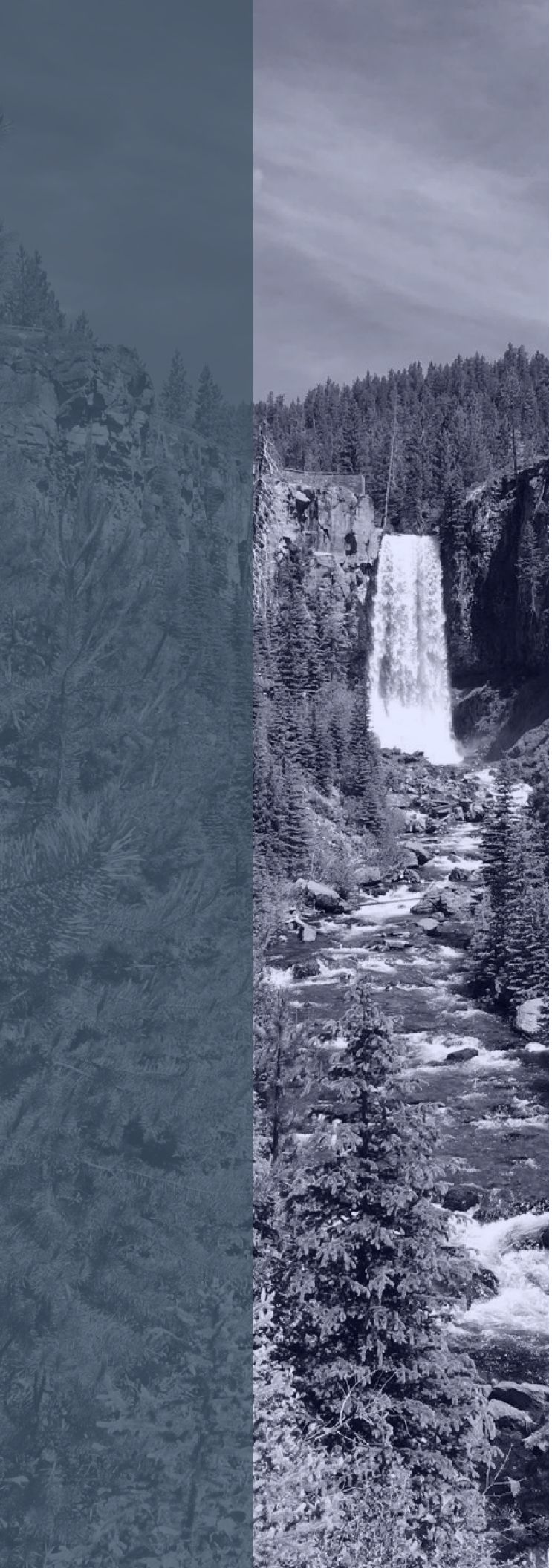
CENTRAL OREGON PUBLIC HEALTH EQUITY REPORT 2020



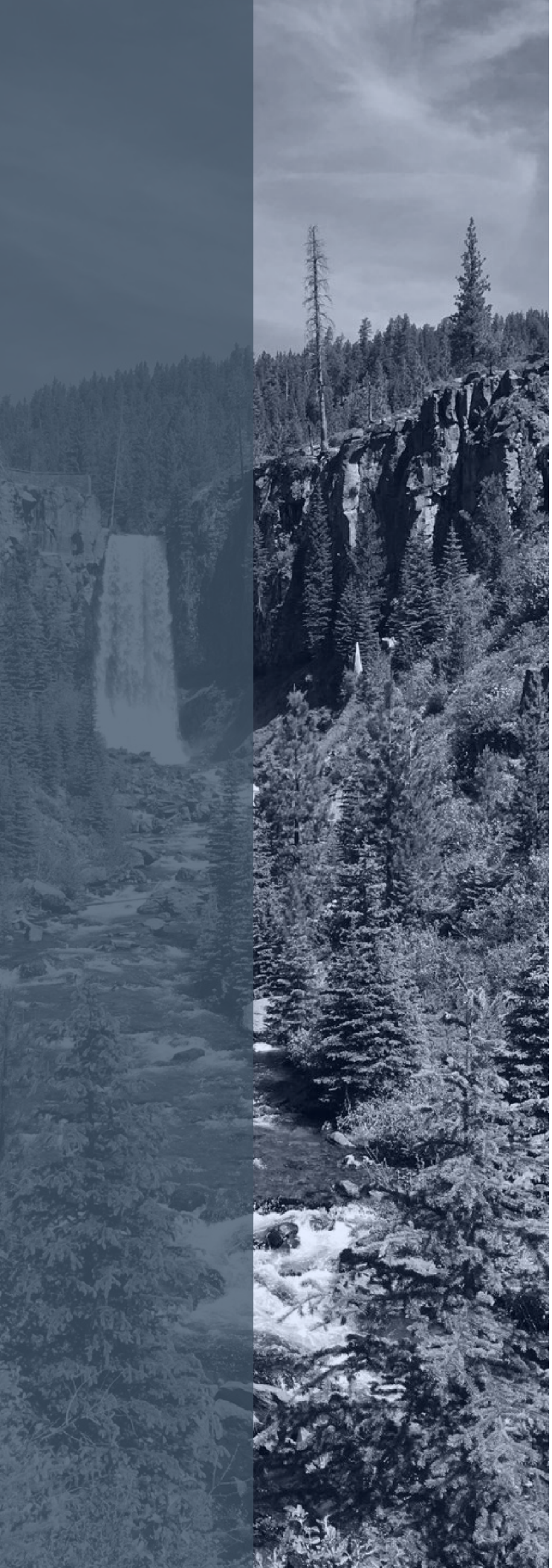
EXECUTIVE SUMMARY

There is a growing body of evidence to support the Crook, Deschutes, and Jefferson County Public Health's core belief that health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social, economic, physical conditions or other factors. To that end, Crook, Deschutes, and Jefferson County Public Health aspire to create a place where health is attainable for everyone in Central Oregon.

This report represents an effort and commitment to assess the current state and to identify opportunities for improvement. The report includes several components:

1. How Public Health leveraged Accreditation and Modernization to prioritize work on health equity.
2. A brief review of the literature on the social determinants of health and health equity.
3. Available population-level data on health equity and the determinants of health in Central Oregon.
4. Results from the BAR HII Health Equity Assessment.
5. Recommended Health Equity strategies to improve our effectiveness in promoting optimal health.

Anyone in Central Oregon can use the information and results in this report to promote health equity.



Local data indicates that health outcomes vary by race and socioeconomic status, with those of higher socioeconomic status and those who identify as White/Caucasian, generally experiencing better health outcomes. Results from the staff and collaborating partner surveys suggest that health departments should advance their leadership role in addressing the environmental, social, and economic conditions that impact health. Also, central Oregon health departments should improve work around the creation and distribution of materials that meet the cultural, language, and literacy needs of the population. The assessment also highlights the importance of developing workforce strategies to assure hiring, retention, and promotion of diverse staff.

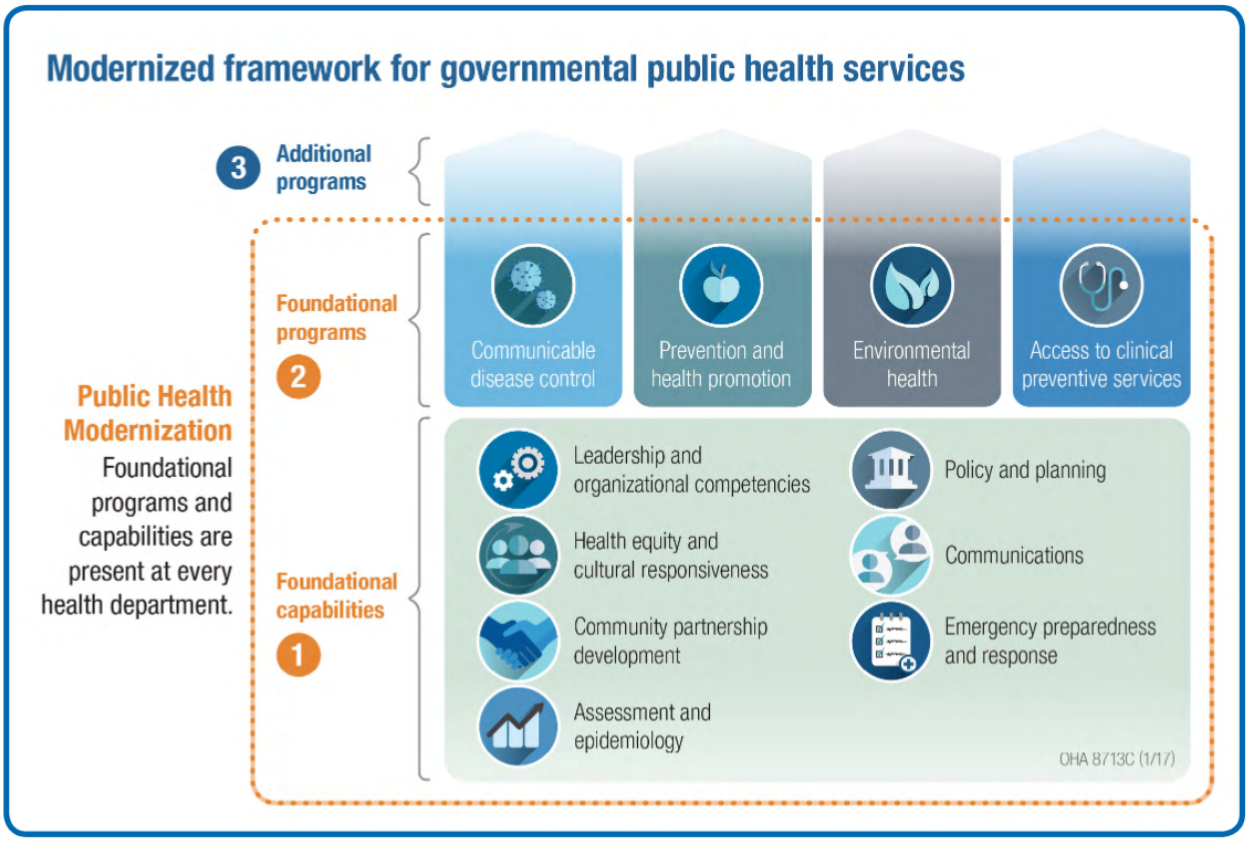
Health Department staff will use this information to identify, prioritize, and implement strategies around health equity and the determinants of health. When public health interventions focus on health equity and the
determinants of health, the greatest population health improvements are achieved.

Background

In 2018, Central Oregon leveraged public health modernization and national public health accreditation standards and measures to initiate an assessment of public health departmental health equity work. In order to better emphasize and continuously improve health equity perspectives for our agencies, Central Oregon Public Health Departments implemented a health equity assessment and created a report that includes assessment results and recommended actions.

Goals

The goal of the report is to understand the distribution of social determinants of health, health behaviors, and health factors within Central Oregon. It also helps identify how Central Oregon Public Health currently works to addresses health equity, community partner perception, and strategy identification.



Public Health Modernization Framework

Modernization and Accreditation

Oregon's Statewide Public Health Modernization and National Public Health Accreditation highlight the importance of incorporating health equity into the work of local health departments.

National Public Health Reaccreditation lists Health Equity as one of the several guiding principles used to develop the Reaccreditation Standards and Measures.

Within Public Health Modernization, "Equity and Cultural Responsiveness," is a foundational capability (Figure 2). The vision of this foundational capability is to, "Ensure… health for all populations through policies, programs, and strategies that respond to the cultural factors that affect health. Correct historic injustices borne by certain populations. Prioritize development of strong cultural responsiveness by public health organizations." (Oregon Health Authority, 2017).

Central Oregon Public Health Departments have prioritized this work and are actively working to continue improving how programs and the divisions promote health equity. This report is an effort to tackle one of the six essential components listed in the public health modernization manual, "Implement a system-wide assessment of health equity to address and measure health and social determinant (social/economic/environmental factors) outcomes by income, race, ethnicity, language, geography, and disability." (Oregon Health Authority, 2017).

PHAB

Advancing public health performance

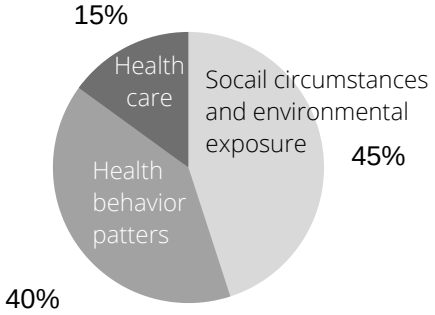
WHY FOCUS ON SOCIAL DETERMINANTS OF HEALTH AND EQUITY?

A person's health is determined largely by social, economic, and environmental factors, although prevention and healthcare services contribute substantially to maintaining health. According to the World Health Organization (1948), "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Where we live, go to school, and work affects our overall health, as does the safety and livability of our communities, whether we are economically stable or struggling to get by, and whether we have strong social connections. These factors are called social determinants of health and help explain why certain segments of the population experience better health outcomes than others. They also explain how external factors influence our ability to live healthily.

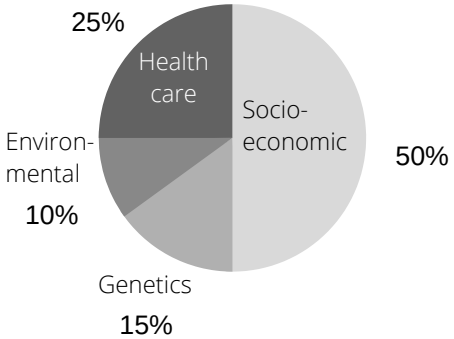
"To reduce health inequalities requires action to reduce socioeconomic and other inequalities. There are other factors that influence health, but these are outweighed by the overwhelming impact of social and economic factors—the material, social, political, and cultural conditions that shape our lives and our behaviors." (Marmot & Allen, 2014)

The most effective way to impact health and health equity at the population level is to focus on the social determinants of health. The pie charts below are from several studies that estimated the impact of these determinants on population health. Based on these estimates, 60-85% of health status is determined by social circumstances, health behavior, and/or environmental factors (Marmot & Allen, 2014).

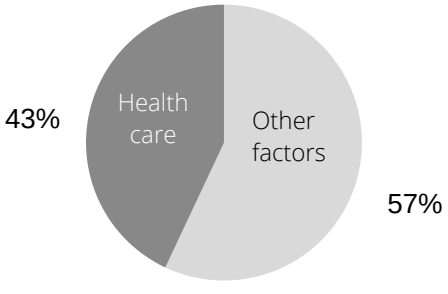
Mc Giniss et al (2002)



Canadian Institute of Advanced Research (2012)

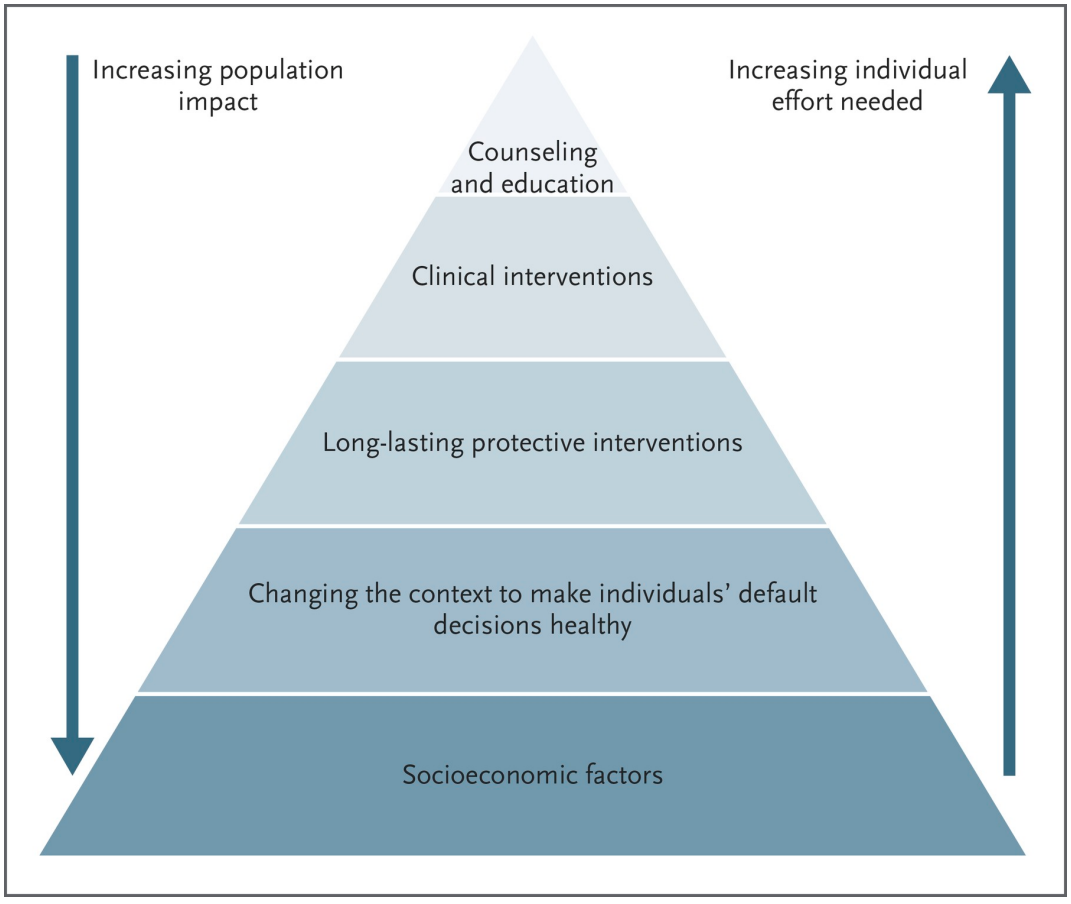


Bunker et al (1995)



To improve population health, it is crucial to address social and environmental factors. The Health Impact Pyramid shows the respective impact of different types of public health interventions. As demonstrated in the image, the greatest gains toward improving population health are the interventions that address socioeconomic factors. Socioeconomic factors include the economic and social position of individuals, such as income, education, and occupation. This next level of impact focuses on interventions that change the context for health, for instance, assuring clean drinking water and clean air. The next level, long-lasting protective interventions include things like immunizations. These are followed in effectiveness by clinical interventions, then counseling and education. While there remains a need for individual counseling and education, it is important to note that the interventions at the bottom of the pyramid not only have the greatest impact but also require less individual effort than interventions at the top (Community Commons, 2018).

Addressing social determinants not only improves health, but also reduces longstanding disparities in health and health care (Kaiser Family Foundation, 2018). Although all interventions are useful and should be considered when planning public health work, socioeconomic factors have the greatest impact on overall population health and health equity.

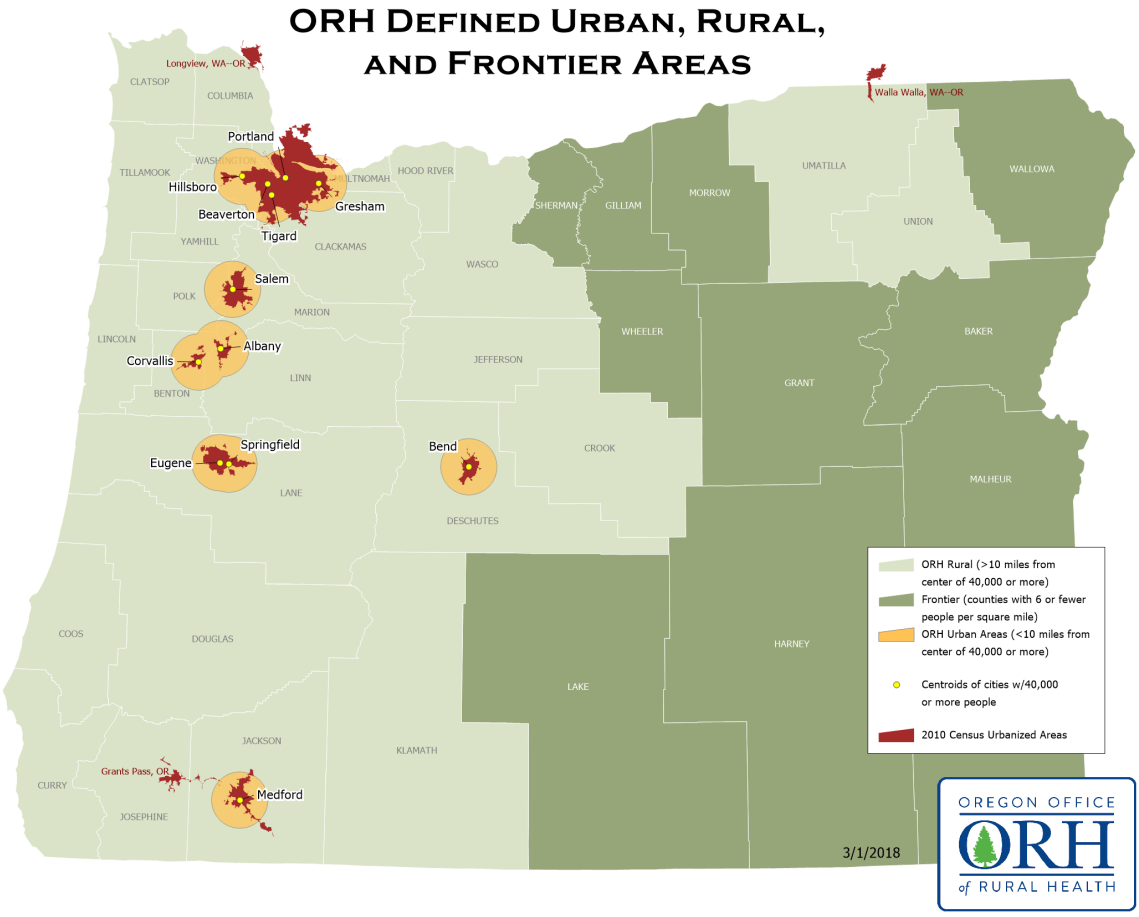


Frieden TR. Shattuck lecture: the future of public health. N Engl J Med. 2015;373:1748–54.

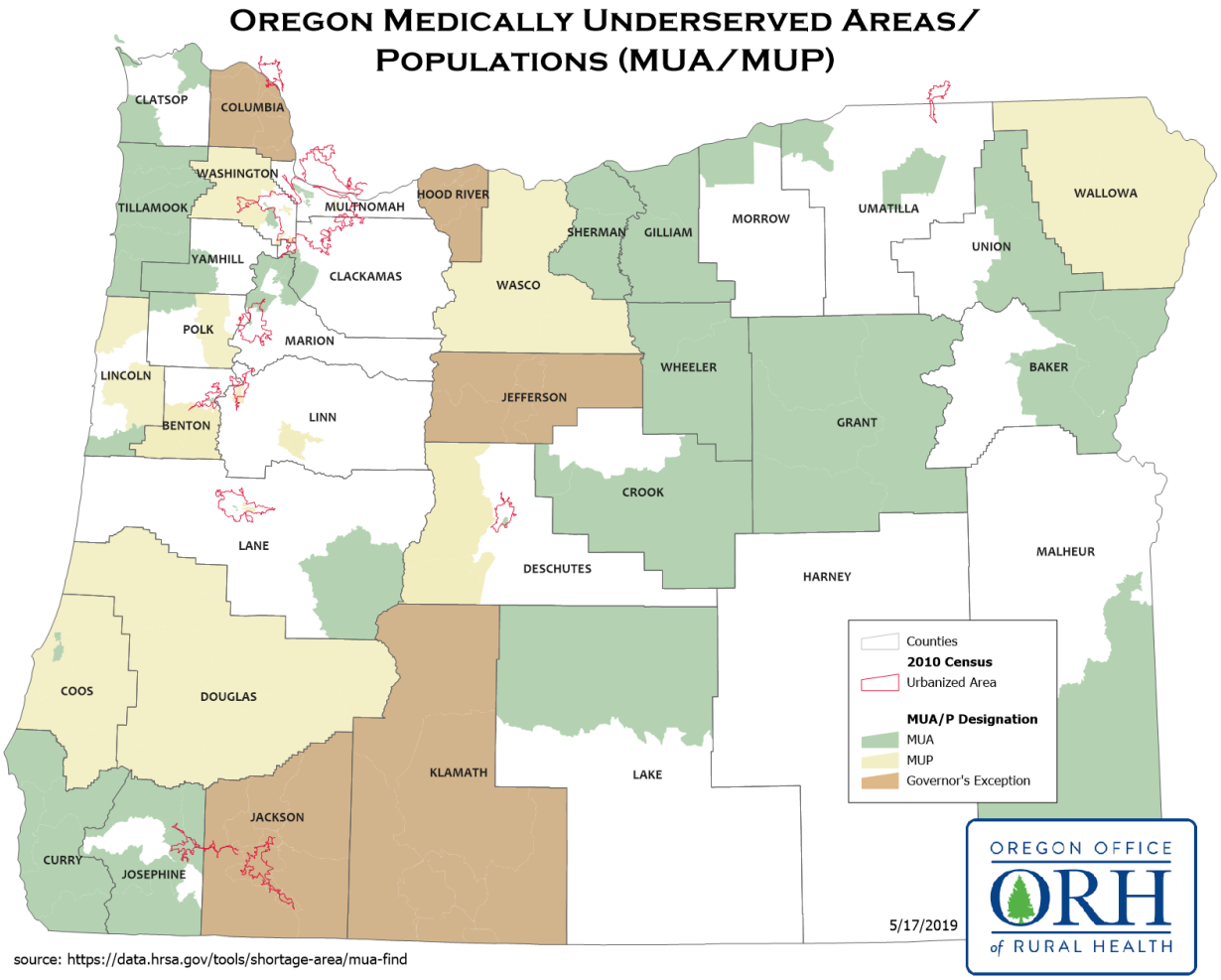
About Central Oregon

The data included here should by no means be considered a complete or thorough representation of the determinants of health in Crook, Deschutes, or Jefferson County. Additional health data related to equity is in the 2019 Regional Health Assessment. https://cohealthcouncil.org/regional-assessments/

Central Oregon (Crook, Deschutes, and Jefferson Counties) is growing rapidly with a population growth of 10.2%, 18.5%, and 9.4% respectively from 2010 to 2017. This growth does not change the fact that much of the region is considered rural (>10 miles from a center of 40,000 or more) (ACS, 2017), and that access to medical services are inequitably distributed based on geography. Rural areas typically have less access than urban centers. Large swaths of Crook, Deschutes, and Jefferson County are identified as Medically Under-served Areas (MUA) or Medically Under-served Populations (MUP).



About Central Oregon



source: https://data.hrsa.gov/tools/shortage-area/mua-find

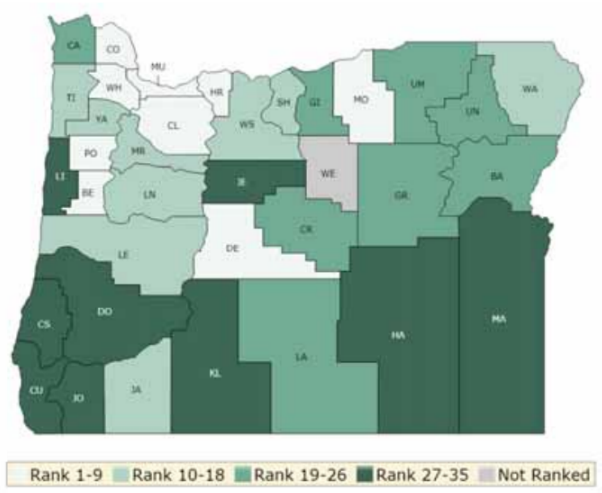
County Health Rankings in Central Oregon

The annual County Health Rankings measure health factors in counties across America. The rankings provide a snapshot of how health is influenced by where we live, learn, work and play.

Health Outcome Rank in Oregon (2020)

5: Deschutes County
22: Crook County
34: Jefferson County

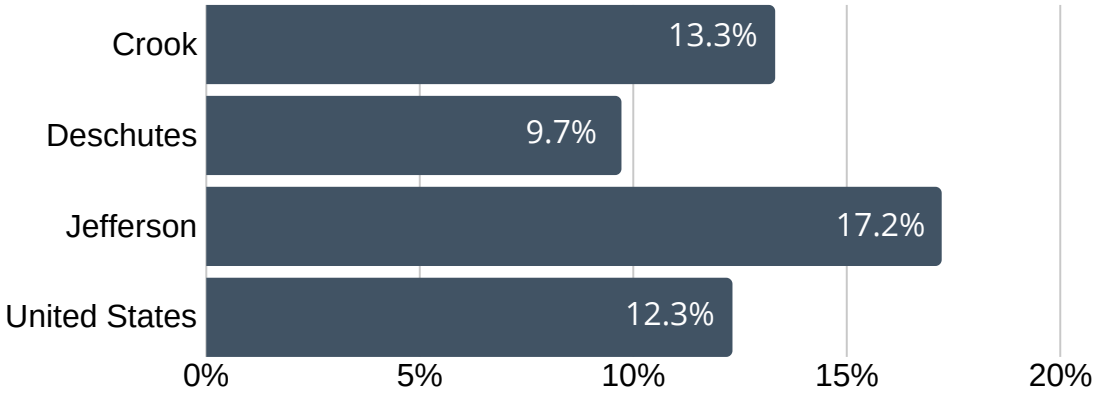
**Out of 35 Oregon Counties*



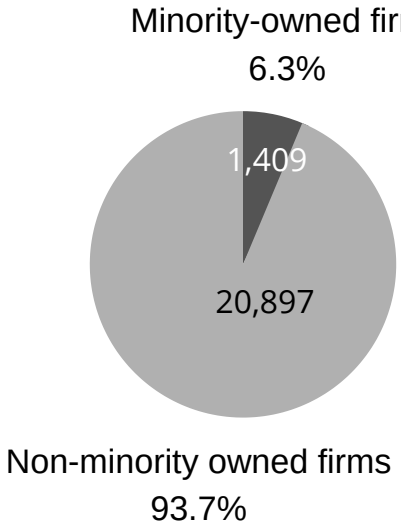
Ranking by Category (2020)			
	Crook	Deschutes	Jefferson
LENGTH OF LIFE	20	4	28
QUALITY OF LIFE	23	5	35
HEALTH BEHAVIORS	32	2	35
CLINICAL CARE	16	2	35
SOCIAL/ ECONOMIC FACTORS	29	6	28
PHYSICAL ENVRIONMENT	20	24	7

Poverty and Economic Opportunity by County

Percent of the Population Living in Poverty, 2013- 2017



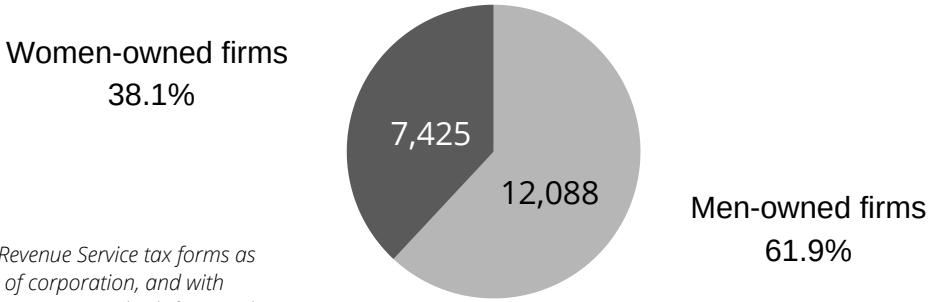
Number and Percent of Central Oregon Firms owner by Minority Status, 2012



A higher percentage of the population in Crook and Jefferson Counties live in poverty compared to the United States.

Within Central Oregon, the majority of firms are owned by men (62%) and non-minorities (94%).

Number and Percent of Central Oregon Firms by Gender Status, 2012



(Census, 2019)

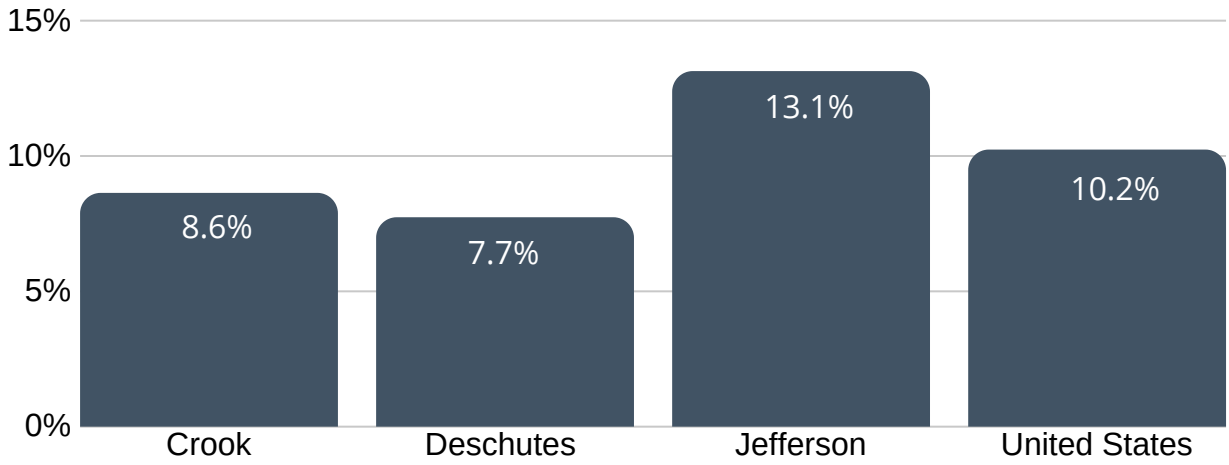
**Included are all nonfarm businesses filing Internal Revenue Service tax forms as individual proprietorships, partnerships, or any type of corporation, and with receipts of $1,000 or more. The Survey of Business Owners covers both firms with paid employees and firms with no paid employees.*

Disability

The percent of people under sixty-five years of age and living with a disability is higher in Jefferson county (13.1%) than the percentage across the United States (10.2%), as well as higher than the rates in Crook (8.6%) and Deschutes (7.7%) counties.

"The medical community needs to be more aware of the needs that come with disability. And the community in general is unaware."
Central Oregon Community Resident, 2019 Regional Health Assessment Focus Groups

Percent of persons living with a disability, under 65 years of age, 2013-2017



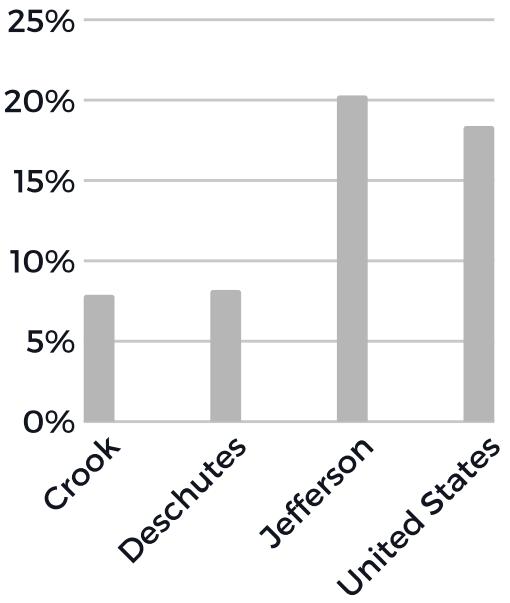
(Census, 2019)

Race/ Ethnicity/ Language Spoken

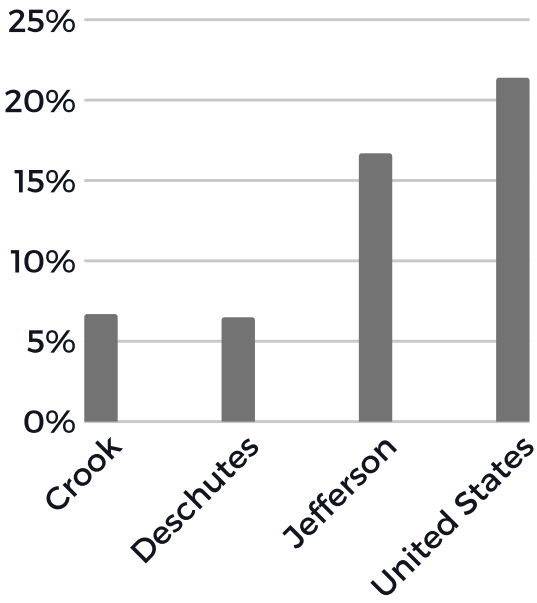
Within Crook, Deschutes, and Jefferson County, 7.8%, 8.1%, and 20.2% of the population respectively, identify as Hispanic or Latino, and in Jefferson County 18.8% of the population identifies as American Indian and Alaska Native alone.

6.6% of the population in Crook County, 6.4% in Deschutes, and 16.6% in Jefferson County speak a language other English at home (Census, 2019).

Percent of the Population that Identifies as Hispanic or Latino, 2013-2017, Census



Percent of the Population who speaks a non-English Language at Home 2013-2017, Census

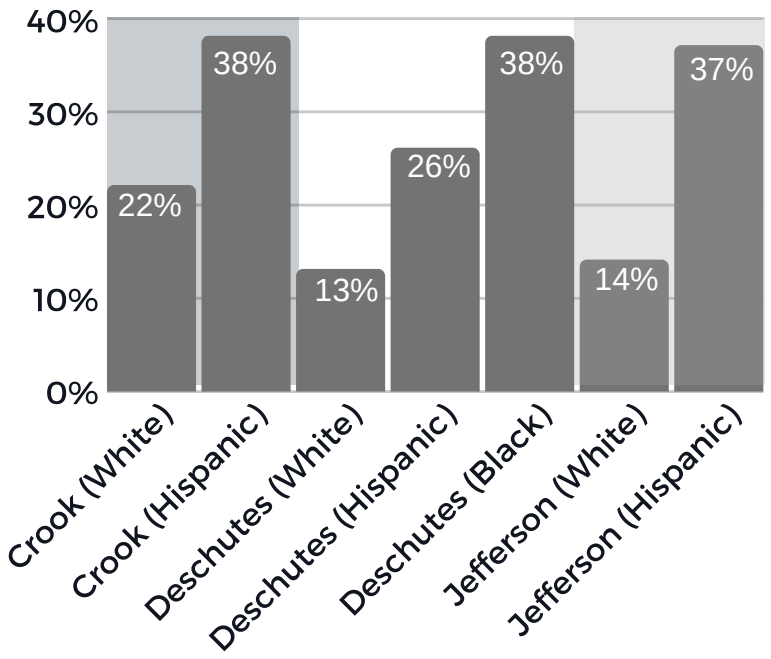


"[We need] culturally relevant and appropriate care, reducing bias in communication and service provision, and work together with organizations to deliver education services."

Central Oregon Community Partner, 2019 Central Oregon Regional Health Assessment

Race/ Ethnicity

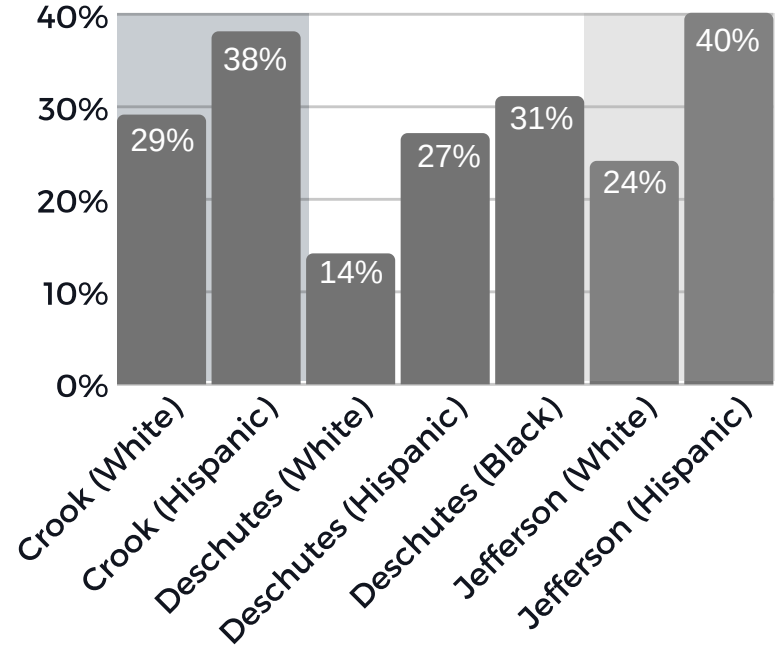
Percentage of Children (Under 18) Living in Poverty by County and Race/ Ethnicity, 2017



The percent of children living in poverty varies greatly by Race/ Ethnicity, with a lower percentage of children who identified as White living in poverty compared to those who identified as Hispanic or Black.

In Crook, Deschutes, and Jefferson counties respectively, 22%, 13%, and 14% of children who identify as White lived in poverty. This is lower than the percent who identified as Hispanic; 38%, 26%, and 37%, respectively. In Deschutes county data was available for the percent of children living in poverty and who identified as Black, 38%. This was higher than either those who identified as White or Hispanic (County Health Ranking, 2019).

Percent of births per 1,000 female population ages 15-19, 2011-2017

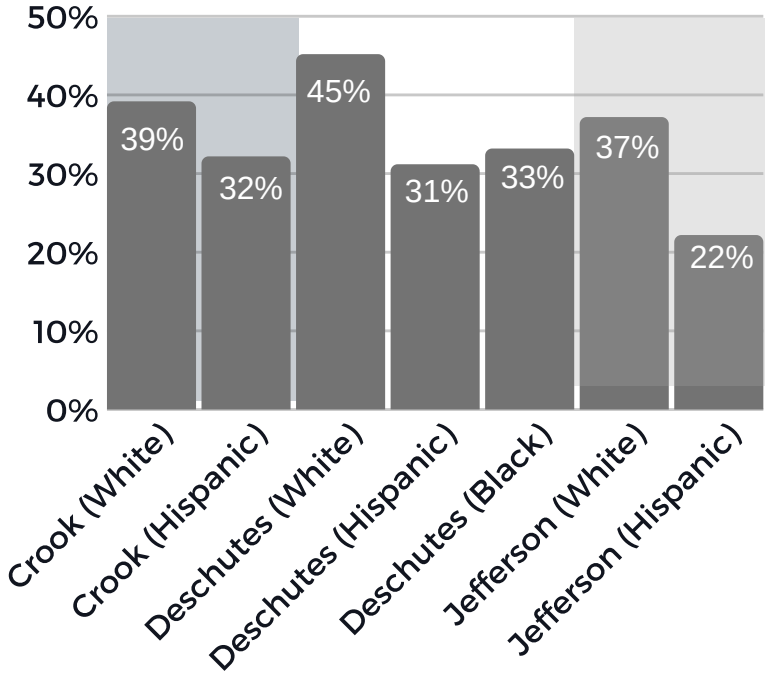


Trends for the percent of teen births by county and race/ethnicity were similar to the trend for the number of children living in poverty.

The percent of teen births varies greatly by race/ ethnicity, with lower percentages for those who identified as White (14%-29%) compared to those who identified as Hispanic (27%-40%) or Black (31%) (County Health Ranking, 2019).

Race/ Ethnicity

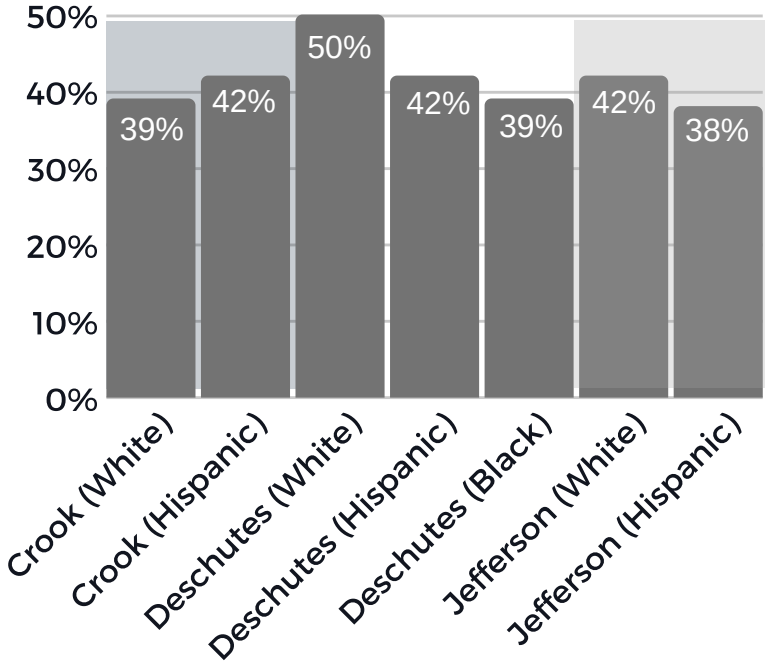
Percent of female Medicare Enrollees ages 65-74 that received an annual mammography screening, 2016



The percent of female Medicare enrollees ages 65-74 who received an annual mammography screening varied by race ethnicity and county. Women who identified as White in Deschutes County were the most likely to receive an annual mammography (45%), while women who identified as Hispanic in Jefferson county were the least likely (22%) (County Health Ranking, 2019).

> *"[Healthcare organizations] don't recruit Spanish speaking providers... We need credentialed providers. Getting more translators is a band-aid."*
> *Central Oregon Community Resident, 2019 Regional Health Assessment Focus Groups*

Percent of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination, 2016

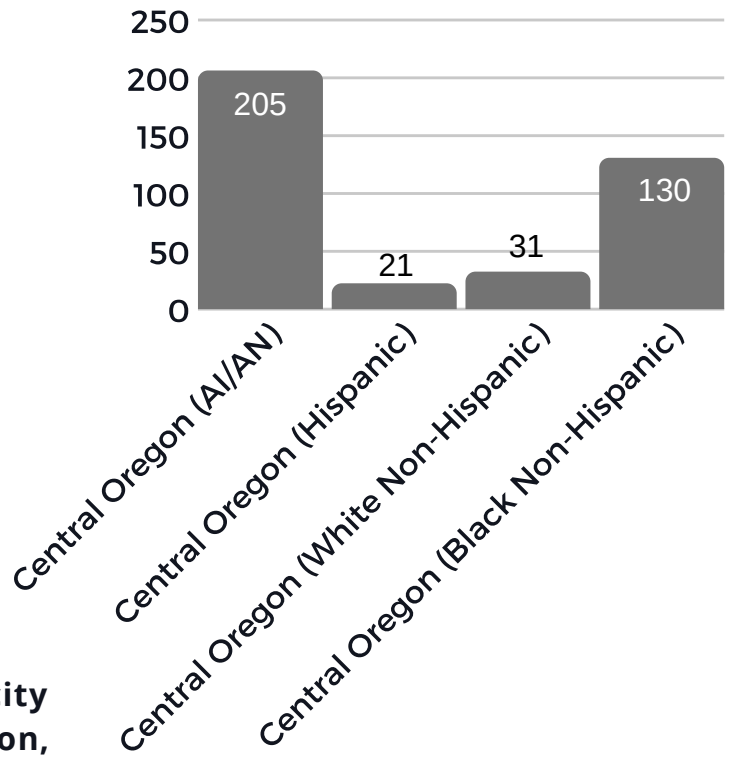


There were some differences in flu vaccination rates for FFS Medicare enrollees by county and race/ethnicity, with the percent of enrollees vaccinated annually ranging from 38% (Hispanic, Jefferson) to 50% (White, Deschutes) (County Health Ranking, 2019).

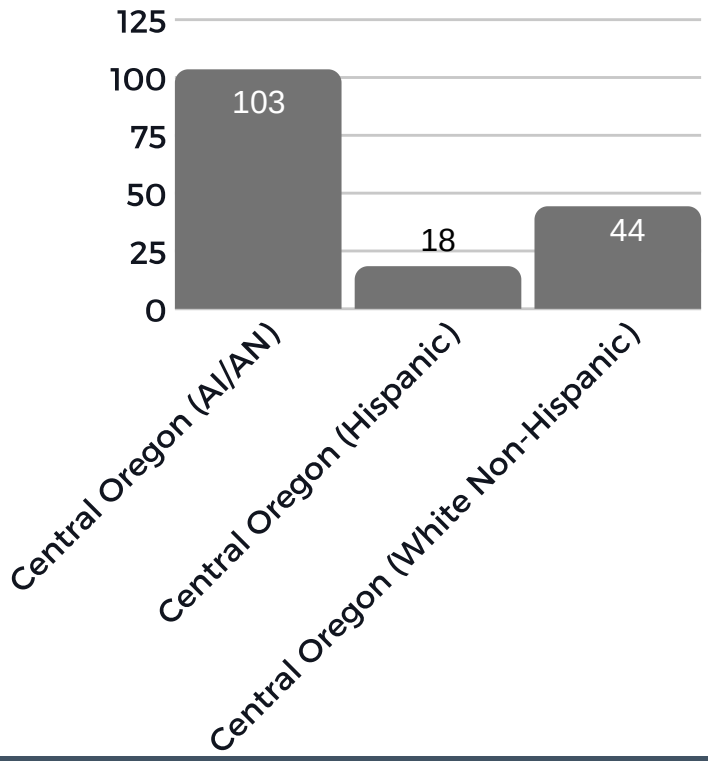
Race/ Ethnicity

In Central Oregon, the gonorrhea incidence rate among those who identified as White, non-Hispanics and Hispanics was statistically lower than the total/overall gonorrhea incidence rate. The American Indian/Alaska Native, non-Hispanic and Black, non-Hispanic rates were statistically higher than the total/overall gonorrhea incidence rate. * AI/AN: American Indian/Alaska Native

Age-adjusted gonorrhea incidence rate per 100,000 population by race/ethnicity, OPHAT, 2013-2017



Age-adjusted mortality rate from unintentional injuries by race/ethnicity per 100,000 population, Central Oregon, OPHAT, 2013-2017

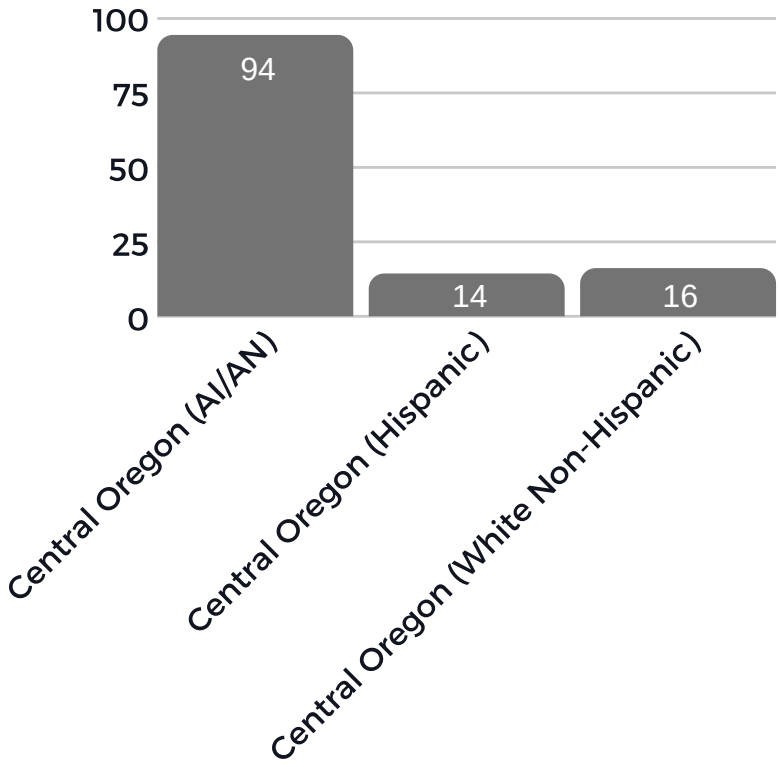


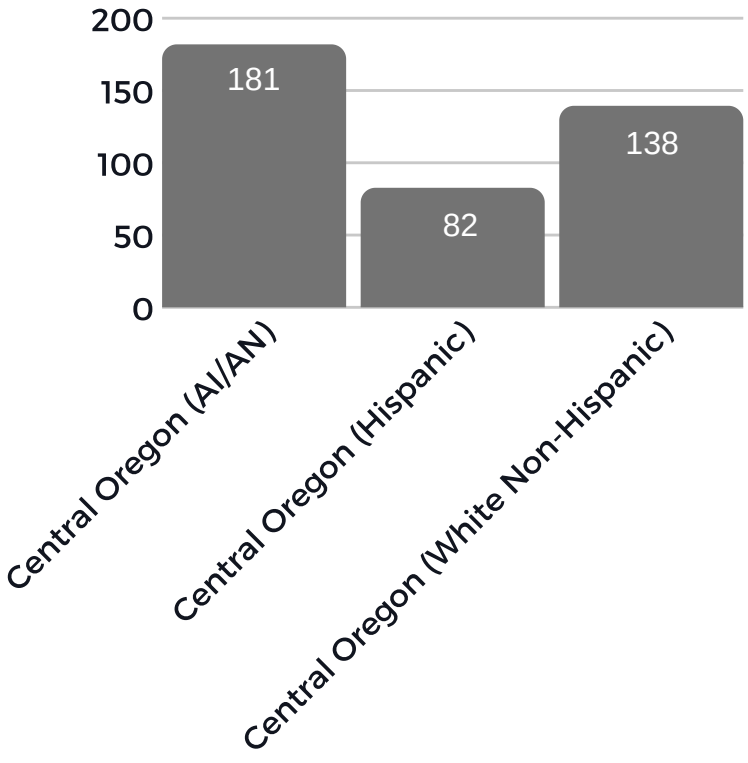
In Central Oregon, the mortality rate from unintentional injuries is statistically significantly lower among Hispanics compared to the total/overall population. In Central Oregon, the mortality rate from unintentional injuries is statistically significantly higher among American Indian/Alaska Native, non-Hispanics compared to the total/overall population; across Oregon as a whole, there is no significant difference between American Indian/Alaska Native non-Hispanics compared to the total/overall population.

Race/ Ethnicity

Age-adjusted mortality rate from "alcohol-induced deaths" by race/ethnicity per 100,000 population, Central Oregon, OPHAT, 2013-2017

In Central Oregon, the mortality rate from alcohol-induced causes is statistically significantly higher among American Indian/Alaska Native non-Hispanics compared to the total/overall population.



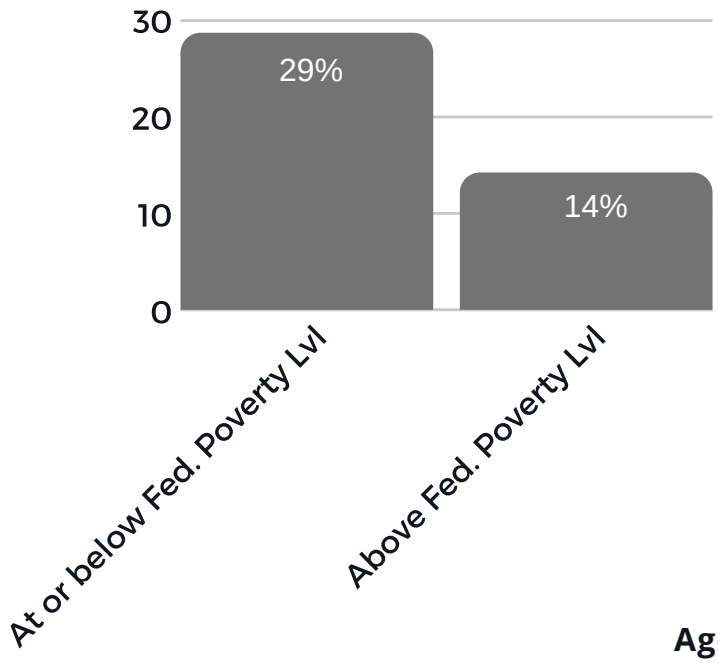


Age-adjusted mortality rate from "tobacco-related causes" by race/ethnicity per 100,000 population, Central Oregon, OPHAT, 2013-2017

In Central Oregon, the mortality rate from tobacco-related causes is statistically significantly lower among Hispanics than among the total/overall population. Across Oregon, American Indian/Alaska Native non-Hispanics have a statistically higher rate of mortality from tobacco-related causes than the total/overall population, but there is no statistically significant difference in Central Oregon. * AI/AN: American Indian/Alaska Native

Poverty Level

Age-adjusted percent of adults who currently smoke, by poverty status, Oregon BRFSS, 2014-2017



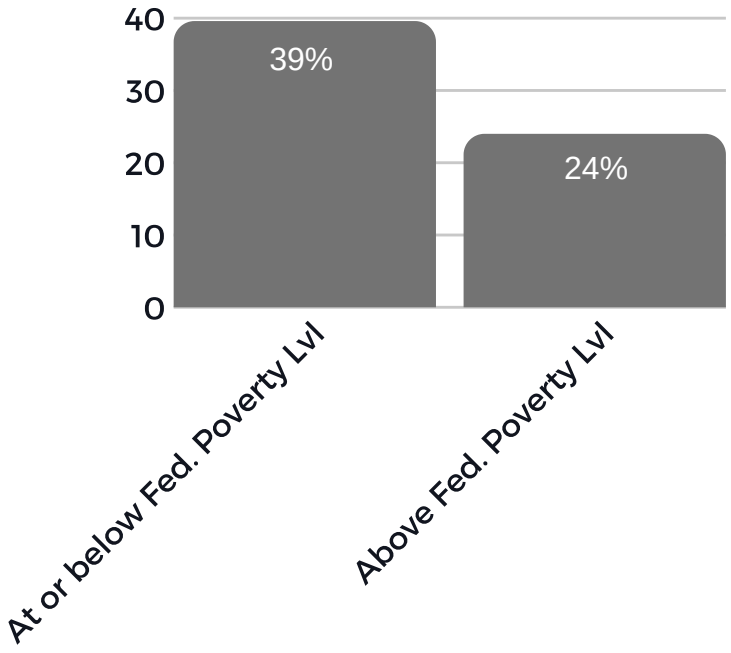
In Central Oregon, the percent of adults who currently smoke is statistically significantly higher among those living at or below the federal poverty level compared to those living above the federal poverty level.

> *"I can't feed my kids healthily. If you buy healthy food you spend all your money in a single week out of the month. They can't eat healthy, they can't be healthy."*
> *Central Oregon Community Resident, 2019 Regional Health Assessment Focus Groups*

In Central Oregon, the age-adjusted percent of adults classified as obese was statistically significantly higher among those living at or below the federal poverty level than those living above the federal poverty level.

> *"I see a big gap for children of color compared to white children. It seems it is getting bigger and it is hard to explain to younger siblings. Some families struggle with mental health or poverty issues and the gaps continue to become larger when comparing white versus minorities."*
> *Central Oregon Community Resident, 2019 Regional Health Assessment Focus Groups*

Age-adjusted percent of adults who are classified as obese, by poverty status, Central Oregon BRFSS, 2014-2017



Poverty

Age-adjusted percent of adults who have been diagnosed with depression, by poverty status, Central Oregon BRFSS, 2014-2017

In Central Oregon, the age-adjusted percent of adults who report having been diagnosed with depression was statistically significantly higher among those living at or below the federal poverty level than those living above the federal poverty level.

BAR HII Assessment Results

Central Oregon Results Summary

While results varied by Local Health Department (LHD), some themes remain consistent across Central Oregon.

- The top environmental, social, and economic conditions that impact health were similar for partners and staff, and closely aligned with 2019 Regional Health Assessment community focus group findings:
    1. Cost of Living.
    2. Housing.
    3. Behavioral Health.
- 94% of partners indicated that the LHD should play a significant role in addressing health inequities and social determinants of health, while 84% of partners perceive that LHDs demonstrate this commitment.

Assessment Steps

http://barhii.org/resources/barhii-toolkit/

1. Internal Staff Survey
2. Collaborating Partner Survey
3. Staff Focus Groups
4. Leadership Focus group/ Management Interview
5. Internal Document Review and Discussion

"Addressing the high cost of living in Central Oregon, including housing, healthy foods, healthcare, and childcare was consistently identified as a main community need during focus groups hosted throughout the region."
- 2019 Regional Health Assessment

"[To improve collaboration] Provide a [Public Health Department] organizational overview with the structures, functions, and contacts to facilitate understanding and communication."

- Areas for improvements across Central Oregon include:
    - The creation and distribution of materials appropriate for the cultural, linguistic, and literary needs of the community.
    - Modifying workforce efforts to actively recruit and promote ethnically, racially, and culturally diverse staff.
    - Efforts to increase community understanding of public health roles, programs, and initiatives to support collaboration and partnership.

139

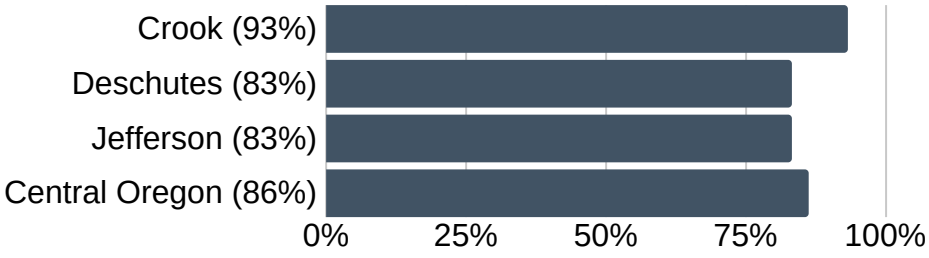
Central Oregon community partners responded.
56 CCHD, 51 DCPH, 14 JCPH, 18 Tri-County.

CCHD: Crook County Health Department
DCPH: Deschutes County Public Health
JCPH: Jefferson County Public Health

Survey Summary: Community Partner

**This page highlights partner perception of programs and services related to equity and the social determinants of health.*

Public Health staff that I interact with understand the major causes of health inequities in the County.



54%

Agree LHDs play an active role in developing, maintaining, and supporting networks/partnerships in the community.

Top Health Inequity Contributors

1. Cost of Living
2. Housing
3. Behavioral Health

86% Of partners agree Central Oregon LHDs value input from residents and organizations.

46% Of partners agree Central Oregon LHDs create & distribute oral and written materials appropriate for cultural, linguistic, & literacy needs.

83%

Of partners have trusting relationships with LHD staff.

71%

Of partners are always or sometimes meaningfully involved in LHD planning.

76%

Of partners believe the LHD provides resources to address health inequities.

"Staff are sometimes spread too thinly, but this is hard due to limited funding for public health."

Partner Ideas to Improve Collaboration

"Provide an organizational overview with the structures, functions and contacts to facilitate understanding and communication."

"Awareness of organizations that are not big or always at the table."

"Be more visible by reaching out to other public bodies to create an awareness of efforts."

94%

Of partners believe the LHD should play a significant role in addressing the environmental, social, and economic conditions that impact health.

84%

Of partners believe the LHD demonstrates a commitment to addressing the environmental, social, and economic conditions that impact health.

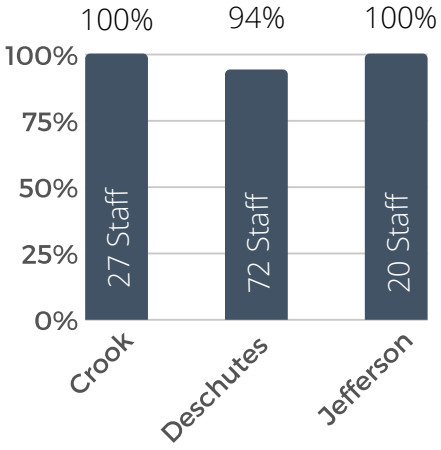
83%

Of Partners work with the LHD to address equity and social determinants of health.

Survey Summary: Staff

**This page highlights staff perception of programs and services related to equity and the social determinants of health.*

Response Rate



Staff agree that the Crook, Deschutes, and Jefferson public health departments are committed to addressing health inequities.

85%

Of staff believe the LHD has trusting relationships with partners.

37%

Of staff believe the LHD equitably promotes diverse staff (ethnicity, race, and culture).

29%

Of staff believe the LHD recruits culturally diverse leadership staff.

90%

Of staff take steps to enhance cultural understanding.

Central Oregon LHDs collaborate with a range of community groups and organizations, including groups focused on improved living conditions, neighborhood, faith-based, youth-development, leadership, healthcare, prevention, law enforcement, and others.

Top Health Inequity Contributors

1. Cost of Living
2. Housing
3. Behavioral Health *(Including alcohol, tobacco, and other drugs)*

100% of...

Central Oregon LHDs include community leaders, residents, and community based organizations in strategic planning.

Central Oregon LHD staff work to improve equity in a variety of ways including surveillance, diagnosis, investigation, information distribution, education, partnership mobilization, policy and plan development, law and regulation enforcement, referrals to services, internal workforce development, evaluation, and more.

56%

Of staff report, LHDs focus the right amount on health inequities.

59%

Of staff report, LHDs demonstrate a commitment to address equity and the social determinants of health.

71%

Of staff report, LHDs create and distribute oral and written information that is appropriate for the cultural, linguistic and literacy needs in the community.

ACDP HEALTH EQUITY MINI-GRANT 2019

**In addition to the BAR HII assessment, Central Oregon LHD staff hosted community parter meetings.*

Deschutes County Public Health (DCPH) hosted two community meetings, one in Bend on June 26, 2019, and the other in Redmond on June 27, 2019.

- The Attendance at the Bend, Oregon event (6/26/19): 30 People.
- The Attendance at the Redmond, Oregon event (6/27/19): 19 People.
- The number of partner organizations represented in the two meetings: 23 Organizations.

Jefferson County Public Health (JCPH) scheduled two community events (Madras and Warm Springs).

- The attendance at the Madras, Oregon event (4/23/19): 52 People.
- Confederated Tribes of Warm Springs Event (6/11/19): Cancelled due CTWS Emergency Declaration and drinking water issues. Rescheduled for September 2019.
- The number of partner organizations represented in the meeting: 18 Organizations.

Crook County Health Department hosted two community events, one in Prineville on April 7th, 2019 and one on May 14th at the Early Learning Meeting in Prineville.

- The Attendance at the Prineville, Oregon event (4/7/19): 55 People.
- The Attendance at the Early Learning Meeting in Prineville event (5/14/19): 12 People.
- The number of partner organizations represented in the two meetings: 19 Organizations.

Qualitative Data (Crook, Jefferson, Deschutes)

Based on the community meetings, partners think that local public health should:

- Provide more education about the many varied public health services.
- Serve as the community catalyst and convener.
- Assure DCPH staff has training on health equity.
- Provide access to more community-level health equity data.
- Support access to services using an equity lens.
- Be more deliberate in discussions on Social Determinants of Health
- Provide more education about the many varied public health services offered locally and in the region.
- Increase focus in all communities of Jefferson County; not just Madras area.
- Serve as the community point of contact for Social Determinants of Health issues.
- Increase staffing levels to support this type of work.
- Work with local partners to develop, compile, and share community-level health equity data.
- Highlight the importance of providing services through a health equity lens
- Improve communication to community partners.
- Include community partners in the planning of programs.

Action Plan 2020-2023

**This page highlights staff perception of LHD programs and services related to equity and the social determinants of health.*

Crook County Public Health

Integrate health equity considerations into PH policies and practices as well as contracting, grant, and RFP processes (DUE: 6/30/2021).

Formalize process(es) for the development of strategies that address factors contributing to health inequities (DUE: 6/30/2022).

Assure incorporation of equity goals and metrics in the 2020 Strategic Plan (DUE: 10/1/2020).

Assess community and staff equity perception and needs (i.e. BAR HII assessment), Identify opportunities for improvement, create a report and action plan (DUE: 6/30/2023).

Implement onboarding and annual health equity training for all health department staff (DUE: 10/1/2020).

Build community coalition capacity to address health inequities related to substance use and mental health (DUE: 4/1/2021)

Engage two AmeriCorps VISTA members to improve communications and access to services for populations experiencing health inequities (DUE: 6/30/2023)

Provide leadership in public policy setting to ensure evidence-based public health practice, cultural competence, health equity, system level changes, and effective community engagement in public health policy (DUE: 6/30/2023).

Lead and advocate for addressing social determinants of health and health equity and mobilize community resources to improve public health (DUE: 6/30/2023).

Make the Health Equity Report and Plan available to partners and stakeholders by posting to CCHD website (DUE: 4/1/2020).

Work directly with communities to co-create policies, programs and strategies to ensure that health interventions are equitable and culturally responsive (DUE: 6/30/2023).

Obtain community input and incorporate into the 2020 Strategic Plan. Make the Plan available to the public on the CCHD website (DUE: 10/1/2020).

Action Plan 2020-2023

**This page highlights staff perception of LHD programs and services related to equity and the social determinants of health.*
**The items included in the action plan are from focus groups with all DCPH teams, PE 51, the equity mini-grant and accreditation activites.*

Deschutes County Public Health

Assure Equity metrics and goals are incorporated in the 2021 Strategic Plan (DUE: 12/31/20).

Create and share an equity toolkit that includes tangible examples of equity & inequity by program, the equity framework, definition, etc. (DUE: 6/30/2021).

Create a partnership portfolio, identify partnership gaps, especially as it pertains to equity (DUE: 6/30/20). Identify and implement strategies to work collaboratively with organizations whose activities advance health equity and promote Health in All Policies (PE 51) (DUE: 6/30/21).

Reach out to partners to assess, identify, and implement strategies to better communicate information that meets the language, literacy, and cultural needs of the community (DUE: 6/30/2021).

Identify and implement strategies to assure more diverse representation on the local PHAB (DUE: 6/30/2023).

Assess and integrate equity into internal processes and core documents, including hiring and workforce development, the local advisory board, fiscal planning, and grants (DUE: 6/30/2021).

- Create a process within DCPH similar to the Oregon State University Search Advocate Program.
- Work with Deschutes County Human Resources to implement blind hiring and other best practices that promote workforce diversity.

Create a central Oregon (Deschutes and Jefferson) health equity data report to identify health inequities and areas of disproportionate disease rates. Use tools such as data collection, analysis, assessment, literature review to identify needs, public health role and best practices for prioritizing and addressing targeted conditions identified in the report (PE 51) (DUE: 6/30/2021).

Promote/ engage in initiatives or policies that promote evidence-based public health practice cultural competence, and/or a focus on health equity (PHAB) (DUE: 6/30/2023).

Implement tangible strategies that incorporate equity concepts into DCPH culture, including internal communication and collaborative decision-making processes. Staff should be empowered to let leadership and others know how changes will impact their job before a decision is made to allow for pro-active planning (DUE: 6/30/2023).

Action Plan 2020-2023

**This page highlights staff perception of LHD programs and services related to equity and the social determinants of health.*
**The items included in the action plan are from focus groups with all DCPH teams, PE 51, the equity mini-grant and accreditation activites.*

Deschutes County Public Health Cont.

Prioritize activities that promote public health sustainability, especially for programs predominately funded by grants, to maintain community partnerships and better integrate equity into DCPH processes and programs (DUE: 6/30/2023).

- Internally share a dashboard on how each PH program is funded (i.e., grants, general funds, Medicaid, etc.) and staffing changes over time might help explain that this concern affects multiple public health programs.
- Use strategies from the Center for Public Health Systems Science (CPHSS), Program Sustainability Framework and Assessment Tool.

Provide leadership in public policy setting to ensure evidence-based public health practice, cultural competence, health equity, system level changes, and effectiveness in community engagement in public health policy (PHAB) (DUE: 6/30/2023).

Health department acts as a leader and advocate for addressing social determinants of health and health equity, and mobilizes community and community resources to improve the public's health (PHAB) (DUE: 6/30/2023).

Assess community and staff equity perception and needs (i.e. BAR HII assessment), identify opportunities for improvement, create a report, and action plan (DUE: 6/30/2023).

For client services, implement strategies to help provide services in the community, such as a shared van for the clinic, Syringe Exchange, and WIC (DUE: 6/30/2023).

Action Plan 2020-2023

**This page highlights staff perception of LHD programs and services related to equity and the social determinants of health.*
**The items included in the action plan are from Discussion at the February JCPH All Staff , PE 51, the equity mini-grant and accreditation activites.*

Jefferson County Public Health

Create partnership portfolio, identify partnership gaps, especially as it pertains to equity. Identify and implement strategies to work collaboratively with organizations whose activities advance health equity (PE 51) (DUE: 12/31/20).

Assure Equity metrics and goals are incorporated in the 2021 Strategic Plan (DUE: 12/31/20).

Reach out to partners to assess, identify, and implement strategies to better communicate information that meets the language, literacy, and cultural needs of the community. (i.e. Latino Community Association, Let's Talk Diversity) (DUE: 6/30/2023).

Communicate and educate others about how public health's work impacts the social determinants of health, including Maslow's Hierarchy of Needs and how public health impacts each level (DUE: 6/30/2023).

Provide leadership in public policy setting to ensure evidence-based public health practice, cultural competence, health equity, system level changes, and effectiveness in community engagement in public health policy (PHAB) (DUE: 6/30/2023).

Health department acts as a leader and advocate for addressing social determinants of health and health equity, and mobilizes community and community resources to improve the public’s health (PHAB) (DUE: 6/30/2023).

Promote/ engage in initiatives or policies that promote evidence-based public health practice cultural competence, and/or a focus on health equity (PHAB) (DUE: 6/30/2023).

Assess community and staff equity perception and needs (i.e. BAR HII assessment), identify opportunities for improvement, create report, and action plan (DUE: 6/30/2023).

APPENDIX

EQUITY QUESTIONS TO CONSIDER DURING PLANNING

1. Who are the racial/ethnic and underserved groups affected?
    a. What is the potential impact of the resource allocation to these groups?
2. Identify disparities: What are the current/ existing disparities for the target population?
    a. Does the decision ignore or worsen the existing disparities or produce other unintended consequences? What is the impact on eliminating the opportunity gap?
    b. Does the decision address or alleviate disparities or produce other unintended consequences? What is the impact on eliminating the opportunity gap?
3. What are the barriers to more equitable outcomes? (e.g. mandated, political, emotional, financial, programmatic or managerial)
4. How have you intentionally involved stakeholders who are also members of the communities affected by the resource allocation?
    a. How does the decision being made align the target populations' priorities? Identify priorities.
    b. How do you validate your assessment in (1) and (2)?
5. How will you modify or enhance your strategies to ensure each learner and communities individual and cultural needs are met?
6. How are you collecting data on race, ethnicity, and native language?
7. What is your commitment to professional learning for equity? What resources are you allocating?

**Multiple sources were considered in development of these questions, including equity resources from Multnomah County.*

APPENDIX

DEFINITIONS AND FRAMEWORKS

There are a variety of ways to define Social Determinants of Health and Health Equity. Below are some examples from National and International leaders in Public Health.

Social Determinants of Health

Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature. Scientists generally recognize five determinants of health of a population:

- Biology and genetics. Examples: sex and age
- Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, and smoking
- Social environment. Examples: discrimination, income, and gender
- Physical environment. Examples: where a person lives and crowding conditions
- Health services. Examples: Access to quality health care and having or not having health insurance

(Center for Disease Control and Prevention, 2018)

Health Equity

When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'"

(Center for Disease Control and Prevention, 2018)

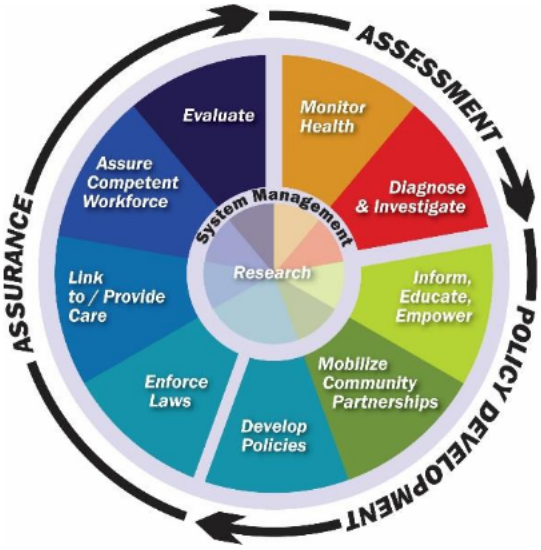
APPENDIX

DEFINITIONS AND FRAMEWORKS

The CDC's Social Determinants of Health Framework (below) considers health equity, the social determinants of health, and essential public health services. It helps outline the role and scope of public health in addressing social deferments of health and health equity (Center for Disease Control and Prevention, 2018). For more information about how the addressing the social determinants of health helps public health address health equity, and vice versa, please reference the section, "Why Focus on Social Determinants of Health Equity?", of this report.

Ten Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities

Public health departments and their partners need to consider how conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These social determinants of health (SDOH), and actions to address the resulting health inequities, can be incorporated throughout all aspects of public health work. Through broader awareness of how the key public health practices can better incorporate consideration of SDOH, public health practitioners can transform and strengthen their capacity and impact to advance health equity.



10 Essential Public Health Services

Five Key Areas of SDOH (HP 2020)

Framework continued on next page.

APPENDIX

DEFINITIONS AND FRAMEWORKS

	Roles of Public Health Agency (Based on 10 Essential Public Health Services)	Examples of How Essential Public Health Services Can Address
1.	Monitor health status to identify and solve community health problems	Include SDOH measures as basis for addressing community health problems and inequities Ensure community health assessments (CHA) include SDOH measures and engage communities and multi-sectoral partners in CHA efforts
2.	Diagnose and investigate health problems and health hazards in the community	Include community-level determinants of health in investigations, as well as policies and practices that involve other sectors to support them. For example • Ensure water sources meet required standards • Ensure brownfield sites Identify hazardous waste that might contaminate a community • Address deteriorating housing conditions to prevent lead poisoning and other hazards to health
3.	Inform, educate, and empower people about health issues	Ensure outreach and education efforts address social and structural determinants of health inequities Ensure access to culturally and linguistically appropriate approaches to community health (e.g., REACH) to help address SDOH. Approaches should take into account such challenges as structural racism and stigma against immigrants, both of which can decrease likelihood of seeking needed health care.
4.	Mobilize community partnerships and action to identify and solve health problems	Engage and collaborate with community members and non-traditional partners associated with SDOHs, such as • Housing authorities • Law enforcement • Schools • Community organizations
5.	Develop policies and plans that support individual and community health efforts	Leverage evidence-based policies in non-health sectors that affect SDOH and health outcomes, such as • Safe and affordable housing that can reduce risk for asthma, lead poisoning, homelessness • Full-day kindergarten that can reduce adverse health prospects such as teenage pregnancy Develop and implement state/community health improvement plans that include and address the SDOH in collaboration with community partners
6.	Enforce laws and regulations that protect health and ensure safety	Develop strategies to ensure enforcement of existing regulations and laws that affect health, such as • Housing and health codes to prevent childhood lead poisoning. • Batterer intervention program laws to prevent violence against women and children

Framework continued on next page.

DEFINITIONS AND FRAMEWORKS

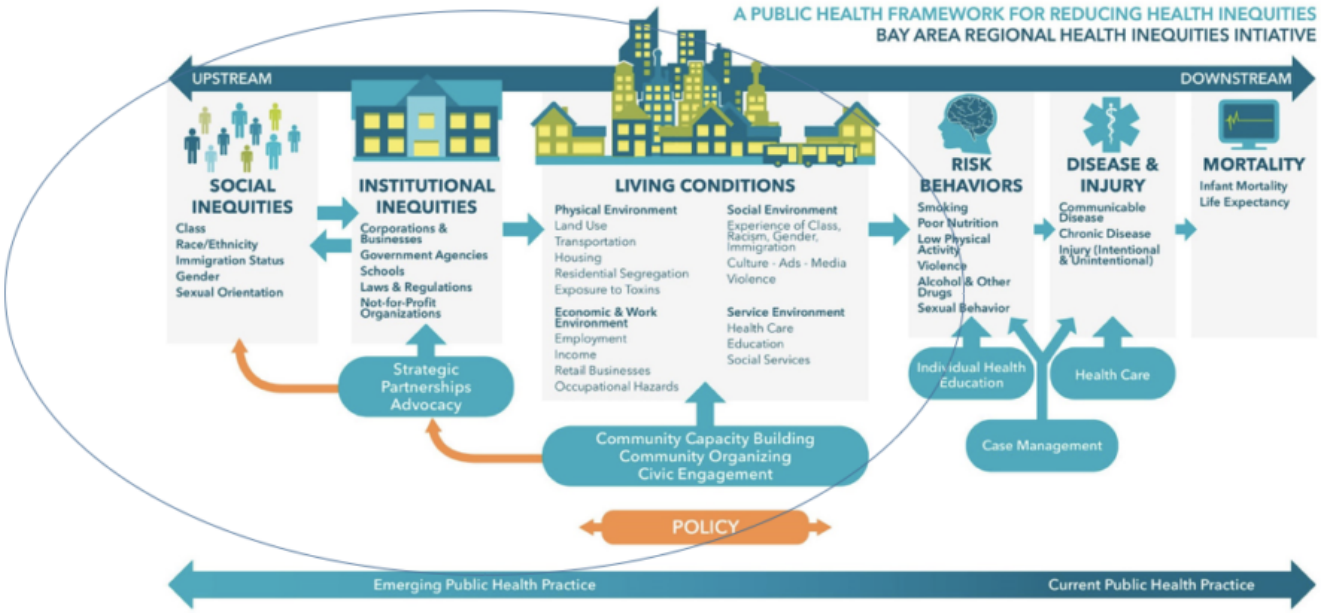
7.	Link people to needed personal health services and ensure the provision of health care when otherwise unavailable	Educate community members about their eligibility for and access to entitlement programs • Medicaid, including its medical, mental health, and housing benefits • TANF • SNAP Ensure that essential health benefits and the free preventive services provisions of the Affordable Care Act are correctly and equitably implemented
8.	Assure competent public and personal health care workforce	Support staff training and development efforts that help workforce incorporate social determinants of health inequity into their job responsibilities Promote hiring of workforce that reflects population being served
9.	Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Ensure evaluation and research designs include interventions that address SDOH inequity Use performance management and quality improvement methods to explore and address more effectively the root causes of issues, which often include SDOH
10.	Research for new insights and innovative solutions to health problems	Expand research agendas to include SDOH and related health outcomes, especially in evaluation of natural experiments where a project is already addressing SDOH but is not studying health effects (e.g., implementation of the Essentials for Childhood Framework) Use community-based participatory research designs Apply evidence-based practices (e.g., *The Community Guide*) to address health inequity and demonstrate improved health outcomes

Visit the CDC website to learn more about social determinants of health.

APPENDIX

DEFINITIONS AND FRAMEWORKS

BAR HII Health Equity Framework (2017)



Health in All Policies

Central Oregon aims to move towards a Health in All Policies (HiAP) approach to better incorporate social determinants and health equity considerations in public health programs and activities, as well as community and partner initiatives.

"Health in All Policies (HiAP) is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas." (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).

Five Key Elements to HiAP

1. Promote health, equity, and sustainability.
2. Support intersectoral collaboration.
3. Benefit multiple partners.
4. Engage stakeholders.
5. Create structural or procedural change.
6. HiAP Framework

(Center for Disease Control and Prevention, 2018)

CROOK COUNTY PUBLIC HEALTH BAR HII PARTNER RESULTS SUMMARY

56 community partners responded

79% think addressing the environmental, social, and economic conditions that impact health in our communities is a high priority, and

77% say that their work with the HD addresses the environmental, social, and economic conditions that impact health in some way

93% agree or strongly agree that PH staff understand the major causes of health inequities in the county

95% agree or strongly agree that PH staff advocate on behalf of the community

98% partners agree or strongly agree that they have trusting relationships with the health department staff they work(ed) with

Top Social Determinants that Impact Health

1) Poverty
2) Alcohol, Tobacco, and Other Drug Use
3) Access to Affordable Housing
4) Access to Healthcare

64% reported that the health department creates and distributes oral and written materials that are appropriate for the cultural, linguistic, and literacy needs of the community

Community partners responded that the HD should increase the number of its Spanish literature in public places like the library

93% of partners agree or strongly agree the HD *should play a significant role in addressing the environmental, social, and economic conditions that impact health*

92% of partners agree or strongly agree that the HD *demonstrates this commitment*

APPENDIX

CROOK COUNTY PUBLIC HEALTH BAR HII STAFF RESULTS SUMMARY

27 staff responded to the survey!

**As the survey progresses, more staff opted not to answer questions.*
The majority of questions were answered by 22 staff.

Top Social Determinants that Impact Health

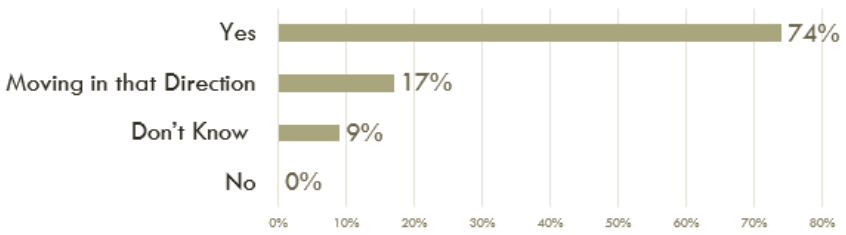
1) Housing (12)
2) Substance Use Disorder (7)
3- tied) Mental Health (6)
3- tied) Low SES/Poverty (6)
3-tied) Access to Health Care (6)

Years at CCHD
Average: 8 years 7 months
Total: 192 Years

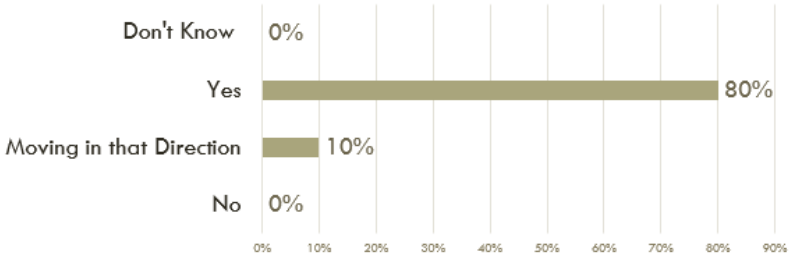
Does Crook County HD's mission, vision, and values demonstrate a commitment to addressing health inequities?

91% Yes

Do We Demonstrate a Commitment to Addressing the Environmental, Social, and Economic Conditions that Impact Health?



Does the HD Create and Distribute Oral and Written **Information** that is Appropriate for the Cultural, Linguistic and Literacy Needs in the Community?



61% believe there is a commitment to equity in both the Strategic Plan and in team plans

70% think program design reflects a general understanding of the environmental, social, and economic conditions that impact health.

45% agree CCHD actively recruits culturally diverse management and leadership staff members.

35% agree staff of diverse ethnic, racial and cultural backgrounds are equitably promoted.

30% Individual staff members' efforts to address health inequities are considered in performance reviews/evaluations.

DESCHUTES COUNTY PUBLIC HEALTH BAR HII PARTNER RESULTS SUMMARY

51 Community partners responded,
1.5x more responses than the 2018 assessment

Top Social Determinants that Impact Health

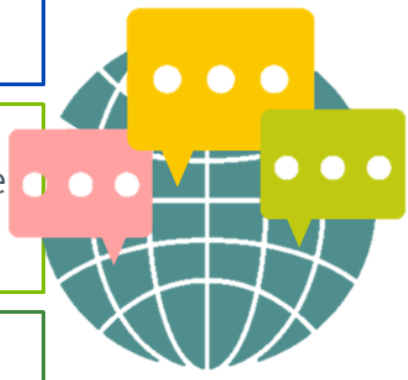
#1 Housing
#2 Income/ Cost of Living
#3 Behavioral Health

94% say the LHD should play a significant role in addressing the SDoH

83% Public Health staff that I interact with understand the major causes of health inequities in the County.

77% think the health department demonstrates a commitment to addressing the SDoH

41% think DCPH creates & distributes oral and written materials appropriate for the cultural, linguistic, and literacy needs of the community.



36% think DCPH provides training to increase the knowledge & skills of partners to address SDoH.

60% Think DCPH values input from community residents and organizations like theirs.

68%

Think DCPH provides resources to residents and partners to support their concerns & address health inequities.

DESCHUTES COUNTY PUBLIC HEALTH BAR HII STAFF RESULTS SUMMARY

Top Social Determinants that Impact Health

#1 Housing
#2 Income/ Cost of Living
#3 Behavioral Health

72 staff responded

94% response rate (72/77) per org chart with staff lists updated 12/2/2019

Years at DCPH

Average: 10 years 5 months

Total: 623.25 years!

50%

Collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community.

34%

DCPH has strategies to advocate for public policies that address SDoH.

57%

DCPH work contributes to developing policies and plans that support health efforts to address the conditions that affect health inequities.

**91% staff think some or a lot of program design reflects and understanding of SDoH.*

83%

Agree or strongly agree that DCPH has trusting relationships with external partners.

42%
Not enough or no focus on health inequities

44%
There is about the right amount of focus

DESCHUTES COUNTY PUBLIC HEALTH BAR HII STAFF RESULTS SUMMARY

	What role do you have in making decisions that affect your program's efforts to address health inequities?	What role do you have in making decisions that affect our organization's efforts to address health inequities?	When a program level decision is made that affects you and your job tasks, do you know why it was made?	When a department level decision is made that affects you and your job tasks, do you know why it was made?
2018	**35%** Active role or primary decision-making role	**20%** Active role or primary decision-making role	**42%** Always or Usually	**36%** Always or Usually
2020	**48%** Active role or primary decision-making role	**48%** Active role or primary decision-making role	**61%** Always or Usually	**61%** Always or Usually

29% agree staff of diverse ethnic, racial and cultural backgrounds are equitably promoted.

22% agree DCPH actively recruits culturally diverse management and leadership staff members.

90-100%

- Have taken steps to enhance their cultural understanding
- Agree that being aware of my own beliefs/ privilege helps understand others', & believe it is important to understand the beliefs/ values of others.
- Regularly have meaningful interactions/ learning from people of different cultures/ backgrounds.

JEFFERSON COUNTY PUBLIC HEALTH BAR HII PARTNER RESULTS SUMMARY

Community Partner Responses

14 JCPH
18 Tri-County

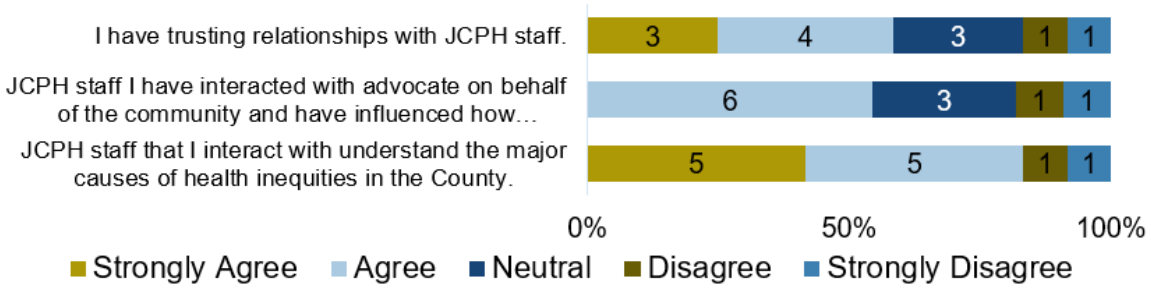
Top Social Determinants that Impact Health

#1: Income & Cost of Living
#2: Mental Health & Substance Use

92% Agree JCPH should play a significant role in addressing SDoH.

67% Agree JCPH demonstrates commitment to addressing SDoH.

45%
"Organizations like mine are meaningfully involved in the planning processes."



20%
JCPH **creates and distributes oral and written materials** that are appropriate for the cultural, linguistic, and literacy needs of the community.

20%
JCPH **collects and shares data** in a manner that is appropriate for the cultural, linguistic, and literacy needs of the community.

30%
JCPH plays an active role in **developing, maintaining, and supporting networks/partnerships** in the community.

10%
JCPH **provides training** to increase the knowledge and skills of community partners to address the environmental, social, and economic conditions that impact health.

JEFFERSON COUNTY PUBLIC HEALTH BAR HII STAFF RESULTS SUMMARY

20 staff (100%) responded

Years at JCPH

Average: 9 years 6 months

Total: 173 years!

Top Social Determinants that Impact Health

#1 Income/ Living Wage Jobs
#2 Housing

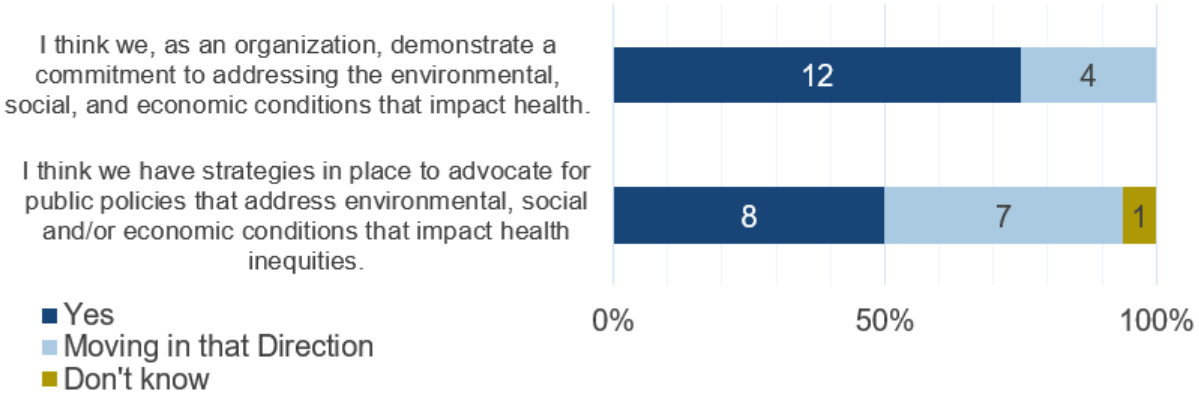
88% JCPH has trusting relationships with external partners.

87% JCPH Plays an active role in developing, maintaining and supporting networks in the community.

85% Right amount of focus on health inequities.

100% Mission, vision, and values demonstrate a commitment to addressing health inequities.

94% Program design reflects *(some or a lot)* SDoH understanding.



33% There are strategies in place to minimize barriers to community participation.

APPENDIX

JEFFERSON COUNTY PUBLIC HEALTH BAR HII STAFF RESULTS SUMMARY

What role do you have in making decisions that affect your program's efforts to address health inequities?	What role do you have in making decisions that affect our organization's efforts to address health inequities?	When a program level decision is made that affects you and your job tasks, do you know why it was made?	When a department level decision is made that affects you and your job tasks, do you know why it was made?
50% Active role or primary decision-making role	**38%** Active role or primary decision-making role	**81%** Always or Usually	**69%** Always or Usually

53% received training about the different ways public health can address equity and/or the environmental, social, and economic conditions that impact health.

50% Agree Staff are encouraged to learn about ways to address SDoH from one another.

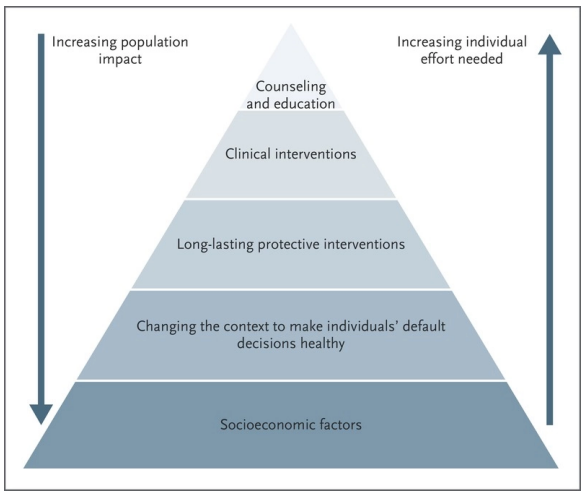
60%
When appropriate, minimum requirements for positions are flexible, allowing for relevant community experience in place of educational degrees.

34%
PH actively recruits culturally diverse management and leadership staff members.

JCPH works with an array of community groups including:

- Groups that advocate for improved living conditions
- Neighborhood groups
- Faith-based groups
- Youth development/leadership
- Community members not affiliated with an organization

33%
Individual staff members efforts to address health inequities are considered in performance reviews/evaluations.



100%

- Are aware of my own beliefs, values and privilege helps me understand others' perspectives.
- Believe it is important to understand the beliefs and values of the residents and community members.
- Regularly have personally meaningful interactions and have learned from people of different cultures and backgrounds from my own.
- Feel my work environment is supportive of many different cultural perspectives.