "no."*] What are the challenges in using [LHD] funds in working with community members?
    b. How does [LHD] use categorical, grant, and other funding to support work to address health inequities? (*Probe:* What strategies and practices have been used to maximize available funds to conduct and support this work?)

25. Does [LHD] seek feedback from community members about the barriers and facilitators of community participation? How? Can you give me an example of how [LHD] has responded to such feedback?

### Staff knowledge of community issues and resources

26. 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?

27. In what ways do you build on community strengths in your work with the community? (*For probes:* Keep in mind that asset-based approaches include considering the strengths of individuals, associations and institutions in the community, and adding resources and support where needed to bolster these strengths.) *If interviewee supervises staff who work with community, also ask:* How do you ensure that your staff build on community strenths in their work?

Finally, I have some questions about workforce development.

## Workforce development

28. What steps has [LHD] taken to cultivate a public health workforce that is prepared to address health inequities?

    *Probes:*

    *(Efforts to inform, train and educate all current staff on new skills needed to address underlying conditions of health inequities will be addressed in the following question.)*

    - Partnering with advocates to increase agency capacity to address the environmental, social, and economic conditions that impact health?
    - Pipeline programs to increase diversity of potential [LHD] workforce?
    - Partnering with local universities and schools of public health?
    - Influencing curricula?
    - Hosting internships/field placements/student research related to health inequities?
    - Efforts to recruit from community?
    - Efforts to provide mentorship and support professional development to give people with non-traditional qualification the knowledge and skills to be promoted at a management level (i.e. coaching, paid classes and training)?
    - Efforts to change promotional practices to increase diversity of [LHD] workforce at all levels?
    - Other?

29. Does [LHD] provide support such as training and/or coaching, continuing education/conferences for staff to learn about health inequities and addressing the social determinants of health?

    a. What are some of the topics covered?

    b. How does [LHD] relay its commitment to addressing health inequities to new employees?
    *(Probe:)* Is this covered in a formal orientation?

    c. Does [LHD] implement in-house trainings?

    d. Are these trainings required?

    e. What segments/levels of staff are involved?

Those are all my questions. Do you have anything else to add about [LHD]'s capacity to address health inequities?

**Thank you for your time.**

## Human Resource Worksheet

1. Please fill in the demographic breakdown for the six largest racial and ethnic groups in the community [LHD] serves. Please be as specific as possible (i.e., "Vietnamese" or "Hmong" instead of simply "Asian").

   *For example, African Americans may represent 25% of the population served by LHD, but account for only 10% of staff overall and only 5% of senior leadership.*

| | Racial/Ethnic Group 1: | Racial/Ethnic Group 2: | Racial/Ethnic Group 3: | Racial/Ethnic Group 4: | Racial/Ethnic Group 5: | Racial/Ethnic Group 6: |
|---|---|---|---|---|---|---|
| Racial/Ethnic Group: | | | | | | |
| Percentage of Area Served by LHD (e.g., County): | | | | | | |
| Percentage of LHD's overall staff: | | | | | | |
| Percentage of LHD's senior leadership: | | | | | | |
| Percentage of LHD's management/professional staff: | | | | | | |
| Percentage of LHD's line/para-professional staff: | | | | | | |
| Percentage of LHD's administrative/clerical staff: | | | | | | |

2. As you review the Human Resources Data System, does LHD staff reflect the communities served? If so, at what levels in the organization?

   Please list any observations:

   ______________________________

   ______________________________

   ______________________________

   ______________________________

   ______________________________

# APPENDIX II: Matrix of Organizational Characteristics and Workforce Competencies

Appendices

**What are the characteristics of a local health department that can effectively address health inequities?**

| Institutional Commitment to Address Health Inequities | Hiring to Address Health Inequities | Structure that Supports True Community Partnerships | Support Staff to Address Health Inequities | Transparent & Inclusive Communication (community, staff, partners, etc.) |
|---|---|---|---|---|
| • integrate public health and health equity into workforce and program development<br>• decision making is inclusive<br>• institutional commitment to primary prevention<br>• institutional commitment to addressing health inequities<br>• clear vision, goals and benchmarks<br>• succession plan provides for continuity of vision and promotes new leadership<br>• strategic plan and mission statement address health inequities<br>• institutional practices reflect stated commitment to address health inequities | • Human Resources operations develop and promote job specifications and qualifications that reflect the skills and characteristics desired to address health equity<br>• Human Resources operations' incorporate social justice principles, seek diversity, reflect the populations served, expand language capacity, build the workforce's capacity to address health inequities<br>• Human Resources operations' provide living wages, schedule flexibility and continuing education<br>• diversity at all levels of organization | • community partnerships are welcome and supported<br>• structured to act<br>• collaborates with other agencies and stakeholders to amplify health equity<br>• addresses the needs of community residents such as child care, refreshments, etc., to promote their participation | • mentors staff<br>• strongly supports professional growth<br>• consistent supervision to reinforce practice<br>• required training for all new permanent staff | • transparent communication<br>• communication is multi-directional<br>• solicits and uses community input<br>• decision making is shared with community partners |
| **Institutional Support for Innovation** | **Creative Use of Categorical Funds** | **Community Accessible Data & Planning** | **Streamlined Administrative Process** | |
| • supports innovation (thinking outside box)<br>• time for reflective thought<br>• time to plan | • categorical and other funding sources are creatively braided or interwoven to provide a continuum and are sustained over time<br>• non silo-ed ongoing/ stable funding | • data and needs assessments are accessible to community<br>• integrated data are used for planning | • administrative processes are flexible and promote ease of use | |

## What are the skills and abilities needed by local health department staff to effectively address health inequities?

| Personal Attributes | Knowledge of Public Health Framework | Understand the Social, Environmental and Structural Determinants of Health | Community Knowledge | Leadership |
|---|---|---|---|---|
| • life-long learner<br>• self-reflective<br>• reflects the diversity of the population that is served<br>• passionate<br>• creative and innovative<br>• perseverant<br>• active listener | • prepares program plans<br>• understands / uses data in a systematic approach<br>• takes a systems approach<br>• understands PH core functions and services<br>• conducts evaluation<br>• conducts assessments<br>• develops, analyzes and advocates for policies<br>• organizes community | • understands and applies social justice principles<br>• understands underlying causes of health inequities<br>• understands connection between race, class, gender and health | • builds on strengths and assets of self and the community<br>• works well and is comfortable with diversity<br>• comfortable working in communities<br>• knowledgeable about community issues & resources<br>• understands current immigration patterns and issues | • works well within the LHD and in the community and serves as liaison between the two<br>• engages, mobilizes, coaches and mentors others<br>• understands and navigates power dynamics<br>• "politically astute": is committed to understanding diverse interest groups and power bases including but not limited to City and County officials, State and Federal policy makers, leaders within organizations and the wider community, and the dynamic between them, so as to lead the organization more effectively. |
| **Collaboration Skills** | **Community Organizing** | **Problem Solving Ability** | **Cultural Competency Humility** | |
| • employs good interpersonal skills<br>• "team" player<br>• shares power<br>• trusts partners<br>• communicates well across disciplines | • inspires community involvement and ownership<br>• inspires and builds trust<br>• develops & promotes community leadership<br>• develops & promotes community networks<br>• values/elicits input and feedback from community | • uses negotiation and conflict resolution<br>• willing to take risks<br>• learns from failure | • respects cultures and demonstrates cultural humility<br>• appreciates that diverse perspectives and roles are necessary to promote public health issues<br>• communicates effectively across cultures<br>• interprets data effectively across cultures | |

# APPENDIX III: Roadmap to the Self-Assessment Framework: Linking the Matrix of Workforce Competencies and Organizational Characteristics to the Self-Assessment

Appendices

The following document demonstrates the process by which the original matrix developed into assessment tools. It can assist in determining instruments and questions to include in your LHD's assessment process. Review the Domain and Element columns to prioritize those that your LHD wishes to assess. The table illustrates the question numbers from each of the instruments that correspond to a given element. Elements and questions considered to be the most pivotal have been **bolded**. It is recommended that these elements and/or questions minimally be included in your assessment.

| Major Domain | Matrix Element | Instrument | Question Number |
|---|---|---|---|
| **Institutional Commitment to Address Health Inequities** | **Integrate public health purpose and health equity into workforce and program development** | Staff Survey | 16; **23**; **26–35**; 100 |
| | | Staff Focus Group Protocol | 3; 5 |
| | | Management Interview Protocol | **6e–f**; **28–29** |
| | | Internal Document Review Guidelines | 3 |
| | **Decision making is inclusive** | Staff Survey | **21–22**; 24; **40–41** |
| | | Management Interview Protocol | 5b, c, d; 6b, c, d; **7**; 15; **17**; 18 |
| | Institutional commitment to primary prevention | Staff Survey | 18 |
| | | Management Interview Protocol | 5f; 6f; 8d |
| | **Institutional commitment and practices address health inequities** | Staff Survey | 11–12; **13–14**; 15–16; **17**; 18–20 |
| | | Staff Focus Group Protocol | 8; 9 |
| | | Collaborating Partner Survey | **26–27** |
| | | Management Interview Protocol | **4**; **5e**, **f**; **6e**, **f**; **9**; **10** |
| | **Clear vision, goals and benchmarks** | Staff Survey | **11**, **81–82** |
| | | Management Interview Protocol | **4**; **5e**, **f**; **6e**, **f**; 9–10 |
| | | Internal Document Review Guidelines | **1–2** |
| | Succession plan provides for continuity of vision and promotes new leadership | Management Interview Protocol | **11** |
| | **Strategic plan addresses health inequities** | Staff Survey | **19**; **21** |
| | | Management Interview Protocol | **5e**, **f**; 6e, f |
| | | Internal Document Review Guidelines | **2** |
| | **Mission statement addresses health inequities** | Staff Survey | **12** |
| | | Management Interview Protocol | **4** |
| | | Internal Document Review Guidelines | **1** |

| Major Domain | Matrix Element | Instrument | Question Number |
|---|---|---|---|
| **Hiring to Address Health Inequities** | **HR develops and promotes job specifications and qualifications that reflect skills and characteristics needed to address health inequities** | Staff Survey | **121–122**; **124–125** |
| | | Management Interview Protocol | **12b** |
| | | Internal Document Review Guidelines | **14**; **16a** |
| | **HR policies incorporate social justice principles, seek diversity, reflect the populations served, expand language capacity, build workforce's capacity to address health inequities** | Staff Survey | **115**–116; **117**–118; **119–121**; 124–**125** |
| | | Management Interview Protocol | **14**; 16; 17 |
| | | Internal Document Review Guidelines | **14b**, **d**; 15; **16c**, **d**, **f**, **h**; **17a**, **b**, **c**, **d** |
| | **HR operations provide living wages, flexible scheduling and continuing education** | Staff Survey | 90 |
| | | Management Interview Protocol | 28; 29 |
| | | Internal Document Review Guidelines | 13; **17b** |
| | **Diversity at all levels of organization** | Staff Survey | 114–**115**; 116–**117**; **119**–120; **125** |
| | | Staff Focus Group Protocol | **10** |
| | | Management Interview Protocol | 13; **14** |
| | | Internal Document Review Guidelines | **17**; Human Resources Worksheet |
| **Structure that supports true community partnerships** | **Community partnerships are welcome and supported** | Staff Survey | 22; **76–77**; 78; 79–**80**; 87 |
| | | Collaborating Partner Survey | **41**; 42–43; **50** |
| | | Management Interview Protocol | 20–**21**; **23–25** |
| | Structured to act | Staff Survey | **75–76** |
| | | Staff Focus Group Protocol | 8; 9 |
| | | Management Interview Protocol | **23–25** |
| | | Internal Document Review Guidelines | **3**; **5** |
| | Collaborates with other agencies and stakeholders to amplify health equity | Staff Survey | 47–59; 71 |
| | | Staff Focus Group Protocol | 4a; 12 |
| | | Collaborating Partner Survey | **11–24**; **54** |
| | | Management Interview Protocol | 21 |
| | Addresses the needs of community residents (child care, food, meeting space, refreshments, etc.) to promote their participation | Staff Survey | **77**; **80** |
| | | Collaborating Partner Survey | **33–35**; **41** |
| | | Management Interview Protocol | **23** |
| | | Internal Document Review Guidelines | **13** |

| Major Domain | Matrix Element | Instrument | Question Number |
| --- | --- | --- | --- |
| **Support Staff to Address Health Inequities** | Mentor staff | Staff Survey | 91; 98 |
| | | Staff Focus Group Protocol | 4d |
| | | Management Interview Protocol | 28 |
| | Strong support for professional growth | Staff Survey | 45; **89**; 91–92; **93**; 96; 101 |
| | | Staff Focus Group Protocol | **3** |
| | | Management Interview Protocol | 14d; 28–29 |
| | | Internal Document Review Guidelines | **3**; 10; 17d |
| | Consistent supervision to reinforce practice | Staff Survey | 91; 98; **99** |
| | | Management Interview Protocol | **27** |
| | **Required training for all permanent staff** | Staff Survey | **88–89** |
| | | Staff Focus Group Protocol | **3**; 4d, f |
| | | Management Interview Protocol | 29 |
| | | Internal Document Review Guidelines | **3**; **10** |
| **Transparent & Inclusive Communication (community, staff, partners, etc.)** | **Transparent communication** | Staff Survey | **42–43**; **69**; **79** |
| | | Management Interview Protocol | 7g; 15 |
| | Communication is multi-directional | Staff Survey | 21; 24–**25**; 36–**37**; 38; 40–41; 44 |
| | | Staff Focus Group Protocol | 6 |
| | | Collaborating Partner Survey | **39**; 40; 42–**44** |
| | | Management Interview Protocol | **5**; **6**; **7**; **15**; 17 |
| | **Solicits and uses community input** | Staff Survey | **21–22**; **25**;79 |
| | | Staff Focus Group Protocol | 6, 12 |
| | | Collaborating Partner Survey | 36–37; 42–**43**; **44–45**; 46 |
| | | Management Interview Protocol | 5; 6; **7**; 23; **25** |
| | **Decision making is shared with community partners** | Staff Survey | **21–22**; 66 |
| | | Staff Focus Group Protocol | 12 |
| | | Collaborating Partner Survey | 43; **45** |
| | | Management Interview Protocol | **7d** |
| **Institutional support for innovation** | **Support for innovation (think outside the box)** | Staff Survey | 46 |
| | | Staff Focus Group Protocol | **7** |
| | | Management Interview Protocol | **12** |
| | Time for reflective thought | Staff Survey | 99–100 |
| | | Management Interview Protocol | **10** |
| | Time to plan | Staff Survey | 99–100 |
| **Creative use of categorical funds** | **Creative use of categorical funding** | Management Interview Protocol | **24** |
| | | Internal Document Review Guidelines | **6** |
| | **Non-siloed ongoing/stable funding** | Management Interview Protocol | **24** |
| | | Internal Document Review Guidelines | **7** |

| Major Domain | Matrix Element | Instrument | Question Number |
|---|---|---|---|
| **Community Accessible Data & Planning** | **Community Accessible Data** | Staff Survey | **85** |
| | | Collaborating Partner Survey | **48** |
| | | Management Interview Protocol | **8f** |
| | | Internal Document Review Guidelines | **11** |
| **Streamlined Administrative Process** | Administrative processes are flexible and promote ease of use | Staff Survey | **77**; 80 |
| | | Management Interview Protocol | 23–**29** |
| **Personal Attributes** | Wants to continuously learn | Staff Survey | 101; **106** |
| | | Management Interview Protocol | **9–10** |
| | Ability to self reflect | Staff Survey | 104; **106** |
| | | Management Interview Protocol | **10** |
| | **Reflects the diversity of the population that is served** | Staff Focus Group Protocol | **10b** |
| | | Management Interview Protocol | **14** |
| | | Internal Document Review Guidelines | **17**, **Human Resources Worksheet** |
| | Passionate | Staff Focus Group Protocol | **5** |
| | Humble, perseverant, listening skills | Staff Focus Group Protocol | 4a |
| | Creative and innovative | Staff Focus Group Protocol | 4a |
| | | Management Interview Protocol | 12 |
| **Knowledge of Public Health Framework** | Prepares program plans | Staff Survey | 30; 89 |
| | | Management Interview Protocol | 6 |
| | **Understands and uses data (Data for program planning)** | Staff Survey | 8; 26; 89 |
| | | Management Interview Protocol | **8** |
| | | Internal Document Review Guidelines | **12b** |
| | **Takes a systems approach** | Staff Survey | 36; 47–59 |
| | | Staff Focus Group Protocol | 4a |
| | **Understands PH Core Functions and Essential Services and can adapt them to addressing health inequities**<br>**Evaluation skills**<br>**Assessment**<br>**Policy**<br>**Advocacy**<br>**Community Organizing** | Staff Survey | 23; **26–35** |
| | | Staff Focus Group Protocol | 4a |
| | | Collaborating Partner Survey | 49–52; 54 |
| | | Internal Document Review Guidelines | **4** |
| **Understand the social environmental and structural determinants of health** | **Understands and applies social justice principles** | Staff Survey | 9; 102–103; 110–113 |
| | | Staff Focus Group Protocol | **2**; 11 |
| | **Understands underlying causes of health inequities** | Staff Survey | **9** |
| | | Staff Focus Group Protocol | **2**; **11** |
| | | Collaborating Partner Survey | **7** |
| | | Internal Document Review Guidelines | **3** |
| | **Understands connection between race, class, gender and health** | Staff Survey | 110–113; 123 |
| | | Staff Focus Group Protocol | **2**; **11** |

| Major Domain | Matrix Element | Instrument | Question Number |
|---|---|---|---|
| **Community Knowledge** | **Builds on strengths and assets of self and the community** | Staff Survey | 64; **68**; **78** |
| | | Staff Focus Group Protocol | **12** |
| | | Collaborating Partner Survey | 30 |
| | | Management Interview Protocol | **16**; **27–28** |
| | | Internal Document Review Guidelines | **12a** |
| | Works well and is comfortable with diversity | Staff Survey | 107 |
| | | Management Interview Protocol | 14 |
| | | Internal Document Review Guidelines | **8**; 9; 10 |
| | Comfortable working in communities | Staff Survey | 60 |
| | | Staff Focus Group Protocol | 12 |
| | **Knowledgeable about community issues and resources** | Staff Survey | 62–65 |
| | | Staff Focus Group Protocol | 12 |
| | | Collaborating Partner Survey | **28–30** |
| | | Management Interview Protocol | **26**–27 |
| | | Internal Document Review Guidelines | **12** |
| | **Understands current immigration patterns and issues** | Staff Survey | 65; 86 |
| | | Internal Document Review Guidelines | **12** |
| **Leadership** | **Works well within the LHD and in the community and serves as liaison between the two** | Staff Survey | 60; **66–68**; 69 |
| | | Collaborating Partner Survey | **31** |
| | **Can engage, mobilize, coach and mentor others** | Staff Survey | 28–29; **98** |
| | | Staff Focus Group Protocol | 4a, **b** |
| | Understands and navigates power dynamics | Staff Survey | **69** |
| | | Staff Focus Group Protocol | **4a**, **b** |
| | Politically astute | Staff Survey | 69 |
| | | Staff Focus Group Protocol | **4a**, **b** |
| **Collaboration Skills** | Good interpersonal skills | Staff Survey | 107 |
| | | Staff Focus Group Protocol | **4a**, **b** |
| | Team player | Staff Survey | 37; 73 |
| | | Staff Focus Group Protocol | **4a**, **b** |
| | | Collaborating Partner Survey | 32; 39–40 |
| | **Knows how to share power** | Staff Survey | 68 |
| | | Staff Focus Group Protocol | **4a**, **b** |
| | | Collaborating Partner Survey | 41; 45 |
| | **Trusts in partners** | Staff Survey | **60**; 73 |
| | **Cross disciplinary communication skills** | Staff Survey | 37 |
| | | Collaborating Partner Survey | 39 |

| Major Domain | Matrix Element | Instrument | Question Number |
|---|---|---|---|
| **Community Organizing** | **Ability to inspire community involvement/ownership** | Staff Survey | 28–29; 78–79 |
| | | Staff Focus Group Protocol | **4a**, **b**; **12** |
| | | Collaborating Partner Survey | 50–**51** |
| | | Management Interview Protocol | 20 |
| | **Ability to build trust** | Staff Survey | 60; 73 |
| | | Staff Focus Group Protocol | **4a**, **b** |
| | | Collaborating Partner Survey | **32** |
| | **Ability to develop and promote leadership of community** | Staff Survey | **78**; 87 |
| | | Staff Focus Group Protocol | **4a**, **b**; **12** |
| | | Collaborating Partner Survey | **49**; **51–52** |
| | | Management Interview Protocol | **20** |
| | **Ability to develop and promote community networks** | Staff Survey | 47–59; 75–76; **83** |
| | | Staff Focus Group Protocol | **4a**, **b**; **12** |
| | | Collaborating Partner Survey | **50** |
| | | Management Interview Protocol | **21** |
| **Problem Solving Ability** | **Negotiation and conflict resolution skills** | Staff Survey | 69 |
| | Willing to take risks | Staff Focus Group Protocol | **7** |
| | | Management Interview Protocol | 11 |
| | **Able to learn from failures** | Staff Focus Group Protocol | **9** |
| **Cultural Competency Humility** | **Cultural respect and humility** | Staff Survey | **104–107**; 110–111 |
| | | Management Interview Protocol | 16 |
| | | Internal Document Review Guidelines | **8–10** |
| | **Appreciates that diverse perspectives and roles are necessary to promote public health** | Staff Survey | 106; 123 |
| | | Staff Focus Group Protocol | **11** |
| | | Management Interview Protocol | **14**; **16**; **17** |
| | | Internal Document Review Guidelines | **8–10**; **17** |
| | **Effective cross cultural communication** | Staff Survey | 84; 107 |
| | | Collaborating Partner Survey | **47** |
| | | Internal Document Review Guidelines | **8–11** |
| | **Interprets data to diverse audiences** | Staff Survey | **84** |
| | | Collaborating Partner Survey | 47; **48** |
| | | Internal Document Review Guidelines | **11** |

# APPENDIX IV: Sample Communications for Self-Assessment Participants

Appendices

## Staff Survey

*This is a sample email sent to all internal staff of the LHD to ask for their participation in the Staff Survey. This sample email can be used if the Staff Survey is to be conducted using a unique-link protocol.*

**Subject line:** Online Staff Survey: Assessing [LHD Name]'s Capacity to Address Health Inequities

Dear [LHD Name] staff,

As you know, [LHD Name] is engaging in an organizational Self-Assessment to determine its capacity to address the root causes of health inequities. An important part of this process is an agency-wide survey of all staff members. These surveys are completely confidential; none of your responses will be linked to you individually.

Please click here to enter the survey, or enter this link into your browser:

[Survey link]

***Please complete the survey by 5 pm on [Day, Date].***

If you would like to return to your survey to finish at a later time or change any responses, you can do so at any time within the survey period by following the original survey link from *YOUR OWN EMAIL ACCOUNT.* **Each staff member has their own unique link to the survey, so it is important that you do not forward your survey link to others or use a co-worker's link to access the survey.** Your responses will be saved each time you click the "next" button on each survey page, so if you need to leave the survey before you complete it, just hit "next" at the bottom of the last page completed and close the browser. You will be taken automatically to the page where you left off when you come back to the survey.

**Thank you very much for taking the time to complete this survey. Your perspective on this important topic is valuable and appreciated! Prizes will be given out for high completion rates: [include incentive details].**

If you have any questions at any time, you may ask any member of the implementation group: [names of staff members].

If you have any trouble accessing the survey or have any other questions, please contact [name of survey administrator] at [email] or by phone at [number].

*This is a sample email sent to all internal staff of the LHD to ask for their participation in the Staff Survey. This sample can be used if the Staff Survey is to be conducted using a general-link protocol.*

**Subject line:** Online Staff Survey: Assessing [LHD Name]'s Capacity to Address Health Inequities

Dear [LHD Name] staff,

As you know, [LHD Name] is engaging in an organizational Self-Assessment to determine its capacity to address the root causes of health inequities. An important part of this process is an agency-wide survey of all staff members. These surveys are completely confidential; none of your responses will be linked to you individually.

Please click here to enter the survey, or enter this link into your browser:

[Survey link]

***Please complete the survey by 5 pm on [Day, Date].***

The survey should take 30–45 minutes to complete. It is important that you complete the survey in one sitting. If you leave the survey before completing it, you will need to start the survey again from the beginning.

**Thank you very much for taking the time to complete this survey. Your perspective on this important topic is valuable and appreciated! Prizes will be given out for high completion rates: [include incentive details].**

If you have any questions at any time, you may ask any member of the implementation team: [names of staff members].

If you have any trouble accessing the survey or have any other questions, please contact [name of survey administrator] at [email] or by phone at [number].

## Collaborating Partner Survey

*This is a sample letter to alert community partners to the Self-Assessment process the LHD is undertaking, and to the upcoming survey they will be asked to participate in. It should be signed by the public health official or lead executive at LHD or, if that is not feasible, it can be signed by other members of senior management/leadership staff.*

**Subject line:** [LHD] Survey

Greetings! You are receiving this email because you are someone who works with [LHD name]. [LHD] is currently working on assessing our capacity to address health inequities/disparities and the social determinants of health, such as income and education. As a representative of a community group, community-based organization or public agency serving the [local place name] community, we would very much like to get your perspective on how well-prepared you believe we are to address health inequities in our community.

In the next few days, we will be contacting you with information on completing an on-line survey about the [LHD]. The answers will be completely confidential. We know you are very busy and appreciate you taking time to complete the survey to help us do a better job of reducing health inequities in [local place name] and helping EVERYONE live long, healthy lives.

If you have any questions, please feel free to contact anyone you work with at the health department or [designate point person from the implementation team].

Thanks again for your help.

Sincerely,

[Name], Lead Executive/Public Health Official

*Signatories can include other leadership staff*

*This is a sample invitation to take the online Collaborating Partner Survey that should be used if the survey is to be conducted using a unique-link protocol.*

**Subject line:** [LHD name] Survey

Dear [firstname],

As you have been informed in a recent email from [Lead Executive/Public Health Official], [LHD] is currently working on assessing its **capacity to address health inequities/disparities** and the social determinants of health such as income and education **and is asking for your participation in the form of a brief survey.** The goal of the Collaborating Partner Survey is to gather perspectives from a broad range of community groups, community-based organizations and other public agencies that may partner with [LHD] on public health approaches, strategies and activities that help address health inequities.

Let me assure you that your name and organization will never be linked to your responses, and your participation has no impact on your current or future work with [LHD]. The analysis of survey results will be conducted by a contractor/staff member with no direct influence into any contract/agreement between [LHD] and your organization.

***Please complete the survey by 5 pm on [Day, Date].***

Please complete this questionnaire at your earliest convenience by following this link:

[Survey link]

The survey should take you no more than 15 minutes.

If you would like to return to your survey to finish at a later time or change any responses, you can do so at any time within the survey period by following the original survey link from *YOUR OWN EMAIL ACCOUNT.* **Each participant has their own unique link to the survey, so it is important that you do not forward your survey link to others or use anyone else's link to access the survey.** Your responses will be saved each time you click the "next" button on each survey page, so if you need to leave the survey before you complete it, just hit "next" at the bottom of the last page completed and close the browser. You will be taken automatically to the page where you left off when you come back to the survey.

**Thank you very much for taking the time to complete this survey. Your perspective on this important topic is valuable and appreciated!**

If you have any questions or concerns, please do not hesitate to contact me at [phone number] or [email address].

Thank you again for your participation.

Sincerely,

[Name]

*This is a sample invitation to take the online Collaborating Partner Survey if the survey is to be conducted using a general-link survey protocol.*

**Subject line:** [LHD name] Survey

Dear [firstname],

As you have been informed in a recent email from [Lead Executive/Public Health Official], [LHD] is currently working on assessing its **capacity to address health inequities/disparities** and the social determinants of health such as income and education and **is asking for your participation in the form of a brief survey**. The goal of the Collaborating Partner Survey is to gather perspectives from a broad range of community groups, community-based organizations and other public agencies that may partner with [LHD] on public health approaches, strategies and activities that help address health inequities.

Let me assure you that your name and organization will never be linked to your responses, and your participation has no impact on your current or future work with [LHD]. The analysis of survey results will be conducted by a contractor/staff member with no direct influence into any contract/agreement between [LHD] and your organization.

***Please complete the survey by 5 pm on [Day, Date].***

Please complete this questionnaire at your earliest convenience by following this link:

[Survey link]

The survey should take you no more than 15 minutes.

**Thank you very much for taking the time to complete this survey. Your perspective on this important topic is valuable and appreciated!**

If you have any questions or concerns, please do not hesitate to contact me at [phone number] or [email address].

Thank you again for your participation.

Sincerely,

[Name]

## Staff Focus Groups

*This is a sample email to inform staff of upcoming focus groups.*

*Before specific staff members are invited to participate in a focus group, the Public Health Official or another leadership staff member involved with the Self-Assessment process should email all staff to encourage their participation in the focus groups and assure them that it is an approved use of their time at work. This email is also an opportunity to remind staff of the LHD's commitment to the Self-Assessment process and provide follow-up from the survey component, creating momentum for staff participation.*

**Subject line:** Staff Focus Groups: Assessing [LHD Name]'s Capacity to Address Health Inequities

Dear staff,

As you may recall, our [LHD] is participating in an organizational Self-Assessment process to determine our capacity to successfully reduce health inequities in our community. In [month] there was an on-line Staff Survey that was designed to assess some aspects of our capacity, and [X%] of staff completed the survey, which is a GREAT response rate.

The next phase of the assessment involves staff focus groups that will be conducted by [description of who will be facilitating the groups]. They will be contacting randomly-selected staff that represent all classification levels to participate in these focus groups. Supervisors will be allowing their staff release time to participate in the focus groups. Staff will be paid for their time as regular work time.

Your participation in the focus group is voluntary. Information you share in the focus groups will be kept confidential. Common themes among participants will be shared in a report. Any statements quoted in the report will not be linked to any individual.

Please let me or one of the other members of the assessment team know if you have any questions [names].

Thanks again for all of your thoughts and input in this important assessment that will allow us to better do our work.

Sincerely,

[Name of Lead Executive/Public Health Official or other leadership staff]

*This is a sample letter sent by the focus group facilitator—not an internal LHD staff member—to invite staff to participate in the Staff Focus Groups.*

**Subject line:** Staff Focus Groups: Assessing [LHD]'s Capacity to Address Health Inequities

Dear _____________,

As you know, [LHD name] is undergoing an assessment process to determine its ability to address the root causes of health inequities.

An important part of the assessment process involves conducting focus groups with staff members. The focus groups will explore the elements of the organizational culture and structure that you may find support or interfere with the agency's ability to address health inequities. We are also interested in learning about the personal characteristics and skills you think people at [LHD] need in order to enable the organization address the root causes of health inequities. To provide for the most comfortable environment in which to speak freely, managers and non-management staff will participate in different focus groups. All of the information we collect in the focus group will be kept CONFIDENTIAL. The information we collect from all the focus groups will be combined and the report will only focus on the themes that emerged from the combined information. No comments or themes will be linked to specific participants. Your input is very important to this assessment process and we hope you will participate.

[Introduce self and describe role as outside facilitator], and I would like to invite you to participate in a focus group. The focus group will last 90 minutes and will be held in [location].

Please let me know which of the following times you are NOT available:

[Offer up to three dates/times]

I hope very much that you will take the time to participate; your perspective is an important piece of the assessment. If you have any questions please feel free to contact me at [phone number].

Thanks in advance for your assistance!

Sincerely,

[Facilitator name]

*This sample communication is a "thank you" letter to be sent to the focus group participants after the group discussion takes place. Because of the personal and time-consuming nature of the participation in a focus group, it is particularly important to acknowledge individuals' contributions to the Self-Assessment process.*

Dear [participant names]:

I would like to extend my sincerest thanks to you all for participating yesterday in the staff focus group for the [LHD]'s health inequities assessment. I really enjoyed meeting each of you, and appreciate the time you took out of your busy day to contribute so thoughtfully to our conversation. This assessment process has been truly enriched by each of your perspectives and insights.

If you have any questions or comments, please contact me at [contact information].

Sincerely,

[Facilitator name]

## Management Interviews

*This is a sample email inviting senior management staff members to participate in individual interviews.*

**Subject line:** Staff Interviews: Assessing [LHD]'s Capacity to Address Health Inequities

Dear [participant name]:

As you know, the [LHD] is undergoing an assessment process to determine its ability to address the root causes of health inequities. The assessment was developed by the Bay Area Regional Health Inequities Initiative (BARHII), a collaboration of eleven health departments in California's San Francisco Bay Area.

An important part of the assessment process is conducting key informant interviews with staff members. The interviews will explore the elements of the organizational culture and structure that you find may support or interfere with the agency's ability to address health inequities. We are also interested in learning about the personal characteristics you think people at [LHD] need in order to enable the organization to address the root causes of health inequities. All of the information we collect in the interviews will be kept CONFIDENTIAL Your input is very important to this assessment process and we hope you will participate.

[Introduce self and describe role as outside facilitator], and I would like to invite your participation in a key informant interview, which should be about an hour long.

**Please let me know if you are available for a phone interview during the following time:**

**[Date and Time]**

If you are not available during any of these times please suggest a time that you are available. Also, if you'd prefer to have an in-person interview, we can arrange to meet at your office or another convenient location.

**I hope very much that you will take the time to participate; your perspective is an important piece of the assessment.** If you have any questions please feel free to contact me at [phone number]

Thanks in advance for your assistance!

Sincerely,

[Interviewer name]

## APPENDIX V: Time and Materials Budget for Implementing the Self-Assessment

Appendices

## Staff Survey

The Toolkit was pilot tested at the City of Berkeley Public Health Division (BPHD) in 2008. The 100 staff of the CBPHD and approximately 50 collaborating partners were invited to participate in the Self-Assessment. To account for the time involved in developing and modifying the implementation process, time estimates for each step in the Self-Assessment are provide in number of hours only and not across a time-span.

The table below shows the estimated investment required for implementing the Staff Survey.

| Survey Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Convening Implementation Team | Leadership and Selected Staff | 5–10 hours per person |
| Communicating with Staff | Leadership, Implementation Team and Managers | 5–10 hours per person |
| Managing Survey | Selected Implementation Team Member | 8–12 hours |
| Completing the Survey | All Staff | 20–45 minutes per person |
| Data Management and Analysis | Analyst | 10–15 hours for data management;<br>15–40 hours for data analysis, including qualitative analysis. This may vary depending on the number of survey participants. |

**Additional Resources Needed:**

- Subscription to online survey tool
- Computer access for all staff
- Optional: Consultant for survey administration and/or data analysis

## Community Partner Survey

The table below shows the estimated investment required for implementing the Collaborating Partner Survey.

| Survey Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Convening implementation team, Survey Preparation | Leadership and Selected Staff | 2–5 hours per person |
| Identifying and Communicating with Partners | Leadership, Implementation Team, and Managers | 2–8 hours per person |
| Managing Survey | Selected Implementation Team Member | 8–12 hours |
| Completing the Survey | Selected Partners | 15–25 minutes per partner |
| Data Management and Analysis | Analyst | 6–8 hours for data management;<br>10–12 hours for data analysis, including qualitative analysis. This may vary depending on the number of survey participants. |

**Additional Resources Needed:**

- Subscription to online survey tool
- Optional: Consultant for survey administration and/or data analysis

## Staff Focus Groups

The table below provides an estimate of the investment required for implementing the Staff Focus Groups.

| Focus Group Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Reviewing focus group protocol and customizing to reflect survey findings and LHD priorities | Facilitator, with assistance from Implementation Team member | 10 hours |
| Selecting and Scheduling Staff | Facilitator, with assistance from Implementation Team member | 1 hour to manage and randomize staff lists; 2 hours to schedule |
| Preparing for and Facilitating Focus Groups | Facilitator | 2 hours per focus group, plus travel time if necessary |
| Participating in the Focus Group | Selected Staff | 90 minutes |
| Qualitative Data Analysis | Analyst/Consultant | 15-20 hours. This may vary depending on the number of focus groups conducted |

### Additional Resources Needed:

- Private meeting room, possibly off-site (but nearby), in which to conduct the focus groups.
- Refreshments for participants.
- *Optional:* Digital recorder to record interviews and funds for a professional transcription service.
- If not trading facilitation services with a colleague organization/neighboring LHD: funds to secure a consultant to facilitate the focus groups and analyze the data.

## Management Interviews

The table below shows the estimated investment required for implementing the Management Interviews.

| Management Interviews Implementation Task | Who | Estimated Staff Time |
|---|---|---|
| Reviewing interview protocol and customizing to reflect survey findings and LHD priorities | Leadership and Implementation Team | 5 hours |
| Selecting and Scheduling Staff | Facilitator, with assistance from Implementation Team member | 1 hour to manage and randomize staff lists; 2 hours to schedule |
| Preparing for and Conducting Interviews | Facilitator | 1 hour per interview, plus travel time if interviews are in-person |
| Participating in the Interview | Selected Management Staff | 1 hour |
| Qualitative Data Analysis | Analyst/Consultant | 10–12 hours |

### Additional Resources Needed:

- Private meeting room/office, possibly off-site (but nearby), in which to conduct the interviews, if desired. Interviews can also be conducted over the phone.
- *Optional:* Digital recorder to record interviews and funds for a professional transcription service.
- If not trading interview services with a colleague organization/neighboring LHD: funds to secure a consultant to conduct the interviews and analyze the data.

## APPENDIX VI: Action Planning Worksheet

Appendices

**Instructions:** Use this worksheet to document any actionable ideas that may have come up in the course of your LHD's reflection on and discussions about the findings from the Self-Assessment. This tool is for LHD leadership and staff to use as a catalyst for creating concrete next steps to enhance your organization's capacity to address the root causes of health inequities.

| | Opportunities for Action | Resources needed | Partners needed | Leader | Timeline | Monitoring | Result: What is the change we would see? |
|---|---|---|---|---|---|---|---|
| | What action do we wish to initiate, and what issue or finding does it address, if applicable? | What additional support or resources would help us achieve this more effectively? | Who should we consult, inform, or collaborate with to make this action more effective? | Who will serve as the point person for making this happen? | What are the steps required for this action, and when we will aim to achieve them? | What are the milestones of progress, and how will we measure them? | If this idea is successfully implemented, what specific measurable changes would we see in our organization and/or community? |
| **Action 1** | | | | | | | |
| **Action 2** | | | | | | | |
| **Action 3** | | | | | | | |
| **Action 4** | | | | | | | |
| **Action 5** | | | | | | | |

# APPENDIX VII: Technical Guidelines

Appendices

## Staff and Collaborating Partner Surveys: Analysis Guidelines

The following are rough guidelines on exporting, cleaning and preparing the data for analysis. *SurveyMonkey* provides very basic analysis. It is recommended that once you have completed the survey administration, you should export the data into software such as SPSS or Excel. Following are tips for managing and conducting basic analysis of your data. For more detailed analysis and reporting, we recommend hiring a consultant if you do not have staff with that expertise.

### Quantitative Data

#### Data Management

- [ ] Ensure that all variables are named and labeled correctly.
- [ ] Add and recode value labels for all numeric variables:
    - All scales should be labeled in the correct order. In a five-point scale, the lowest level value should equal 1 and the highest level value should equal 5. For example, in a satisfaction five-point scale, “Not at all satisfied” should equal 1 and “Very satisfied” should equal 5. (Note that the Partner Survey scale is opposite, with 1 equaling “Strongly Agree.”)
    - All questions with an option to check all that apply will export each response option in separate variables. When exported, value labels will appear only for response options selected by the respondent.

      **Example:**

      If a respondent selected response option 1 and 2, but did not select response option 3 then that case will show a 1 for the first variable, a 2 for the second variable, and nothing for the third variable.

      Recode all variables so anything that was selected/checked equals 1 and anything that was not selected equals 0 (i.e. “Checked”=1 and “Not Checked”=0) as shown in the table below.

      Once you have recoded all variables for that question, check for system missing data. If a respondent did not select any of options in that question, then all of those variables should be recoded as system missing (i.e. 99=missing value). Make sure to declare your missing values so that the value you assign then (i.e., 99) won’t be included in analyses.

**Before Cleaning Data**

| Cases | Var 1 | Var 2 | Var 3 |
|---|---|---|---|
| Staff 1 | 1 | 2 | |
| Staff 2 | | 2 | 3 |
| Staff 3 | 1 | | |
| Staff 4 | | | |

**After Cleaning Data**

| Cases | Var 1 | Var 2 | Var 3 |
|---|---|---|---|
| Staff 1 | 1 | 1 | 0 |
| Staff 2 | 0 | 1 | 1 |
| Staff 3 | 1 | 0 | 0 |
| Staff 4 | 99 | 99 | 99 |

    - All questions with Yes/No options should be labeled consistently. Recode values so “Yes” always equals one (1) and “No” always equals zero (0).
    - Check all questions that include an “I don’t know” or “Not Applicable” option. Run preliminary frequencies and determine if you’d like to include that option in your analysis. If not, recode all “I don’t know” values as system missing (i.e. 88=I don’t know, 77 = Not Applicable). Make sure to declare your missing values. You may want to include “I don’t know” and “Not Applicable” in the initial frequencies of all variables, and then declare these responses as missing when calculating means and other statistics.
    - For questions that include an “Other” category, see if the response given in the string variable can be included in one of the existing numeric categories. If so, recode appropriately.

- [ ] After data management, run frequencies on all variables and see if you notice any inconsistencies or additional cleaning that needs to happen before analysis. Check for:
  - Unexpected or counter-intuitive findings, such as consistently low ratings in an area where the agency has done a lot of work (the scale may have exported incorrectly).
  - Very high proportion of missing data (responses may have exported or coded wrong).
  - These responses may be real, but skimming your data for these red flags first can help catch coding errors.

### Data Analysis

- [ ] Run frequencies for all variables. We suggest analyzing the data specific to each domain of the Matrix separately to make it easier to translate the output into tables that group similar data.
- [ ] Run cross tabs for selected variables. The Leadership and/or Implementation Teams should discuss what data groupings would contribute to the understanding of staff responses. For example, breaking out staff responses to certain questions by race/ethnicity, staff position, length of time at the agency, or whether they work directly with the community may provide important context to overall findings.
- [ ] If desired, run statistical tests, such as t-tests and ANOVAs for means differences and chi-square tests for differences in proportions, to test whether differences observed in the cross tabs are statistically significant.

## Qualitative Data

### Data Management

- [ ] Make sure all string (text) variables are exported. If you notice string variables where there are no responses from any of the respondents, check the original data to see if any responses that are actually given are missing in the exported file. Skimming the original data for this red flag first can catch any exporting errors.
- [ ] If a response is greater than 255 characters, it may get cut off when exported into SPSS. If a response appears incomplete, check the original data.

### Data Analysis

- [ ] Organize all open-ended responses into recurring themes to make it easier to interpret.

  Throughout the survey, ratings matrices are often followed by an open-ended question asking survey participants to explain their ratings. It may be helpful to run the frequencies of the string variables individually by each of the preceding questions, so that its corresponding rating can contextualize each comment. In SPSS, an alternative for analyzing open-ended responses in the context of other responses given by the same staff member is to use the “List” function to display selected responses side by side for each respondent.

## Staff Focus Groups and Management Interviews: Analysis Guidelines

### Qualitative Data

The tips below provide suggestions for making use of the qualitative data generated by the focus groups and interviews with management staff.

#### Data Analysis

- ☐ Use the Matrix of Workforce Competencies and Organizational Characteristics for Addressing Health Inequities as an organizing framework for the analysis. Because the focus group and interview protocols are designed to elicit responses about personal and organizational characteristics on the Matrix, it may be helpful to start with the list of Matrix domains at the beginning of this section and assign these domains as themes under which to organize the responses found in the focus group and interview data.
- ☐ Of course, additional themes may emerge from the focus groups and interviews that do not easily fit into the Matrix domains; don't force a quote or theme where it doesn't comfortably fit. These themes that arise organically from one or more focus groups or interviews can hold important insights about the organization and its staff, and should be given equal consideration.
- ☐ For the data for the focus groups and separately for the interviews, it may be helpful to make the transcribed text of each session a different color. Then, for the focus group data and separately the interview data, you can cut and paste the responses from each session into a single document organized by Matrix domain and other categories as needed, allowing an at-a-glance view of whether a theme was repeated by several respondents, or if a respondent had a distinct take on an issue, or if the same respondent raised the same issue repeatedly.
- ☐ After all focus group and/or interview data have been grouped into categories, do a thorough re-read of all data to see if other ways of organizing the data come to light. For instance, something that was assigned to a domain early on may later seem to fit better in a different category, based on other responses that were categorized later.
- ☐ Once all focus group and/or interview data are organized, flesh out the themes of the responses relating to each Matrix domain and pull out illustrative quotes that directly represent the voice, tone and meaning of the group's and/or interviewees' responses on that theme.
- ☐ The final step in making use of these rich qualitative data is to refer back to the Staff Survey findings and use these data to help support, contextualize, explain or give an alternate perspective on those findings.
- ☐ The Leadership and Implementation Teams should discuss the added information about staff and organizational capacity provided by the focus groups and/or interviews. See Section V for recommendations for reflecting on the Toolkit data and translating the information into action for your LHD.

# APPENDIX VIII: Summary Tables for Self-Assessment Findings

Appendices

*The tables below provide examples of how you can organize the data from the Toolkit in order to systematically review findings and identify priority areas and next steps.*

## Exhibit 1: Institutional Support for Innovation

This domain includes characteristics such as:

- Support for innovation (think outside box)
- Time for reflective thought
- Time to plan

The items related to this domain were questions [86, 100] in the Staff Survey.

| Staff Survey | |
|---|---|
| **A. [LHD Name] is able to adapt to new communities and changes within the populations we serve.** | |
| No | 11% |
| Yes | 33% |
| **Moving in that Direction** | **56%** |
| Total (n=60) | 100% |

| B. Within my unit we have engaged in group discussions about how our work could address one or more of the environmental, social and economic conditions that impact health. | Non-management | Senior Management | All Respondents |
|---|---|---|---|
| Strongly Disagree (1) | 13% | 6% | 12% |
| **Disagree (2)** | **35%** | **38%** | **36%** |
| Neutral (3) | 20% | 19% | 20% |
| Agree (4) | 27% | 25% | 26% |
| Strongly Agree (5) | 5% | 13% | 7% |
| Total<br>(n) | 100%<br>(57) | 101%<br>(31) | 101%<br>(88) |
| **Average Rating (on a 5 point scale)** | **2.8** | **3.0** | **2.8** |

SAMPLE

## Exhibit 2

| Staff Focus Group |
|---|
| Theme 1 |
| • Summary of comments<br>– (Insert quoted responses) |

SAMPLE

## Exhibit 3

| Management Interviews |
|---|
| • Quoted responses |

SAMPLE

These tables are at the core of the technical findings. The sheer number of these tables with a thorough level of detail can make reading the document cumbersome.

Another way to present the findings is as a technical appendix to an overall report and have the body of the report have the simplified versions of salient tables. These are some examples of how to simplify the tables:

### Example 1

One solution is to aggregate the top (or bottom) two categories of 5-point scales (Strongly disagree/disagree).

**Percent Responding Agree or Strongly Agree to Institutional Support for Innovation (Staff Survey)**

| Item | Non-Mgt (N=57) | Sr. Mgt (N=31) | All (N=88) |
|---|---|---|---|
| A. [LHD Name] is able to adapt to new communities and changes within the populations we serve. (Yes) | | | 33 |
| B. Within my unit we have engaged in group discussions about how our work could address one or more of the environmental, social and economic conditions that impact health. (Strongly Disagree/Disagree) | 48 | 44 | 48 |
| Etc. | | | |

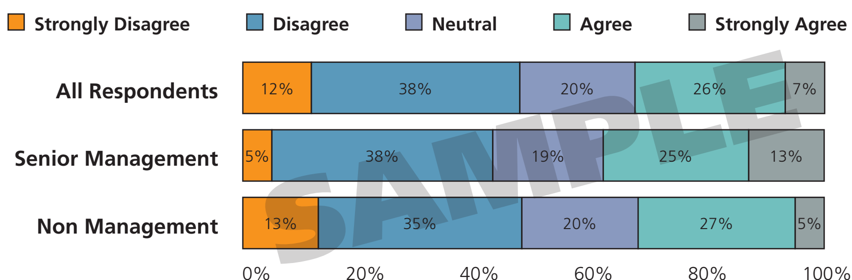
SAMPLE

### Example 2

In the body of the report, ordering the findings within a theme from highest to lowest response number may help prioritize for presentation the most prevalent issues that need follow-up. The top few most prevalent issues of all topic areas may be a way to present the highlights without having to repeat every single survey response (again this applies to the summary in the body of the report. A technical appendix can repeat or summarize the entire survey).

### Example 3

For the main body of the report, please consider graphics to highlight main findings. The tabular information of Likert-like questions can be presented as a horizontal, stacked bar graph.



Appendices

## APPENDIX IX: *SurveyMonkey* Administration Guide

## Getting Started with *SurveyMonkey*

*PRICING: A SurveyMonkey account is a modest investment. At the time of the piloting of the Self-Assessment, a professional SurveyMonkey account cost was $19.95 per month or $200 per year. Go to www.surveymonkey.com for more information.*

The checklist below provides a basic guide on how to use *SurveyMonkey* to implement, collect, and transfer data:

### ☐ Administering Surveys with *SurveyMonkey*

Once the design is complete, the survey is ready to be sent to participants. When distributing the survey, you must determine the method you will use to collect responses. The method used to collect responses is also known as a "collector". While most people use a single collector, you may want to use multiple collectors if you are sending your survey to different groups of people.

The following three "collector" types will determine what restrictions you will have in collecting your data, including whether or not you can track your participants:

**Web Link Collector:** A web link collector collects responses anonymously through the use of a generic link.

**PopUp Collector:** The popup collector provides a code to generate a popup invitation on a designated website. Unless an LHD chooses to implement the surveys through an internal intranet program, this method is not recommended. This method was not used in piloting the Self-Assessment.

**Email Invite Collector:** The email invite collector collects responses that are linked to the participant through a unique link. This collector allows the survey creator to track the status and identity of the participants.

### ☐ Anonymous Responses: Web Link Collector

The Web Link Collector must be used to post generic links, and allows for data collection to occur anonymously.

- On the My Surveys page, click on the Collect icon, this will then show a list of collectors that have been created for that particular survey.
- Click on the first option 'Create a link to send in your own email message or to place on a webpage' then create a name for this link. When finished click on Next Step.
- On the next page, settings and restrictions can be changed by clicking on the options (i.e. Change Settings, Change Restrictions) located on the left side of the page. These options include settings that allow multiple responses to surveys, display a 'thank you' page, and allow participants to edit their responses.
- Click on the Get Survey Link button. From here you have the option of copying and pasting the survey link into emails which will be manually sent out, or the option of copying the HTML code onto a webpage so that participants can click on the link and access the survey from the webpage.
- Save the Collector and distribute the survey to the participant through email or posting the link on a webpage.

### ☐ Tracked Responses: Email Invitation Collector

The Email Invitation Collector must be used in order to send a unique link to each participant, which allows tracking of the status and identity of the participants.

- A list of emails and participants can be added to an Address Book that can be used later on to send out emails. Click on the Address Book tab.
- Create a name for the Address Book and enter the contact information as needed. Make sure that the contact information is added in the correct field order 'Email, First Name, Last Name, Custom Data.' Each email should start on a new line. When done click on Add Contacts.
- On the My Surveys page, click on the Collect icon to create a Collector. If there is already a previously set up Collector click on the button Add New Collector.

- Click on the second option 'Upload your own emails and have us send a survey invitation' then create a name for this link. When finished, click on Next Step.
- On the next page, the survey creator can change settings and restrictions can be changed by clicking on the options (i.e. Change Settings, Change Restrictions) on the left side of the page. These options include settings that allow multiple responses to surveys, display a 'thank you' page, and allow participants to edit their responses.
- Click on the Edit Recipients button to add participants to the survey. Participants can be added manually or from the Address Book. If you would like to use the Address Book to add participants, then choose the appropriate Address Book and click Add Recipients. Participants can be added and removed as needed. When done, click on Create Email Message.
- Customize the email message.
- Survey delivery can be scheduled for *SurveyMonkey* to send out the invitation email with the survey link.

☐ **How to Check Response Rates on *SurveyMonkey***

Using Response Summary, you can check response rates and analyze the survey data.

- To check the Response Summary of survey, first log into the *SurveyMonkey* account and click on the My Surveys tab.
- The My Surveys tab will show all of the surveys currently being administered or surveys that have been closed. Click on the Analyze icon of the survey to check response rates.
- A Response Summary will appear at the top of the page, indicating the number of surveys that were started (Total Started Survey), and the number of surveys completed (Total Completed Survey).
- Total Completed Survey number includes respondents who have clicked the "Done" button on the survey and answered a question on the survey. *This does not mean that they have answered all of the questions on the survey, but have answered enough questions that allowed them to move through all of the pages on the survey and click the "Done" button.*

☐ **How to Send Reminder Emails**

If response rates are low, reminder emails can be sent to participants who have not answered the survey or partially answer the survey. There is also the option of only sending reminder emails to those who have a No Response status.

- On the My Surveys page, click on the Collect icon. Click on the collector that contains the email list that is currently being used for that survey. This will open the Message Manager, which shows a summary of the number of surveys sent, the number of current participants, and the number of those who have not responded to the survey.
- Click on the Edit Message button on the left hand side of the page then click on the Create New Message button. This will allow the survey creator to pick which emails to send the reminder message to.
- There are multiple options for the recipients of reminder emails. Reminder emails can be sent to those who have not responded to the survey or to those who have only partially responded but have not completed the survey. Select the appropriate options for whom to send the reminders to.
- Once you select the names to receive reminder emails, a Compose Email Message page opens. The body of the email message and subject of the email can be customized. Click Save and Preview when done.
- Select the appropriate reminder email recipients.

### ☐ How to Close the Survey Once Data Collection is Done

Surveys can be closed once data collection is done by closing the Collector manually.

- On the My Surveys page, click on the Collect icon located next to the survey title.
- Click on the Open brown box icon in order to set it in the closed position. Once the survey is closed the icon should be a brown box with a red X on top of it, indicating that it is a closed collector.

### ☐ How to Export Data from *SurveyMonkey* to SPSS

To export data from *SurveyMonkey* to SPSS, multiple steps must be conducted.

- First the data must be exported to an Excel file. In order to do this, click on the Analyze icon on the My Surveys page.
- Click on Download Responses found on the left side of the page.
- You must choose the Download format. It is recommended that you use All Response Collected Spreadsheet.
- In the 'Columns' field choose 'condensed', and in the 'cells' field choose 'numerical values'.
- Enter the email address the survey creator wishes the data file to be sent to and click Request Download.
- An email should be sent to the specified email address that was provided for the Request Download configuration. Click on the link sent and download the data. Save the compressed file onto the computer.
- Once you have downloaded the file, open the folder, and open the folder inside titled 'Excel'. Here open the file 'Sheet_1'. It is recommended that you rename and save this as a different file in order to preserve the original data.
- Begin to clean the Excel data sheet. The amount of cleaning in Excel will depend on the nature of the dataset. Rows 1 and 2 contain variable labels in the data set. You must consolidate all information wanted into Row 1, then delete Row 2. Row 1 will read as the variable label in SPSS once exported.
- Open SPSS, and open a blank database.
- In the blank SPSS database, open up the saved and cleaned Excel file. To do this, go to File – Open – Data. Change the file type to .xls files, find the Excel file and click Open. The data from the Excel file should be exported to SPSS. Check to make sure variable labels and data have been transferred correctly and save the file as an SPSS file.

### ☐ How to Transfer the Survey from One Account to Another

Surveys can be transferred from one account to another on *SurveyMonkey*.

- Log into *SurveyMonkey*. Click on the My Account tab.
- Click on the Transfer Survey button located on the left side of the page.
- In order to transfer the survey to another account, the username of that account must be known. Enter the account username the survey is being transferred to.
- Select the survey to be transferred from the dropdown menu and select Copy Survey or Move Survey button. If copying the survey to your own account to administer the survey at your LHD, choose the "Copy Survey" option. This will copy only the survey instrument itself and not any previously recorded data. Once an option is chosen, click on the button and the survey will have been moved or copied to the designated *SurveyMonkey* account.

**Red Flag**

If Copy Survey option is chosen, this will only copy the survey instrument itself into another account. The data and responses from the survey will not be transferred to the other account and will be lost. To transfer responses from the survey choose the Move Survey option.

# APPENDIX X: Implementing the Organizational Self-Assessment for Addressing Health Inequities: Lessons Learned

Appendices

## Key Lessons Learned from Berkeley Pilot Experience

The pilot-testing process produced invaluable information for any LHD that is considering implementing the Self-Assessment (bold). The following are the key lessons learned:

### Timing

The Self-Assessment is most appropriate when an LHD has already begun to have conversations about health equity and root causes of health inequities. It may be less useful if used too early in an organizational change process focused on health equity.

### Leadership Commitment

Senior and middle leadership in the LHD must clearly communicate their commitment to long term engagement on health inequities. They must express their support for the assessment process, the time involved in implementing the assessment and to taking actions informed by the assessment to increase the department's capacity to effectively address health inequities.

### Strong Implementation Team

The LHD needs a strong implementation team to coordinate with organization leadership and keep internal processes moving toward implementation of the Self-Assessment. This team should utilize motivational strategies to encourage staff participation.

### Context

The Self-Assessment is one component of an LHD's broader plan and activities to address health inequities. This broader plan should lay the groundwork for staff to place the Self-Assessment in a larger context of the organization's work.

### Analysis and Follow-Up

It is important that Self-Assessment lead to actions. The LHD must commit adequate resources to the analysis and summary of assessment findings, as well as committing to the formulation of a response, recommended actions, or action plan. The self-assessment yields a wealth of information which may be daunting if the LHD is not prepared for and committed to using it constructively. The Self-Assessment can serve as a tool to engage staff on health equity issues and inform future LHD activities that implement a broad health equity plan.

## Prior to Self-Assessment

About three months prior to initiating the assessment, the leadership should form an "implementation team". They should designate a core group of staff (4-15 people, as appropriate for the size and structure of the organization) that will coordinate with organization leadership and keep internal processes moving. Ideally there should be representatives of most department sites and major classifications in this group so that they can promote the assessment throughout the organization and answer questions from staff as the assessment is implemented.

About two months prior to the assessment the leadership and the "implementation team" should revise the tools to make sure that the language and content makes sense for their department.

Beginning two months prior to launching the assessment, staff should be informed that the assessment is coming. This is best accomplished through regular department communication strategies. For example, if a department generally disseminates information about new projects first through meetings with upper management who then communicate the information to their staff and down through the front-lines, that is recommended for this assessment as well. If the department generally communicates such information through "special meetings", we recommend using that method for this process.

## Survey Implementation

It is important for organization leadership to prepare those that will be participating in the assessment process (i.e., public health department staff, community partners):

- ☐ Communicate the purpose of Self-Assessment and why staff/partners are being asked for input. Ensure that this communication is clear and that it penetrates all levels of the organization.
- ☐ Make sure that the terms, definitions and activities referenced in the survey are familiar to the staff that will be completing the survey so that the meanings of the responses can be interpreted clearly.
- ☐ Give managers and supervisors the information, time and flexibility they need to answer staff's questions and to enable and encourage staff to participate.
- ☐ Ensure that all staff have the time and computer access to complete the survey.
- ☐ Give staff an incentive to participate while still protecting their confidentiality in the assessment process (i.e., all staff are eligible for raffle prizes if overall response rate reaches a certain level.)

**Berkeley Case Example:**

After communicating about the Self-Assessment to all staff through staff meetings and emails from leadership and supervisors, offering computer lab access to the survey at multiple designated times, offering an all-staff raffle for high completion rates, and sending only one reminder email about the Self-Assessment, Berkeley achieved a 65% response rate. Targeted, individualized follow-ups with non-responders and those who only partially completed their surveys boosted the response rate to 81%.

- ☐ Clear instructions are critical, especially those relevant to technological aspects of the survey.
- ☐ Consider the tradeoffs of various survey administration methods and be proactive about the potential drawbacks of the chosen method.

**Berkeley Case Example:**

Berkeley decided to use individual email links to staff so that the consultant could track the identities of respondents to enable targeted follow-up for a high response rate, and for staff to be able to start their surveys and finish them at a later time since the surveys were long. Berkeley did not anticipate that staff would forward survey links to each other, as a means of encouraging survey participation. This resulted in unforeseen consequences of incomplete surveys, surveys attributed to the wrong person, and potential breaches of confidentiality. Clarity about how to access the survey would have avoided this. It is important to be familiar with the technical aspects of the survey administration tools used.

## Implementation of Focus Groups and Interviews

☐ Consider the balance of power being represented in the qualitative data.

**Berkeley Case Example:**

Because those in leadership positions in Bay Area health departments were heavily involved in the development of the tools and in otherwise designing the Self-Assessment, the voices of those with less power were already underrepresented. Berkeley realized that the qualitative components of the Self-Assessment provided an opportunity to bring more line staff voices into the process. Berkeley modified the focus groups to include more line staff and fewer senior management staff, because senior management staff was heavily involved in the design and development of the self-assessment tools. LHDs should consider what focus group composition will be most useful for their own self-assessment.

☐ Protect participants' identities and confidentiality as much as possible.

- If feasible, ask the internal implementation team to develop large pools of staff from which focus group participants can be randomly selected. The implementation team should generate a list of potential focus-group participants, and participants can be selected randomly from that pool. Important considerations include adequate representation of classifications, functions, and organizational units, and the impact of including supervisors and supervisees in the same groups.
- A similar process should follow for the senior staff interview participants.
- The focus groups should be held in a private space, and can even be held offsite, but nearby the workplace for convenience.
- The interviews can be held in person in private offices, meeting rooms, or other private space on or offsite. Phone interviews may better accommodate busy schedules that don't allow for travel time to and from a site outside the interviewees' own offices.
- Participants should be offered a choice of workday and after-hours times in which to participate, to accommodate individuals' preferences for balancing their time and privacy. In the Berkeley pilot, we found that all participants were comfortable participating during working hours.

## Review of Existing Documents and Materials

As originally piloted, this step of the Self-Assessment was very time consuming and did not yield consistently fruitful findings. For that reason, the original tool developed for this process is not included in the Toolkit at this time. However, it may still be useful for an LHD to systematically examine certain institutional documents, especially budget documents, with respect to its commitment to addressing the root causes of health inequities. Therefore, guidelines for a selective review that reflects agency priorities are offered in the Toolkit. Any review of internal documents, educational/community materials, proposals, budgets, and other data sources should be done in the context of deliberate efforts by the LHD's leadership to reflect on the findings of such a review.

## Frequently Asked Questions & Recommendations from the Berkeley Pilot

**Question** What steps should be taken to give people adequate notice/information/background about the project in order to maximize participation?

**Answer** We recommend that a LHD have some formal and informal basic training and discussion on issues of health inequities at least 6 months prior to initiating the emails, regular meetings, and training.

**Question** What are the duties of the "implementation team"?

**Answer** At Berkeley, this "Implementation Team" performed such tasks as:

- Reviewing, adapting and approving tools
- Communicating pilot process and purpose department-wide
- Promoting the self-assessment among staff. This included "cheerleading/motivation" activities, clarifying tool purpose, and being available to answer questions
- Communicating to staff and partners about the Self-Assessment
- Providing consultants with all-staff email distribution list for survey administration
- Identifying appropriate community partners to survey
- Providing focus group facilitator with names and contact information for potential focus group and interview participants, including information about position level and organizational location to ensure an appropriate mix of perspectives in the qualitative data
- Managing the internal document review process

**Question** Were there key individuals/motivators who made the project successful?

**Answer** The "Implementation Team" was critical to success. We recommend this group include a mix of organizational levels and reflect the diversity of the LHD. We also recommend staff from various department sites be represented.

**Question** Can the role of implementation be assigned to people whose jobs it is normally to collect things and encourage participation from others? Who makes the ideal "Implementation Team" member? How critical is it that they be already engaged in and understand health equity issues?

**Answer** The most important characteristic of the "Implementation Team" members was that they were effective in motivating their peers and other staff. They needed to have positive "can do" attitudes. It was less important that they be familiar with health equity or have "organizational power".

**Question** Was there a separate/different framing for people who are not familiar with "health equity" and the LHD efforts in this area?

**Answer** As we have noted, it is important that some basic training/discussion on health inequities has been completed prior to beginning the Self-Assessment. All staff should have a basic awareness of the issues.

**Question** How often should people be reminded to participate in the survey and focus groups?

**Answer** Staff received weekly email reminders to participate and numerous informal verbal reminders by implementation team members.

**Question** What mechanisms should be used in order to be clear that the process is confidential/anonymous?

**Answer** Completing the on-line survey without a link to individual emails increases trust. The trade-off is that you can't determine which staff have completed it, so reminders can't be given to specific staff. Having focus groups facilitated by outside facilitators rather than LHD staff increases trust as well. Repeated assurances from leadership that they can't access individual responses may help increase trust.

**Question** What incentives were used, at which stages? Were there other incentives that you heard would have worked better?

**Answer** For the all-staff on-line survey, Berkeley used the following incentives (since leadership staff would not know the names of staff who completed or didn't complete, individual incentives were not possible). The final completion rate was 81%. With a 90% completion rate, all staff would receive a chocolate thank you and be entered into a raffle for fifteen $10 Peet's coffee gift cards. With an 85% completion rate, all staff would receive a chocolate thank you and be entered into a raffle for ten $10 Peet's coffee gift cards. With an 80% completion rate, all staff would receive a chocolate thank you and be entered into a raffle for five $10 Peet's coffee gift cards.

We recommend that each LHD utilize incentives unique to their staff preferences. If you don't know what would incentivize your staff, you should find out!

**Question** What were the pitfalls of the project components/tools that we should be mindful of?

**Answer** A problem with the Collaborating Partner Surveys was that they were conducted electronically and thus some partners without computer access were left out. Berkeley recognized this problem early on, but due to resource limitations, we felt that it was better to get on-line survey feedback from partners than no data at all. We recommend interviews and focus groups with community partners where resources allow.

A problem with the focus group was having a facilitator unfamiliar with LHDs so follow up probe questions were often missing or off the mark. There were also too many focus group questions, resulting in less time to explore answers more deeply. We recommend only 3-4 major questions for an hour-long focus group. We also recommend that the focus group be taped and an experienced transcriptionist transcribe the notes where resources allow. If this is not feasible, we recommend that a second staff person type notes on a laptop during the discussion. Focus groups must be conducted and analyzed by individuals with skill and experience in using this qualitative assessment tool. In inexperienced hands the results can be misleading.

**Question** What are the advantages/disadvantages of having focus group facilitators who are familiar with the people/structure/environment at the individual LHD?

**Answer** We recommend that focus group facilitators have a good knowledge of LHDs, but it is not necessary to be familiar with the individual health department. They should have a basic orientation to the LHD organizational chart and mission/vision/goals. It is important that they have expertise in facilitating discussions about racism, poverty and other challenging subjects. If an LHD does not have access to an experienced facilitator, it is best to not do the focus groups at all. Summarizing the salient points from key informant interviews and focus groups is critical, time consuming, and must be done by adequately skilled and trained staff.

**Question** How much was trust an issue, and what advice do you have for creating an environment of trust with this project?

**Answer** Trust was a big issue among some staff and not for others. We recommend that LHDs ensure that the "Implementation Team" is representative of all staff and that communications are ongoing and clear. We recommend

that as many "safety features" as are possible are put in place (ex: anonymous surveys, external facilitators for focus groups, etc.)

**Question** Are there other ways that we could have gotten honest information from staff, management, community, etc?

**Answer** One idea that was discussed was to talk with staff who recently left the LHD and with community partners that we no longer sub-contracted with. This would remove some of the power differential, although it might include some people who were upset with the LHD.

**Question** Are there key recommendations from the pilot process?

**Answer** It is extremely important that LHDs plan for and commit to substantive analysis of findings and use the results to inform next steps. We would recommend a final report that includes interpretation of findings and recommendations for action. The report should include a clear and concise "executive summary" to be distributed internally and to community partners and others. Finally, the LHD should plan from the beginning how it will go about developing next steps or an action plan.

**Question** What was the biggest challenge for Berkeley in the piloting of the Self-Assessment?

**Answer** The biggest challenge has been interpreting the information to build on strengths and successes as well as identifying gaps and determining how to rectify them. We need to continue to identify mismatches between internal and external perceptions and develop an action plan to address all of the findings.

Appendices

## APPENDIX XI: Annotated Bibliography

Allegrante, J.R., Moon, R. W., Auld, E. M., & Gebbie, K. M. (2001). Continuing-education needs of the currently employed public health education workforce. *American Journal of Public Health*, 91(8), 1230-1234.

This article examined the needs of people currently employed in the public health education workforce. A panel was created to identify skills and competences that currently employed individuals in the public health workforce needed in order to effectively practice. The panel identified areas of critical competence that must be strengthened. These areas include computing and technology; business management and finance; communication; strategic planning; coalition building and leadership; evaluation; community health planning and development and cultural competence.

Amodeo, A.R. (2003). Commentary: Developing and retaining a public health workforce for the 21st century: Readiness for a paradigm shift to community-based public health. *Journal of Public Health Management Practice.* 9(6), 500-503.

This commentary describes different efforts to reform the public health system and bring public health and medicine closer together. It profiles initiatives in California that link health departments and community-based organizations in an effort to improve community health, and recommends that further work be done in showing that community collaborations is a necessary next step to improve the health of communities.

Andrulis, D. Delbanco, T. Avakian, L. and Shaw-Taylor, Y. Conducting a Cultural Competence Self-Assessment.

This article provides an overview and purpose for conducting an audit of an organization's cultural competence as well as the steps to follow in the self-assessment process. The authors identify 5 steps: Organization, Competing the Questionnaire (included in the article), Interviews, Evaluation of Results, and Report and Action. This article will help an organization evaluate where it sits within a "spectrum of cultural competence."

**This article includes questions for interviews as well as a cultural competence questionnaire.*

Betancourt, J.R., Green, A.R., & Carrillo, J.E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. *The Commonwealth Fund,* 1-27.

This article underscores the importance of cultural competence strategies as a way to address the disparities in access to and quality of health care across different racial and ethnic groups, and identifies barriers to culturally competent care. The authors conducted site visits to an academic, government, managed care and community health care programs to compare and contrast different models of cultural competence health care. The article includes detailed recommendations to achieve organizational cultural competence and systematic cultural competence drawn from research and site visits.

Brach, C. & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review.* 57, 181-217.

This article identifies nine major cultural competency techniques which form a framework for how the health field can combat the negative health consequences that result from inadequate or no cultural competence. The techniques are: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The authors posit that cultural competency measures such as their nine techniques reduces racial and ethnic health disparities, but they note that further experimental study must be done.

Davies, H.T., Nutley, S.M., & Mannion, R. (2000). Organizational culture and quality of health care. Quality and Safety in Health care. http://qhc.bmjjournals.com/cgi/content/full/9/2/111. 2006 July 18.

With authors based in the UK health system, this article gives a perspective on how health care reform is being discussed outside of the USA. The authors assert that systemic change is necessary in order to improve the quality of healthcare, specifically by honoring the diversity of healthcare consumers and diversity in organizational culture. However, the authors propose that in order to revolutionize the quality of health care through cultural transformation, more specificity is needed regarding what type of organizational culture is most desirous.

Deschaine, J., E., & Schaffer, M.A. (2003). Strengthening the role of public health nurse leaders in policy development. *Policy, Politics, & Nursing Practice,* 4, 266 – 274.

This qualitative study identified and analyzed factors that affect public health nurses leaders and their ability to influence public health policy development. Factors that were examined, included political competencies, barriers to effective policy making, leadership support systems, and knowledge of the health policy-making process. Results indicated support for Longest's model of focusing on three phases of the public policy-making process. This includes policy formulation, policy implementation, and policy modification. Recommendations from this study include supporting growth in leadership and political competence, research skills, and preparation in policy development.

Dreachslin, J.L. (1999). Diversity leadership and organizational transformation: Performance indicators for health services organizations. *Journal of Healthcare Management,* 44(6), 427-439.

Based on case study research that document strategies of health service organizations striving to achieve competitive advantage through market positions as (racial and ethnic) diversity leaders, this article defines 5-part process and behaviorally based performance indicators for each. Some of the indicators described in this article are are pertinent to the Matrix of Workforce Competencies and Organizational Characteristics.

Goode, T.D., Jones, W., & Mason, J. (2002). A guide to planning and implementing cultural competence organizational self-assessment. *National Center for Cultural Competence, Georgetown University Child Development Center,* 1-6.

This article posits that in order to improve services in a culturally competent manner, tools are needed to assess the attitudes and needs of administrators, service providers and consumers. The National Center for Cultural Competence advocates for self-assessment as a means to accomplish this, and they outline the benefits of self-assessment, five guiding principles of self assessment, and steps for planning and implementing self-assessment.

Handler, A., Iseel, M., & Turnock, B. (2001). A conceptual framework to measure performance of the public health system. *American Journal of Public Health,* 91(8), 1235-1239.

This article presents ways to facilitate the measurement of public health system performance by using a unifying conceptual framework. An expert panel along with the Public Health Practice Program Office of the Centers for Disease Control and Prevention (CDC) developed this framework that consists of 5 interrelated components. These components are mission, structural capacity, processes, macro context, and outcomes. The article concludes that such an interconnected conceptual framework is recommended in order to provide a scientific base of the performance of the public health system performance.

Hutchinson, K.D., & Turnock, B.J. (2000). Feasibility of linking core function-related performance measures and community health outcomes. *Center for Public Health Practice,* 1-33.

This article examines the core function-related performance of Illinois local health jurisdictions in order to develop a methodology for examining relationships between public health practice and actual community health outcomes.

Potentially generalizable findings include:

- Core function-related performance is dynamic and is sensitive to changes in local health jurisdiction leadership as well as the time cycle of the IPLAN (Illinois Project for Local Assessment of Need) process.
- Outcome measures that are sensitive to short-term interventions tend to be of greater value in linking local health jurisdiction core function-related performance to health outcomes.
- Impact measures and short-term outcome measures will be more useful in examining links between public health practice performance and community health outcomes than crude death rates.

The authors were unable to identify any positive association and suggest the need for further research on methods for examining the relationship between practice and health outcomes.

This article provides an assessment of Illinois's Project for Local Assessment of Need that links public health agencies with community partners in community health assessment and planning.

**There is some overlap in indicators used with the broad skills areas in the BARHII matrix*

*Examples: includes community input and participation, analyze for determinants of health problems, incorporate public participation in planning, agency strategic plan is linked to community health action plan.*

Iton, A. Transforming Public Health Practice to Address Health Inequities: Communicating with Staff. 2006 NACCHO annual conference.

This PowerPoint presentation includes the information from the Alameda County Health Status Report 2006 that explores health inequities and provides ways for ACPHD to address those inequities.

**The presentation includes BARHII's own conceptual model of the factors influencing health inequities.*

Lichtveld, M.Y., & Cioffi, J.P. (2003). Public health workforce development: progress, challenges, and opportunities. *Journal of Public Health Management Practice,* 9(6), 443-450.

This article summarizes The Third Annual Public Health Workforce Development Meeting that was held in January 2003 to facilitate implementing a national action agenda to strengthen the public health infrastructure. The framework for action consists of 6 elements which include identifying competencies, developing related curriculum, monitoring workforce composition, providing individual and organizational incentives to ensure competency development, designing an integrated life-long learning delivery system, conducting evaluation and research and assigning financial support. Priorities for competency development within the field were reached due to the meeting.

Kretzmann, J. & McKnight, J. (1993). Building communities from the inside out: A path towards finding and mobilizing a community's assets. Institute for Policy Research at Northwestern University-Evanton, IL.

This guide examines how troubled communities within the United States have become successful with the help of their local leaders. The authors of this guide refer to the process used for these community transformations as "asset-based community development" in which leaders focus on the strengths of their communities and ask them what they can do to help, in contrast to what does the community need. The guide provides summaries of lessons learned from community building initiatives within the United States that have been successful. In addition, suggestions are provided about what local communities can start to do to begin their own asset-based developmental changes.

Magyary, D.L., & Brandt, P. (2005). A leadership training model to enhance private and public service partnerships for children with special healthcare needs. *Infants and Young Children,* 18(1), 60-71.

This article provides an assessment of a Department of Health and Human Services (DHHS) nursing training grant model of leadership for private-public partnerships in area of children with special healthcare needs. The training

grant's culturally competent leadership model includes dimensions of multicultural competency, complexity of human development and diversity, and social-political responsibility and activism. Cultural competence is a necessary leadership quality in order for the 4 levels of health care services from the Maternal Child Healthcare Service Pyramid model to be successful.

Mayer, J.P. (2003). Are the public health workforce competencies predictive of essential service performance? A test at large metropolitan local health department. *Journal of Public Health Management Practice,* 9(3), 208-213.

This article examined the association between competency and essential service job performance within the public health workforce. In 1999, 420 employees of local health departments participated in a cross-sectional survey. The survey consisted of cultural, program development, analytic and communication competencies that were adapted from a report that was an early version for the Council on Linkages competency set (this was before the 2001 official release of the instrument). The framework for job performance measures was created using ten essential services of public health. The Lewin group report commissioned by the Assistant Secretary of Health for Program Evaluation of the U.S. Department of Health and Human Services was used as bases for four to nine items represented in each essential service. Support for core competencies as a foundation for training program content was found, however a larger role of other organizations, individuals and community influence was also accounted for.

**This article includes three cultural competency questions as part of their survey for competency measurement.*

Mays, G. P., McHugh, M. C., Shim, K., Perry, N., Lenaway, D., Halverson, P. K., & Moonesinghe,R. (2006). Institutional and Economic Determinants of Public Health System Performance. *American Journal of Public Health,* (96)3, 523- 531.

This article examines how the institutional, financial, and community characteristics of local public health delivery systems affect the availability and quality of public health services. The authors use multivariate, linear, and nonlinear regression models that showed significant effects of public health system size, financial resources, and organizational structure on the performance of those systems. Staffing levels and community characteristics also affected performance of selected services. The authors recommend improving performance by reconfiguring the organization and financing of public health systems through consolidation and enhancement of intergovernmental coordination.

McAlearney, A.S., Fisher, D., Heiser, D., Robbins, D., & Kelleher, K. (2005). Developing effective physician leaders: Changing cultures and transforming organizations. *Hospital topics: Research and Perspectives on Healthcare,* 83, 11–18.

The cultures of clinical care and organizational management often clash. Medical culture emphasizes autonomous, reactive, quick decision-making that is focused on individual patients whereas managerial culture emphasizes collaboration and pro-active problem-solving that is systems-oriented. These differences are largely a result of different types of training and different methods of advancement in each field. This article examines how one successful physician leadership development program promotes transformational organizational change by educating physicians about organizational leadership. The assessed program included the components of careful curriculum design, program monitoring, and opportunities to apply new skills in practice.

Ministry for Children and Families. Cultural Competency Assessment Tool. Vancouver Ethnocultural Advisory http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm

This article is a comprehensive tool intended to assist the Vancouver region of the Ministry for Children and Families and community based agencies of all sizes in the Vancouver area in becoming more culturally competent. The tool is meant to be used as a way to identify strengths and weaknesses, and to develop an action plan for improvement.

**This article includes a cultural competence assessment tool.*

National Association of County and City Health Officials (2006). Tackling health inequities through public health practice: A handbook for action. Retrieved June 30, 2007, from Alameda County Public Health Department Website: http://www.acphd.org/AXBYCZ/Admin/DataReports/ood_naccho_handbook.pdf

This publication provides a variety of suggested approaches to help transform the public health departmental structures, public health practice and the inequalities in health practices due to various social conditions. The document focuses on restructuring the culture, organization, and daily work of people in the public health field. Cases studies and a conceptual framework are presented to help local health departments be prepared to face challenges from a social justice perspective.

Organizational Self Assessment subset of the AIDS Education and Training Center (AETC) Cultural Competence and Multicultural Care Workgroup. Cultural Competency Organizational Self Assessment (OSA) Question Bank.

This question bank is founded primarily on the Culturally and Linguistically Appropriate Services (CLAS) standards in healthcare as published on December 22, 2000. The OSA subgroup reviewed hundreds of questions included in the Department of Health and Human Services, Office of Minority Health (OMH) guide for implementing CLAS standards, identified questions most appropriate to AETC work, and chose a small number of questions to include in the final version of the Cultural Competency OSA Question Bank. Questions were grouped into themes that became the six modules in this Question Bank.

This article includes cultural competency questions grouped into six modules: Client and Community Input, Diverse and Culturally Competent Staff, Evaluation and Data Management, Language and Interpreter Services, Organizational Policies and Procedures, and Client and Provider Relations.

Potter, M.A., Ley, C.E., Eggleston, M.M., & Dunman, S. (2003). Evaluating workforce development: Perspective, processes and lessons learned. *Journal of Public Health Management Practice,* 9(6), 486-495.

This article summarizes an evaluation of a competency based on a training course in an urban health department. Due to the high interest in five stakeholders (public health agencies, federal funders, trainers, academic research and trainees) The evaluation consisted of a baseline assessment of organizational capacity by agency, demographic data on trainees, pre/post training inventory beliefs and attitude followed by post-training satisfaction survey, 9 month post-training survey and discussion of learning usefulness and organizational impact as desired by academic research and trainers.

Poulton, B. & McCammon, V. (2007). Measuring self-perceived public health nursing competencies using a quantitative approach. *Nurse Education Today,* 27, 238–246.

Public health nurses make invaluable contributions to the field of public health. While much attention has been paid to developing competency frameworks and theory related to public health nursing, tool development for the self-assessment of those competencies has been neglected. This article tests a self-assessment tool for public health nursing competencies on a cohort of nursing students in the United Kingdom. Students completed pre- and post-program self-assessments. Results indicate significant improvements in students' self-perceived public health competencies after completing the program. The authors conclude that their tool is valid for self-assessment of public health nursing competencies.

Putsch, R., SenGupta, I., Sampson, A., & Tervalon, M. (2003). Reflections on the CLAS standards: best practices, innovations and horizons.

This article investigates five public health sites to report on best practices in the field that are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Profiles of the five sites illustrate how organizations bring CLAS standards to life through innovative community-specific practices.

Best practices include:

- Community-driven programs with community control
- Providing linguistically appropriate care to Limited-English Proficiency (LEP) and English speaking populations; historical and contextual diversity find many forms of linguistic expression. For this reason, programs often consider background, life experience and culture in matching programs, providers and patients.
- Themes of relationship and trust raised and woven into programs

Putsch, R.W. & Pololi, L. (2004). Distributive justice in American healthcare: Institutions, power, and equitable care of patients. *The American Journal of Managed Care,* 10, 45-53.

This article examines the widespread inequality in the American healthcare system, which may be permitted and supported by institutional structures, and the inequalities based on race, gender, ethnicity and poverty. Factors that contribute to these inequalities include institutional power and cost and finance of American healthcare. Bias made in decision making by healthcare practitioners, clinical training environments linked to abuse of patients and coworkers, politics and healthcare provider ethnicity increase these inequalities within the healthcare system.

Scutchfield, F.D, Knight, E., Kelly, A.V., Bhandari, M.W., & Vasilescu, I.P. (2004). Local public health agency capacity and its relationship to public health system performance. *Journal of Public Health Management Practice,* 10(30), 204-215.

Local public health agency capacity characteristics that are related to local public health systems' performance scores on the CDC's National Public Health Performance Standard Program assessment instrument were identified in this article. A sample of 152 jurisdictions were obtained from three states performances scores from a test version of the National Public Health Performance Standards instrument (5b) from county and city/county jurisdictions that were matched to organizational capacity data from the 1997 National Association of County and City Health Officials profile of health departments. Results indicated that public health agency capacities in areas of organizational leadership, funding, and certain non-provider partnerships were significantly related to public health system performance.

National Standards for Culturally and Linguistically Appropriate Services in Health Care. (2001). U.S. Department of Health and Human Services Office of Minority Health.

This report outlines 14 different standards for health care providers that would support a consistent and comprehensive approach for a more culturally and linguistically competent health care system. These 14 standards include themes such as Culturally Competent Care (Standards 1 -3), Language Access Services (Standards 4 – 7), and Organizational Supports for Cultural Competence (Standards 8 – 14).

Weech-Maldonado, R. (2002). Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management,* 47(2), 111-126.

Data in 2000 were pulled from the National Consumer Assessment of Health Plans (CAHPS) Benchmarking Database 3.0 to examine adults enrolled in Medicaid managed care plans in 14 states. The study examined whether race/ethnicity and language varied consumer reporting and rating of care of Medicaid managed care plans. Items examined included global rating items such as personal doctor, health care, health plan, and specialists. Multi-items reports of care such as getting needed care, provider communication, plan service, staff helpfulness, and timeliness of care were also rated. Overall, adults who were racial/ethnic and linguistic minorities reported receiving worse care than whites. Worse care was also reported for those who were linguistic minorities compared to those who were racial/ethnic minorities. The authors recommend that quality improvement efforts should be made in disparities in access to care for linguistic and racial/ethnic minorities.

Wright, K. et al. (2003). Health education leadership development: A conceptual model and competency framework. *Health Promotion Practice,* 4(3), 293-302.

This article includes a model and framework for the Public Health Education Leadership Institute, a 15-month professional leadership development program aimed at senior level health educators. Institute created through collaboration among national health education professional organizations, CDC, and a school of public health.

**Many similarities to BARHII Matrix in leadership competencies, innovation, collaboration skills, cultural competencies, communication, and staff support.*

*Some parallels with BARHII Matrix in community knowledge, and understanding determinants of health inequities.*

Wright, K. Rowitz, L. Merkle, A. Reid, W. M. Robinson, G. Herzog, B. Weber, D. Carmichael, D. Balderson, T. R. Baker, E. Competency Development in Public Health Leadership. *American Journal of Public Health.* 2000 August; 90(8): 1202–1207.

This article discusses the creation of the National Public Health Leadership Development Network (NLN), a consortium of institutes providing a system of leadership development, and reviews the network's creation of the Leadership Competency Framework for core curriculum design and development of performance standards for public health practice.

## Other Resources

**National Association of County and City Health Officials**
http://www.naccho.org/

**The Center for Health Equity, Louisville Metro Department of Public Health and Wellness**
http://www.louisvilleky.gov/Health/equity/

**National Center for Cultural Competency, Georgetown University**
http://www11.georgetown.edu/research/gucchd/nccc/foundations/assessment.html
Cultural and Linguistic Competence Policy Assessment (CLCPA): Instrument and Guide
Health sector reform and public sector health worker motivation: A conceptual framework. (2002, April), by L. M. Franco, S. Bennett, and R. Kanfer, Social Science Medicine, Volume 54, No. 8, 1255-1266.

**American Public Health Association – Exploring Accreditation**
http://www.exploringaccreditation.org/documents/EAFinalRecommendations9-29.pdf
http://www.apha.org/searchresults.htm?query=accreditation

**Public Health Infrastructure Resource Center**
http://www.phf.org/infrastructure/

# Appendix C

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Introduction

**The purpose of this survey is to help your Local Health Department (LHD) assess the overall capacity for addressing health inequities. While some questions do not deal explicitly with health inequities, all questions contain important information about the overall capacity of your organization to impact the factors that influence community health and wellbeing, including institutionalized racism and social and environmental factors.**

**Results from this survey will contribute to the development of a regional health equity plan for Clatsop, Columbia, and Tillamook Counties.**

**This survey is anonymous– your responses will never be linked to you individually. This is not a test, and no survey response will be used against individuals, programs, or departments.**

**Your honest responses on this survey are truly valuable.**

**Thank you for our time!**

**This survey was adapted from the Bay Area Regional Health Inequities Initiative (BARHII) Local Health Department Organizational Self-Assessment for Addressing Health Inequities Toolkit. Please refer to the definitions of key terms and concepts relevant to this survey with which you were supplied. While these terms may be familiar to you, we ask that you read the definitions provided so that all staff have a common understanding of the major concepts underlying this assessment.**

**This survey will take approximately 15-20 minutes to complete. Kindly complete the survey no later than March 27. You may contact Ellen Heinitz at Eheinitz@co.clatsop.or.us with any questions.**

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section A. Introductory Questions

* 1. First, please check the county health department you work for? (Check only one.)

- Clatsop County
- Tillamook County
- Columbia County

* 2. What is your primary role at your LHD? (Check all that apply)

- [ ] Administrative staff
- [ ] Program staff
- [ ] Supervisor/program lead
- [ ] Other (please describe)

* 3. I am familiar with the major health inequities affecting residents in the community we serve.

- ○ Yes
- ○ No
- ○ Don't know

* 4. What are the top 5 disproportionately and unfairly distributed health issues in your county? (for example, people without insurance have higher rates of diabetes)

* 5. Please list what you think are the most important environmental, social, and economic conditions that impact health in your county. (for example, availability of quality affordable housing)

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section B. Organizational Commitment

**For each of the following statements, please indicate the response that most closely describes your LHD:**

* 6. I think our LHD 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

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section B. Organizational Commitment

* 7. If you answered “Moving in that direction” or “Yes” regarding your LHD demonstrating a commitment to addressing the environmental, social and economic conditions that impact health, please give an example:

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

Section B. Organizational Commitment

* 8. I think our LHD as an organization demonstrates a commitment to working with external partners, policy-makers, and community members to address the environmental, social, and economic conditions that impact health inequities.

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

For the following statements (Q9-Q11), please indicate how much you agree or disagree about the cultural relevance of public health programming at your LHD:

* 9. Assessments of the cultural and linguistic needs of the community we serve are conducted periodically.

  - Strongly disagree
  - Disagree
  - Neutral
  - Agree
  - Strongly agree
  - Don't know

* 10. A range of culturally appropriate services are planned and implemented at our LHD.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree
- Don't know

* 11. Our LHD creates and distributes oral and written information that is appropriate for the cultural, linguistic and literacy needs in the community.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree
- Don't know

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

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

* 12. I know how the work of other parts of our LHD contributes to addressing health inequities in our community.

- N/A: this component is not relevant to my job
- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree
- Don't know

* 13. I collaborate with staff in other programs within our LHD to address the environmental, social, and economic conditions that impact health.

- N/A: this component is not relevant to my job
- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree
- Don't know

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

In this section, you will be asked a series of questions about the types of partners your LHD engages with. Please read each question carefully as the questions will look similar.

* 14. Does your LHD engage with **groups that advocate for improved living conditions, for e.g. food insecurities, safe housing** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 15. Does your work with **groups that advocate for improved living conditions, for e.g. food insecurities, safe housing** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 16. Does your LHD engage with **community based organizations** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 17. Does your work with **community based organizations** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 18. Does your LHD engage with **neighborhood groups** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 19. Does your work with **neighborhood groups** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 20. Does your LHD engage with **faith-based groups** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 21. Does your work with **faith-based groups** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 22. Does your LHD engage with **youth development/leadership groups** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 23. Does your work with **youth development/leadership groups** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

Section C. Partnerships

* 24. Does your LHD engage with **community members not affiliated with an organization or group** to help design and implement programs and services?

- Yes
- No

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

**Section C. Partnerships**

* 25. Does your work with **community members not affiliated with an organization or group** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

**Section C. Partnerships**

* 26. Does your LHD engage with **health systems/CCO's** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 27. Does your work with **health systems/CCO's** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 28. Does your LHD engage with **academic institutions** to help design and implement programs and services?

- Yes
- No

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 29. Does your work with **academic institutions** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 30. Does your LHD engage with **other public agencies** to help design and implement programs and services?

- Yes
- No

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 31. Does your work with **other public agencies** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 32. Does your LHD engage with **businesses/retailers** to help design and implement programs and services?

- Yes
- No

Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

## Section C. Partnerships

* 33. Does your work with **businesses/retailers** address the environmental, social, and economic conditions that impact health?

- No
- Moving in that direction
- Yes

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 34. Does your LHD engage with **other partners (not listed above)** to help design and implement programs and services?

- ◯ Yes
- ◯ No


## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships


* 35. Please specify the other partner

* 36. Does your work with **the specified partner above** address the environmental, social, and economic conditions that impact health?

- ◯ No
- ◯ Moving in that direction
- ◯ Yes


## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### Section C. Partnerships

* 37. To what extent does your LHD collaborate with **public agencies** on the following issues?

| | None | Some | A lot | Don't know |
|---|---|---|---|---|
| Availability of quality affordable housing | ◯ | ◯ | ◯ | ◯ |
| Community safety and violence prevention | ◯ | ◯ | ◯ | ◯ |
| Community economic development (e.g. job creation, business development, etc.) | ◯ | ◯ | ◯ | ◯ |
| Racial justice | ◯ | ◯ | ◯ | ◯ |
| Transportation planning and availability | ◯ | ◯ | ◯ | ◯ |
| Food security | ◯ | ◯ | ◯ | ◯ |
| Early child development and education | ◯ | ◯ | ◯ | ◯ |

* 38. To what extent does your LHD collaborate with **community-based organizations** on the following issues?

| | None | Some | A lot | Don't know |
|---|---|---|---|---|
| Availability of quality affordable housing | ◯ | ◯ | ◯ | ◯ |
| Community safety and violence prevention | ◯ | ◯ | ◯ | ◯ |
| Community economic development (e.g. job creation, business development, etc.) | ◯ | ◯ | ◯ | ◯ |
| Racial justice | ◯ | ◯ | ◯ | ◯ |
| Transportation planning and availability | ◯ | ◯ | ◯ | ◯ |
| Food security | ◯ | ◯ | ◯ | ◯ |
| Early child development and education | ◯ | ◯ | ◯ | ◯ |

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

| | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know |
|---|---|---|---|---|---|---|
| Our LHD has trusting relationships with external partners. | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I believe that our LHD’s external partners really represent the interests and needs of local community residents. | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

### D. Organizational Culture

* 40. Is flexible and/or paid time available to allow staff to attend community meetings and otherwise engage with community residents outside normal business hours?

- ◯ Yes
- ◯ No
- ◯ I don’t know

* 41. I feel comfortable providing mentoring or coaching to other staff to support them in addressing health inequities?

- ◯ Yes, as part of my job
- ◯ Yes, informally
- ◯ No
- ◯ I don’t know

* 42. Please indicate how much you agree or disagree with the following statements about the opportunities you have to reflect on addressing health inequities in your work:

| | Not Applicable to My Job Function | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know |
|---|---|---|---|---|---|---|---|
| Within my unit we have engaged in group discussions about how our work could address one or more of the environmental, social, and economic conditions that impact health. | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 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. | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

* 43. Please indicate how much you agree or disagree with the following statements regarding the recruitment, hiring, and retention of diverse staff at your LHD:

| | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know |
|---|---|---|---|---|---|---|
| Individual staff members' efforts to address health inequities are considered in performance reviews/evaluations | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Staff of diverse ethnic, racial and cultural backgrounds are equitably promoted throughout LHD. | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## Regional Health Equity Assessment Staff Survey: Clatsop, Columbia, & Tillamook Counties

This information is optional, but will help us understand more about the distribution of experiences and attitudes across your LHD with respect to health inequities at work. Your responses are anonymous and confidential.

44. What is the race or ethnicity that you primarily identify with? (please check only one.)

- African American/ Black
- Asian
- Caucasian/ White
- Latino/ Hispanic
- Middle Eastern
- Native American/ Alaska Native
- Pacific Islander/ Native Hawaiian
- Biracial/ Multiracial/ Other (please specify):

Your honest responses on this survey are truly valuable.
Thank you for your time!

»redegroup A SOCIAL IMPACT COMPANY

# Appendix D

## LHD Management Interview Guide

Thank you so much for taking the time to speak with me today. As you know, this interview is part of an organizational Self-Assessment that Clatsop, Columbia, or Tillamook County Health Departments are undertaking to assess their capacity to address the environmental, social, and economic conditions that impact health in the region. The interviews will help us get a more in-depth sense of the Local Health Department's strengths and areas for improvement related to addressing health inequities.

Before we get started, I want to assure your confidentiality in this process. I will be reporting feedback only as overall themes and insights that emerged from all our interviews. Nothing you say in this interview will be attributed to you personally, and nothing you tell us would be used against any person or program. The purpose of the assessment is to help the local health departments define areas of particular strengths, identify where to focus on building capacity, and provide benchmarks for future assessments. So, I hope you will feel free to be honest and candid in this conversation.

The interview should take about 30-45 minutes. We will be taking notes and recording the interview today. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for the accuracy of reporting.

Do you mind if we record the interview?

Do you have any questions for me before we begin?

First, please tell me a little about yourself.

Please state your name and position within the Health Department.

1. How long have you been in your current position?
2. How long have you been at your LHD?
3. How long have you been working in the public health field?

*(give a copy of the vision, mission, value and/or statement of principles to interviewee.)*

*Transition statement:*
We're going to start by talking about the overarching guiding principles and planning processes for your LHD. This includes things like the mission, vision, and values statement, strategic planning, succession planning, and program planning.

**Mission, Vision, and Values**
*(Read aloud the agency's mission statement, vision and values. If they already do include health inequities, then focus the questions/probes on how it was entered in discussion.)*

4. Based on your LHD's vision, mission and values statements, do you think there is a commitment to address health inequities? If so, how is this commitment demonstrated?

5. Does your LHD engage in department-wide strategic planning?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. (*If not mentioned in previous answer*) Are staff at all levels involved in the process?
    d. *(If a strategic plan is in place)* Does the strategic plan discuss health inequities explicitly? Are there specific strategies and objectives for addressing health inequities? What are those?
    e. *(If not mentioned in previous answer)* Are there specific strategies and objectives for addressing the social, economic, and environmental conditions that influence health- areas that public health hasn't been traditionally involved in such as public education, land-use, and economic development? Can you describe those strategies?

(If no to Q5, skip to Q7)

6. How does your LHD manage community input into the planning process?
    a. How does the department get community input?
    b. Who from the community is asked for input?
    c. At what point(s) in planning processes does the department seek community input?
    d. What impact on the final planning products does it have?
    e. Do community leaders have opportunities to give feedback on, or influence changes to existing programs and planning?
    f. How is community input communicated to LHD staff?
    g. How does your LHD communicate back to the community how their input was used?

7. Does your LHD conduct assessments on the conditions that influence health (such as housing, education, economic opportunity, or parks and recreation opportunities)?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. Is the assessment conducted internally or externally (through a third-party evaluator/consultant)? (*Probe*: How do you decide which data you can use for planning purposes? How do you decide on the appropriate uses and limitations of data for planning purposes?)
    d. Does your LHD link data on these social, economic, and environmental conditions to health outcomes or use these data to make the case for their importance in public health?
    e. Does your LHD collect specific data on health inequities in the populations it serves?
    f. How is this data shared with the community? How do you assure that the data-sharing is appropriate for the cultural, linguistic and literacy needs of the community?

8. Does your LHD 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.

*Transition Statement:*

Now, I'd like to ask you some questions about the organizational culture of your LHD.

**Cultivating Organizational Culture of Learning/Professional Development**

9. Would you say your LHD has a culture that encourages learning, growth, and change?
    a. (*Probe:* How are staff encouraged to challenge assumptions and the status quo? How does your LHD give positive incentives for feedback? Are there repercussions if staff make a mistake, etc.)?
    b. What types of risk-taking does your LHD successfully encourage? (i.e. hiring people without traditional qualifications, advocating for public policies that address the determinants of health, etc.)?
    c. Are there any other examples of how it does/does not foster a learning culture?

10. Would you say the attitudes and expectations within your LHD 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 your LHD successfully encourage?
    b. What could your LHD do to change the attitudes and expectations it conveys to encourage other types of diversity?

11. Does your LHD intentionally recruit employees with class or racial/ethnic backgrounds reflective of the communities it serves?
    a. Do managers receive training in managing a diverse workforce?
    b. Do human resources staff receive training relevant if hiring diverse staff?
    c. How are staff members who reflect the community supported to gain the qualifications necessary to advance in your LHD?

12. How are interview questions designed to gain insight into an applicant's capability to address health inequities in the performance of their program responsibilities?

13. Does your LHD provide opportunities for staff feedback about strategies and efforts to address health inequities? In what ways is staff input encouraged or supported?

    13b. (*Senior leadership - public health directors only)*
    · How is the feedback used?
    · Can you give an example of what happened when a lower level staff member submitted an idea in the past? (*Ask as a theoretical if it hasn't happened in the* past.) What happens to that idea? Who else is it communicated to? How is it considered? What was the result? How was the result communicated back to the person who gave that input?

*Transition Statement:*

Now we're going to move on to questions about how your LHD works with communities to address health inequities.

**Community Capacity Building**

14. Does your LHD have strategies to help community members and CBOs assume leadership roles, advocate for public health concerns, and influence the local health department? (*Probe*: What strategies does your LHD use to build the capacity of community members and CBO's? What does community leadership look like? How has this led to community-driven advocacy? What has changed as a result?)

15. Does your LHD provide 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? In what ways?

16. Has your LHD established alliances with community groups that are working to improve conditions that influence health status such as housing, economic development, or living wages? (*Probe*: Please describe your LHD's alliances with formal and informal community groups. *Regarding whatever is mentioned*: What is the desired impact of this work on health inequities?)

**Streamlined Administrative Processes and Funding**

17. How does your LHD 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 LHD decisions? What can the LHD do to address these?
    b. How does your LHD 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 your LHD seek feedback from community members about the barriers and facilitators of community participation? How? Can you give me an example of how your LHD 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?

20. In what ways do you build on community strengths in your work with the community? (For probes: Keep in mind that asset-based approaches include considering the strengths of individuals, associations and institutions in the community, and adding resources and support where needed to bolster these strengths.) *If interviewee supervises staff who work with the community*, *also ask*: How do you ensure that your staff build on community strengths in their work?

Finally, I have some questions about workforce development.

**Workforce development**

21. What steps has your LHD taken to cultivate a public health workforce that is prepared to address health inequities?

*Probes:*

*(Efforts to inform, train and educate all current staff on new skills needed to address underlying conditions of health inequities will be addressed in the following question.)*

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

22. Does your LHD provide support such as training and/or coaching, continuing education/conferences for staff to learn about health inequities and addressing the social determinants of health?
   a. What are some of the topics covered?
   b. How does your LHD relay its commitment to addressing health inequities to new employees? (Probe:) Is this covered in a formal orientation?
   c. Does your LHD implement in-house trainings?
   d. Are these trainings required?
   e. What segments/levels of staff are involved?

Those are all my questions. Do you have anything else to add about your LHD's capacity to address health inequities?

Thank you for your time. The information gathered today will be used to inform the development

of a regional health equity plan.

# Appendix E

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## Commissioner Interview Guide

*(Interviewer: Prior to each scheduled interview, interviewees should be provided with the list of key terms [can be found on page 44], a copy of the LHD vision, mission, value and/or statement of principles, as well as the interview questions in order to give them time to reflect on questions and find answers.)*

Thank you so much for taking the time to speak with me today. As you know, this interview is part of an organizational Self-Assessment that [insert Clatsop, Columbia, or Tillamook] County Health Department is undertaking to assess its capacity to address the environmental, social, and economic conditions that impact health in the region. The interviews will help us get a more in-depth sense of the Local Health Department's strengths and areas for improvement related to addressing health inequities.

Before we get started, I want to assure your confidentiality in this process. I will be reporting feedback only as overall themes and insights that emerged from all our interviews. Nothing you say in this interview will be attributed to you personally, and nothing you tell us would be used against any person or program. The purpose of the assessment is to help the local health department define areas of particular strengths, identify where to focus on building capacity, and provide benchmarks for future assessments. So, I hope you will feel free to be honest and candid in this conversation.

The interview should take about ~45 minutes. We will be taking notes and recording the interview today. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for the accuracy of reporting.

Do you mind if we record the interview?

In this interview, I will ask some detailed questions about the LHD internal systems and structure. We are aware you work closely with the Health Department but are not working within the department. If you do not feel like you have enough information to answer a particular question or set of questions, please let us know and we will move on.

Do you have any questions for me before we begin?

**Introductory Questions**

First, please tell me a little about yourself. Please state your name and position.

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

2. What are the top 5 disproportionately and unjustly distributed health issues in your county?

3. What do you think are the most important environmental, social, and economic conditions that impact health in your county?

**Health Department Planning and Policies**
For each of the following statements, please indicate the response that most closely describes your LHD. The Response options are no, moving in that direction, yes, or don't know:

4. I think my LHD as an organization demonstrates a commitment to addressing the environmental, social and economic conditions that impact health.
    a. No
    b. Moving in that direction
    c. Yes
    d. Don't Know

5. I think my LHD as an organization demonstrates a commitment to working with external partners, policy-makers, and community members to address the environmental, social, and economic conditions that impact health inequities.
    a. No
    b. Moving in that direction
    c. Yes
    d. Don't Know

6. I think there are strategies in place within the LHD to advocate for public policies that address environmental, social, and/or economic conditions that impact health inequities.
    a. No
    b. Moving in that direction
    c. Yes
    d. Don't Know

*Transition statement:*
We're going to be talking about the overarching guiding principles and planning processes for your LHD. This includes things like the mission, vision, and values statement, strategic planning, succession planning, and program planning.

**Mission, Vision, and Values**
*(Read aloud the agency's mission statement, vision and values. If they already do include health inequities, then focus the questions/probes on how it was entered in discussion.)*

7. Based on your LHD's vision, mission and values statements, do you think there is a commitment to address health inequities? How is this commitment demonstrated?

8. Does your LHD engage in department-wide strategic planning?
   (If no to Q8, skip to Q10)

9. How does your LHD manage community input into the planning process?
   a. How does the department get community input?
   b. Who from the community is asked for input?
   c. At what point(s) in planning processes does the department seek community input?
   d. What impact on the final planning products does it have?
   e. Do community leaders have opportunities to give feedback on, or influence changes to existing programs and planning?
   f. How does your LHD communicate back to the community how their input was used?

10. Does your LHD conduct assessments on the conditions that influence health (such as housing, education, economic opportunity, or parks and recreation opportunities)?
    a. If so, on what schedule?
    b. Who is involved in the process?
    c. Is the assessment conducted internally or externally (through a third-party evaluator/consultant)?
    d. Does your LHD link data on these social, economic, and environmental conditions to health outcomes or use these data to make the case for their importance in public health?
    e. Does your LHD collect specific data on health inequities in the populations it serves?
    f. How is this data shared with the community? How do you assure that the data-sharing is appropriate for the cultural, linguistic and literacy needs of the community?

11. Does your LHD 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.

*Transition Statement:*

Now, I'd like to ask you some questions about the organizational culture of the LHD.

**Cultivating Organizational Culture of Learning/Professional Development**

12. Would you say your LHD has a culture that encourages learning, growth, and change?

13. Would you say the attitudes and expectations within the LHD 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 your LHD successfully encourage?
    b. What could your LHD do to change the attitudes and expectations it conveys to encourage other types of diversity?

*Transition Statement:*

Now we're going to move on to questions about how your LHD works with communities to address health inequities.

**Community Capacity Building**

14. Does your LHD have strategies to help community members and CBOs assume leadership roles, advocate for public health concerns, and influence the local health department? (*Probe*: What strategies does your LHD use to build the capacity of community members and CBO's? What does community leadership look like? How has this led to community-driven advocacy? What has changed as a result?

15. Does your LHD provide 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? In what ways?

16. Has your LHD established alliances with community groups that are working to improve conditions that influence health status such as housing, economic development, or living wages? (*Regarding whatever is mentioned*: What is the desired impact of this work on health inequities?)

**Streamlined Administrative Processes and Funding**

17. How does your LHD 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 LHD decisions? What can the LHD do to address these?
    b. How does your LHD 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 your LHD seek feedback from community members about the barriers and facilitators of community participation? How? Can you give me an example of how your LHD 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?

20. In what ways do you build on community strengths in your work with the community? (For probes: Keep in mind that asset-based approaches include considering the strengths of individuals, associations and institutions in the community, and adding resources and support where needed to bolster these strengths.)

Those are all my questions. Do you have anything else to add about your LHD's capacity to address health inequities?

Thank you for your time. The information gathered today will be used to inform the development of a regional health equity plan.

# Northern Coastal Health Equity Community Feedback Data Analysis

## Introduction

Clatsop, Columbia, and Tillamook Counties are working together to evaluate health equity in Oregon's Northern Coastal Region and to plan how to mitigate disparities. Rede Group worked with health partners in the three counties to gather community-level data using community health data, which was collected by state and national institutions in or after 2019. Rede Group also conducted surveys and interviews with health department staff and leadership about their perspectives on local health equity issues between March and May 2020. Before creating a plan to address health disparities identified by health department staff and leadership, the Rede Group project team needed community input on the initial findings. A regional health equity video, which summarized these findings, was presented to community members and organizations from July 2nd through July 30th, 2021. Rede Group distributed the video and survey, along with organizational presentation and open forum opportunities, to a list of over 100 individuals and requested that individuals further distribute the information among their networks. Some of these networks include:

- Coordinated care organizations
- Health coalitions
- Community-based organizations
- Health advisory committees
- Other organizations with ties to communities within each county

Rede Group also conducted two organizational presentations and two community forums to present the initial health equity data and to receive feedback from participants.

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| Feedback by participation type | | |
|---|---|---|
| Survey | 71 | 72% |
| Presentations | 26 | 27% |
| Email | 1 | 1% |
| **Total** | **98** | **100%** |

# Community feedback

The findings presented here are a summary of the feedback from survey respondents and community and organization members who viewed the Regional Health Equity video. Email feedback will be incorporated into the report separately.

## Question 1

"What do you like most about living in our community?"

Survey respondents and community forums and organizational meeting participants were asked to describe, as an open-ended response question, what they like most about living in their community.

### <u>All responses</u>

Northern Coastal Region (Clatsop, Columbia, and Tillamook counties)

| Theme | Description of Theme | Number of Participants (n=97) | Percentage |
|---|---|---|---|
| Location | The outdoor offerings, proximity to cities, not crowded | 48 | 49.48% |

| | | | |
|---|---|---|---|
| Sense of community* | A sense of connected community and friends where people work together, support each other, are collaborative and participatory. Social support including family friendly. Engaged leadership/easy to engage w/leaders | 30 | 30.93% |
| Small & rural | People mention the affordability of houses and land, the built infrastructure, the size of the community, and safety with low crime | 41 | 42.47% |
| The climate | Respondents enjoy the cool weather and temperate climate | 5 | 5.15% |
| Job/career | Enjoy job and coworkers | 4 | 4.12% |
| Community resources | Access to resources that enhance daily life and helping others find needed resources, including access to food, the library, local radio stations, the public health department, and local policy work. | 4 | 4.12% |
| Other | Non specific responses like 'opportunities' and 'quality of life' | 4 | 4.12% |

*In addition, 9 of these 10 people called out the ease and enjoyment of working with local leaders and/or community organizations to achieve goals.

## Responses by county

### Clatsop County Response

| **Theme** | **Description of Theme** | **Number of Participants (n=15)** | **Percentage** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Location | The outdoor offerings, proximity to cities, not crowded | 10 | 66.67% |
| Sense of community | A sense of connected community and friends where people work together, support each other, are collaborative and participatory. Social support including family friendly. Engaged leadership/easy to engage w/leaders | 7 | 46.67% |
| Small & rural | People mention the affordability of houses and land, the built infrastructure, the size of the community, and safety with low crime | 9 | 60.00% |
| The climate | Respondents enjoy the cool weather and temperate climate | 0 | 0.00% |
| Job/career | Enjoy job and coworkers | 3 | 20.00% |
| Community resources | Access to resources that enhance daily life and helping others find needed resources, including access to food, the library, local radio stations, the public health department, and local policy work. | 1 | 6.67% |
| Other | Non specific responses like 'opportunities', 'quality of life', | 0 | 0.00% |

Columbia County Responses

| **Theme** | **Description of Theme** | **Number of Participants (n=39)** | **Percentage** |
|---|---|---|---|
| Location | The outdoor offerings, proximity to cities, not crowded | 15 | 38.46% |

| | | | |
|---|---|---|---|
| Sense of community | A sense of connected community and friends where people work together, support each other, are collaborative and participatory. Social support including family friendly. Engaged leadership/easy to engage w/leaders | 9 | 23.08% |
| Small & rural | People mention the affordability of houses and land, the built infrastructure, the size of the community, and safety with low crime | 18 | 46.15% |
| The climate | Respondents enjoy the cool weather and temperate climate | 1 | 2.56% |
| Job/career | Enjoy job and coworkers | 3 | 7.69% |
| Community resources | Access to resources that enhance daily life and helping others find needed resources, including access to food, the library, local radio stations, the public health department, and local policy work. | 2 | 5.13% |
| Other | Non specific responses like 'opportunities', 'quality of life', | 1 | 2.56% |

Tillamook County Responses

| **Theme** | **Description of Theme** | **Number of Participants (n=39)** | **Percentage** |
|---|---|---|---|
| Location | The outdoor offerings, proximity to cities, not crowded | 22 | 56.41% |

| | | | |
|---|---|---|---|
| Sense of community | A sense of connected community and friends where people work together, support each other, are collaborative and participatory. Social support including family friendly. Engaged leadership/easy to engage w/leaders | 14 | 35.90% |
| Small & rural | People mention the affordability of houses and land, the built infrastructure, the size of the community, and safety with low crime | 12 | 30.77% |
| The climate | Respondents enjoy the cool weather and temperate climate | 4 | 10.26% |
| Job/career | Enjoy job and coworkers | 0 | 0.00% |
| Community resources | Access to resources that enhance daily life and helping others find needed resources, including access to food, the library, local radio stations, the public health department, and local policy work. | 2 | 5.13% |
| Other | Non specific responses like 'opportunities', 'quality of life', | 2 | 5.13% |

Example quotes:

- Sense of community
  - "People here value the place they live and the community they've built. They know they have a good thing here and they want to protect it." - Tillamook County resident
- Jobs
  - "It's honestly much easier to get certain things done, because cooperation is more the rule than competition when it comes to helping vulnerable folks in our communities in Columbia." - Columbia County resident

- Location
  - "The scenery is amazing and access to the outdoors is easy." - Tillamook County resident
  - "Small town connections, beautiful river access." - Columbia County resident
  - "Outdoors, nature, fresh air, less people." - Clatsop County resident
- Relationships
  - "I live in Clatsop County. I like that it is relatively small and I have the opportunity to have personal connections with elected officials, community leaders, school staff and leaders, health care system staff and leaders, faith community, etc." - Clatsop County resident
- Safety
  - "It is a caring community. Most people know each other, and it is relatively safe." - Tillamook County resident
- Small community
  - "Still small but large enough to have resources." - Clatsop County resident
  - "The small town, connected community." - Columbia County resident
- Social support
  - "Small community, supportive of those in need." - Tillamook County resident

# Question 2

"What would you want to improve about our community?"

Survey respondents could choose up to three options from a list of six options, listed below, for the second question. This same question was asked to community forum and organizational meeting participants  as an open-ended question.

- More affordable housing
- Access to better quality healthcare and medicine
- More jobs/better paying jobs
- Addressing racism
- Better access to childcare/early childhood education
- More resources to combat COVID-19

## All responses

The table below shows the number and percentage of respondents (both survey and presentation p participants) who selected or discussed each issue option. This is because responses from presentation participants occasionally aligned with the response options  listed in the survey.

| **Survey Questions** | **More affordable housing** | **Access to better quality healthcare and medicine** | **More jobs/better paying jobs** | **Addressing racism** | **Better access to childcare/early childhood education** | **More resources to combat COVID-19** |
|---|---|---|---|---|---|---|
| % of survey respondents n=71 | 90.14% (64/71) | 52.11% (37/71) | 70.42% (50/71) | 45.07% (32/71) | 46.48% (33/71) | 7.04% (5/71) |
| % of forum/meeting participants n=26 | 15.38% (4/26) | 19.23% 5/26) | 15.38% (4/26) | 0 | 3.85% (1/26) | 0 |

| Total responses n=97 | 70.10% 68/97 | 43.30% 42/97 | 55.67% 54/97 | 32.99% 32/97 | 35.05% 34/97 | 5.15% (5/97) |
|---|---|---|---|---|---|---|

## Additional Responses

Survey respondents also had the option to write-in their own response as an "other" option. There were also many other themes that emerged from talking with community members during presentations. These responses offered areas of improvement that we want to acknowledge and keep separate from the responses above, as these responses arose organically.

| **Theme** | **Resource Navigation** | **Availability of Services** | **Poverty** | **Other** |
|---|---|---|---|---|
| Description | Includes availability of communication resources, such as interpretation, resource outreach, transportation to resources, and broadband connection | Identified as crisis intervention services, services for the unhoused, and generally. | Includes mention of poverty, lack of community engagement, and food insecurity | Includes identified dissatisfaction with local government, polarization of the community, resistance to changing current conditions, identified need for greater representation of underserved communities, and lack of opportunities for youth |
| % of survey respondents n=71 | 1.41% (1/71) | 1.41% (1/71) | 1.41% (1/71) | 2.82% (2/71) |
| % of forum/meeting participants n=26 | 42.31% (11/26) | 30.77% (8/26) | 15.38% (4/26) | 26.92% (7/26) |
| % Total | 12.37% | 9.27% | 5.15% | 9.27% |

| respondents n=97 | (12/97) | (9/97) | (5/97) | (9/97) |
|---|---|---|---|---|

## Question 3

"What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?"

Survey respondents and community forum and organizational meeting participants were asked to describe, as an open-ended response question, what barriers they believed were keeping the community from improving health and quality of life.

Respondents identified availability of services, poverty, and housing affordability as the top three issues keeping their communities from improving health and quality of life.

### All Responses

North Coastal Region (Clatsop, Columbia, and Tillamook counties)

| **Theme** | **Description of Theme** | **Number of Participants (n=97)** | **Percentage of Total Response (n=97)** |
|---|---|---|---|
| Availability of Services | Health services, family support/childcare, transportation, food access | 26 | 26.80% |
| Poverty | Income inequity, job availability, poor wages, and low community engagement | 24 | 24.74% |
| Housing Affordability | Cost of housing, effects of short-term rentals, inventory, buildable land | 22 | 22.68% |

| | | | |
|---|---|---|---|
| Lack of Funding for Resources | Social and physical infrastructure | 17 | 17.53% |
| Resistance to Change | Perceived social and political resistance to change | 14 | 14.43% |
| Under-representation of Underserved Communities | Unequal representation, lack of services for, and discrimination against underserved communities | 14 | 14.43% |
| Community Polarization | Lack of community cohesion or consensus on varying issues | 12 | 12.37% |
| Lack of Information, Education & Awareness | Represents both uncertainty from the respondent and a belief that lack of knowledge is holding the community back | 11 | 11.34% |
| Lack of General Resources | Need for more or improved availability of resources, generally | 8 | 8.25% |
| Lack of Opportunities for Youth | Need for more youth focused vocational, educational, and recreational activities | 6 | 6.19% |

## Responses by county

### Clatsop County Responses

| **Theme** | **Description of Theme** | **Number of Participants (n=15)** | **Percentage of Clatsop Co. (n=15)** | **Percentage of Total Responses (n=97)** |
|---|---|---|---|---|
| Availability of Services | Health services, family support/childcare, transportation, food access | 4 | 26.67% | 4.12% |

| | | | | |
|---|---|---|---|---|
| Poverty | Income inequity, job availability, poor wages, and low community engagement | 6 | 40.00% | 6.19% |
| Housing Affordability | Cost of housing, effects of short-term rentals, inventory, buildable land | 4 | 26.67% | 4.12% |
| Lack of Funding for Resources | Social and physical infrastructure | 2 | 13.33% | 2.06% |
| Resistance to Change | Perceived social and political resistance to change | 4 | 26.67% | 4.12% |
| Under-representation of Underserved Communities | Unequal representation, lack of services for, and discrimination against underserved communities | 4 | 26.67% | 4.12% |
| Community Polarization | Lack of community cohesion or consensus on varying issues | 3 | 20.00% | 3.09% |
| Lack of Information, Education & Awareness | Represents both uncertainty from the respondent and a belief that lack of knowledge is holding the community back | 0 | 0.00% | 0.00% |
| Lack of General Resources | Need for more or improved availability of resources, generally | 1 | 6.67% | 1.03% |
| Lack of Opportunities for Youth | Need for more youth focused vocational, educational, and recreational activities | 4 | 26.67% | 4.12% |

Columbia County Responses

| Theme | Description of Theme | Number of Participants (n=39) | Percentage of Columbia Co. (n=39) | Percentage of Total Responses (n=97) |
|---|---|---|---|---|
| Availability of Services | Health services, family support/childcare, transportation, food access | 14 | 35.90% | 14.43% |
| Poverty | Income inequity, job availability, poor wages, and low community engagement | 8 | 20.51% | 8.25% |
| Housing Affordability | Cost of housing, effects of short-term rentals, inventory, buildable land | 1 | 2.56% | 1.03% |
| Lack of Funding for Resources | Social and physical infrastructure | 6 | 15.38% | 6.19% |
| Resistance to Change | Perceived social and political resistance to change | 4 | 10.26% | 4.12% |
| Under-representation of Underserved Communities | Unequal representation, lack of services for, and discrimination against underserved communities | 2 | 5.13% | 2.06% |
| Community Polarization | Lack of community cohesion or consensus on varying issues | 5 | 12.82% | 5.15% |
| Lack of Information, Education & Awareness | Represents both uncertainty from the respondent and a belief that lack of knowledge is holding the community back | 4 | 10.26% | 4.12% |
| Lack of General Resources | Need for more or improved availability of resources, generally | 4 | 10.26% | 4.12% |

| | | | | |
|---|---|---|---|---|
| Lack of Opportunities for Youth | Need for more youth focused vocational, educational, and recreational activities | 1 | 2.56% | 1.03% |

Tillamook County Responses

| Theme | Description of Theme | Number of Participants (n=39) | Percentage of Tillamook Co. (n=39) | Percentage of Total Responses (n=97) |
|---|---|---|---|---|
| Availability of Services | Health services, family support/childcare, transportation, food access | 6 | 15.38% | 6.19% |
| Poverty | Income inequity, job availability, poor wages, and low community engagement | 9 | 23.08% | 9.28% |
| Housing Affordability | Cost of housing, effects of short-term rentals, inventory, buildable land | 16 | 41.03% | 16.49% |
| Lack of Funding for Resources | Social and physical infrastructure | 8 | 20.51% | 8.25% |
| Resistance to Change | Perceived social and political resistance to change | 5 | 12.82% | 5.15% |
| Under-representation of Underserved Communities | Unequal representation, lack of services for, and discrimination against underserved communities | 7 | 17.95% | 7.22% |
| Community Polarization | Lack of community cohesion or consensus on varying issues | 3 | 7.69% | 3.09% |
| Lack of Information, Education & | Represents both uncertainty from the respondent and a belief that lack of | 7 | 17.95% | 7.22% |

| | | | | |
|---|---|---|---|---|
| Awareness | knowledge is holding the community back | | | |
| Lack of General Resources | Need for more or improved availability of resources, generally | 3 | 7.69% | 3.09% |
| Lack of Opportunities for Youth | Need for more youth focused vocational, educational, and recreational activities | 0 | 0.00% | 0.00% |

No County Identified Responses

| Theme | Description of Theme | Number of Participants (n=4) | Percentage of No County (n=4) | Percentage of Total Responses (n=97) |
|---|---|---|---|---|
| Availability of Services | Health services, family support/childcare, transportation, food access | 2 | 40.00% | 2.06% |
| Poverty | Income inequity, job availability, poor wages, and low community engagement | 1 | 20.00% | 1.03% |
| Housing Affordability | Cost of housing, effects of short-term rentals, inventory, buildable land | 1 | 20.00% | 1.03% |
| Lack of Funding for Resources | Social and physical infrastructure | 2 | 40.00% | 2.06% |
| Resistance to Change | Perceived social and political resistance to change | 1 | 20.00% | 1.03% |
| Under-representation of Underserved Communities | Unequal representation, lack of services for, and discrimination against underserved communities | 1 | 20.00% | 1.03% |

| | | | | |
|---|---|---|---|---|
| Community Polarization | Lack of community cohesion or consensus on varying issues | 1 | 20.00% | 1.03% |
| Lack of Information, Education & Awareness | Represents both uncertainty from the respondent and a belief that lack of knowledge is holding the community back | 0 | 0.00% | 0.00% |
| Lack of General Resources | Need for more or improved availability of resources, generally | 0 | 0.00% | 0.00% |
| Lack of Opportunities for Youth | Need for more youth focused vocational, educational, and recreational activities | 1 | 20.00% | 1.03% |

## Other comparisons

Each county in the northern coastal region emphasized distinct barriers, which we want to call out with specificity to the county to give local public health departments the opportunity to tailor work to their specific county's needs.

### Clatsop County

40% of respondents from Clatsop County recognized poverty as the issue keeping the community from thriving. Poverty was defined as:

- Income inequality
- Lack of job opportunities
- Poor wages
- Low community engagement

### Columbia County

36.84% of respondents from Columbia County believed that the poor availability of services prevents the community from improving health and quality of life. This group's responses led to "availability of services" rising to the top of the all-county list. Included in the desired services were:

- Health-related like trauma care, drug treatment, and mental health
- Family support and childcare
- Transportation
- Food access

Tillamook County

41.03% of respondents from Tillamook County identified housing affordability as the barrier to improved health and quality of life in their community. Housing affordability was described by:

- Cost of housing
- Housing inventory
- Effects of short-term rentals on housing cost and inventory
  - 8 of the 22 respondents called out the impact of short-term rentals on housing cost and availability
- Lack of buildable land

## Example quotes:

- Availability of services - hospital/medical care
  - "The community does not offer what it needs to keep or draw physicians to the area which impacts the ability to provide healthcare." - Clatsop County resident
  - "I think part of what is keeping the community from improving health and quality of life, is resentment. For members of the community, they feel like they are being deserted and then just receiving the "leftover" care that is out there rather than feeling like they are deserving of and receiving the highest quality care available." - Residency unknown
  - "Need a hospital, ER service, or 24 hr medical facility in Columbia County." - Columbia County resident

    - "Funding gaps. Also, in Tillamook our communities are spread out over such distance that getting anywhere takes a lot of time. And if someone doesn't have a car? Forget it. So more resources in small towns and better public transit to get there." - Tillamook County resident
- Housing - affordability
    - "Access to housing. Most houses are short term rentals, second homes, etc. Rent is horribly high and without good paying jobs, many are homeless or couch surfing." - Tillamook County resident
    - "Lack of housing. Young people move away to find housing and jobs. Too many vacation homes, not enough homes for those working here." - Tillamook County resident
    - "Lack of political will to make good sound policy decisions that support local families (affordable housing, jobs, child care)." - Clatsop County resident
- Lack of funding for resources
    - "Small populations make resources and funding challenging." - Tillamook County resident
    - "We seem to have a lot of houseless people moving here from Portland with drug & mental health issues. Crime seems to be going up because of that and we just don't have the resources to help these folks. People seem to be willing to pay higher taxes for community members but are not too happy to be asked to foot the bill for those who come here houseless & jobless." - Columbia County resident
- Lack of information/education/awareness
    - "I don't think most people (including socially liberal folx) understand "equity" and "racial justice" and I think until we have a more widespread understanding of how these things must be considered to address root health issues (hunger, houselessness, etc.), I think we'll keep only changing health/quality of life at a surface level." - Tillamook County resident
- Lack of general resources
    - "Too many resources have a bottom line to meet even those that are meant to help the financially struggling parties, people who need assistance are being turned away." - Columbia County resident
    - "Lack of infrastructure / resources. Not enough staff with dedicated roles - overstretched." - Tillamook County resident
- Opportunities for youth

  - "There aren't many high paying jobs that would motivate youth [to] pursue a higher ed degree and then come back to work and live here." - Clatsop County resident
- Polarization
  - "Lack of consensus on what the priorities are - then being continually distracted by new priorities." - Columbia County resident
  - "Constrained resources for PH and Social Services, the attitudes of some residents/leaders." - Clatsop County resident
- Poverty
  - "Lack of good paying jobs, access to health care (no hospital in our county), homelessness, drug and alcohol abuse." - Columbia County resident
  - "Low wages, poor housing. People don't have enough money to free up time and energy for healthy pursuits." - Tillamook County resident
  - "Schools that either lack the resources or the professional experience to offer quality education - including tech/vocational jobs, recreational experiences (beyond traditional team sports), and health standards. Parenting education and family connection/support is lacking. Addressing generational trauma - minimizing and stigmatizing mental health and addiction." - Clatsop County resident
- Under-representation of underserved communities
  - "Need more voice and political influence for Latinx and other underserved communities." - Clatsop County resident
- Resistance to change
  - "Fear of change, sense of privilege and entitlement ("I worked hard for this, others should too"). Racism. Classism. Lack of cultural awareness. Health care not being seen as an aspect of spirituality and religious life." - Tillamook County resident
  - "Lack of resources combined with a lack of desire to change things stuck in a "that's how it is" mentality." - Columbia County resident

# Location

While there were many common themes among the community feedback, some issues and areas of improvement were more pronounced in certain communities. Location is often a factor in overall health, therefore we collected residency information from participants in the community feedback survey, forums, and meetings. Survey respondents were asked: “What city or area do you live in, or, if you no longer live in the area, where have you lived in, within Clatsop, Columbia, or Tillamook counties?” Presentation attendee location was collected based on where they shared they lived or from the organization with which they participated. Four respondents did not indicate the county in which they live.

| County | Number | Percentage |
|---|---|---|
| Columbia | 40 | 40.82% |
| Tillamook | 39 | 39.80% |
| Clatsop | 13 | 13.27% |
| N/A | 4 | 4.08% |
| **Total** | **98** | **100.00%** |

# Race/ethnicity

Survey respondents were asked this optional question: "What is the race or ethnicity that you primarily identify with?" Respondents were given the options listed below and could choose all that applied.
Presentation attendees were not asked to share the race or ethnicity with which they primarily identify.

| **Race/ethnicity** of survey respondents, n=71* | **Number** | **Percentage** |
|---|---|---|
| African American/Black | 2 | 3% |
| Caucasian/White | 64 | 90% |
| Latino/a/x or Hispanic | 5 | 7% |
| Native American/Alaska Native | 1 | 1% |
| Asian | 1 | 1% |
| Multi-Racial | 2 | 3% |
| No answer | 2 | 3% |
| **Total** | **77*** | **108%*** |
| *Survey respondents could choose more than one option | | |

# Key Take-Aways

More affordable housing (70.1%) and more jobs/better wages (55.67%) were the two main issues survey respondents and presentation participants said they would like to improve in their communities. Better access to healthcare (43.3%) and affordable childcare (35.05%) were also identified by community members as areas of improvement. These issues tracked closely with the issues identified by county health department staff and government leadership as impacting health and representing economic inequities.

Top 5 environmental/social/economic conditions impacting health on the North Coast (staff survey results):

- #1 Affordable housing - 82% of respondents
- #2 Access to health care - 43% of respondents
- #3 Adequate living wages - 32% of respondents
- #4 Affordable childcare - 29% of respondents
- #5 Availability of transportation - 25% of respondents

Government leadership identified several economic inequities in their communities:

- Lack of hospitals and/or appropriate health care
- Having to travel long distances to access specialty health services
- Lack of adequate paying jobs
- Lack of affordable housing

All five health-impacting conditions identified by county health department staff were captured in the top three issues identified by community members as keeping their communities from improving health and quality of life.

Lack of services

26.8% of respondents from the community (all counties) said that the lack of availability of services is a barrier to improved health and quality of life. Overlapping with this, county health department staff identified a lack of similar services as impacting health, such as access to health care, childcare, and transportation. For community respondents, lack of services included:

- Health-related like trauma care, drug treatment, and mental health
- Family support and childcare
- Transportation
- Food access

Poverty

24.74% of community respondents identified poverty as preventing their communities from improving health and quality of life. 32% of county health department staff recognized adequate living wages as having an impact on health. Poverty, for community respondents, was defined as:

- Income inequality
- Lack of job opportunities
- Poor wages
- Low community engagement

Housing

22.68% of respondents from the community said that lack of affordable housing was a barrier to improved health and quality of life, although in Tillamook County this figure was above 40%. Of county health department staff,  82% identified affordable housing as an environmental, social, and economic condition that impacts health in their communities. Community respondents referred to many elements of housing affordability, including:

- Cost of housing
- Housing inventory

- Effects of short-term rentals on housing cost and inventory
- Lack of buildable land

Areas of improvement identified by respondents highlight the intersection of issues. One Clatsop County resident stated, "[There is a] desperate need for childcare and affordable childcare. The hispanic community has identified a need for childcare, which impacts employment and housing."