
# 2018 HEALTH EQUITY REPORT

## DESCHUTES COUNTY HEALTH SERVICES PUBLIC HEALTH DIVISION

# Contents



Last Updated: 7/29/2019

# Executive Summary

There is a growing body of evidence to support the Deschutes County Public Health (DCPH) Equity's Task Force 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 or physical conditions or other factors. To that end, Deschutes County Public Health aspires to create a place where health is attainable for all who live in our county and is aligning efforts with the Healthy People 2020 goal of creating opportunities and conditions to promote optimal health for all.

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 DCPH leveraged Public Health 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 Deschutes County.
4. Results from the DCPH BAR HII Health Equity Assessment.
5. Recommended Health Equity strategies to improve our effectiveness in promoting optimal health.

Anyone in Deschutes County can use the information and results in this report to promote health equity. Deschutes County Health Services staff will use this information to identify, prioritize, and implement strategies to improve work around health equity and the determinants of health.

Currently, available data indicates that in Deschutes County, health outcomes vary by race and poverty, with those not in poverty and those who identify as White/Caucasian, experiencing better health outcomes. Results from the staff assessment and collaborating partner survey suggest that both frontline staff and partner organizations wish to see a greater emphasis on improving our approach and collective efforts to address health equity in program, department-level and regional planning in coming years. Additional survey feedback reflected that

internal training and learning opportunities are needed for DCPH staff. Information obtained from the staff focus groups elucidated a need to increase transparency and proactivity with impactful decisions, give experienced frontline staff more of a voice with decisions impacting them, while also improving communication between teams, health service divisions, and collaborating partners.

This report demonstrates that focusing public health interventions on health equity and the determinants of health yields the greatest opportunity for improvement in population health.

Hillary Saraceno, Deputy Director Public Health Division
Deschutes County Health Services

# The Mission, Vision, and Values

DCHS Mission: To promote and protect the health and safety of our community.

DCHS Vision: Deschutes County Health Services provides leadership, programs, services, education, and protections to improve the health of individuals, families, and communities so people enjoy longer and healthier lives.

DCHS Values: Deschutes County Health Services promotes the following values in all we do:

**Advocacy:** Supporting individual and community health by ensuring access to health care for all.

**Collaboration:** Building relationships that reflect growth, authenticity, and mutual respect.

**Equity & Inclusion:** Demonstrating awareness and respect for the diversity in our workplace and community.

**Excellence:** Committing to using the best data, science, and information available to make decisions that result in high-quality services.

**Healthy Workplace:** Promoting respectful interactions, healthy lifestyles, emotional and physical safety in work environments (trauma-informed practices).

**Leadership:** Advancing a shared vision with inspiration that guides our work at all levels of the organization and in the community.

**Professionalism:** Conducting oneself with the highest level of personal integrity, conduct, and accountability.

**Stewardship:** Using public resources effectively and efficiently.

# Purpose

## BACKGROUND

In 2018, Deschutes County Public Health (DCPH) leveraged public health modernization and national public health reaccreditation standards and measures to initiate an assessment of departmental health equity work. In order to better emphasize and continuously improve health equity perspectives for our agency, DCPH created an interdisciplinary workgroup focused on health equity. Part of the workgroup plan included the implementation of a health equity assessment and creation of a report that includes assessment results and recommended actions.

## MODERNIZATION AND ACCREDITATION

Oregon's Statewide Public Health Modernization and National Public Health Reaccreditation both 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.

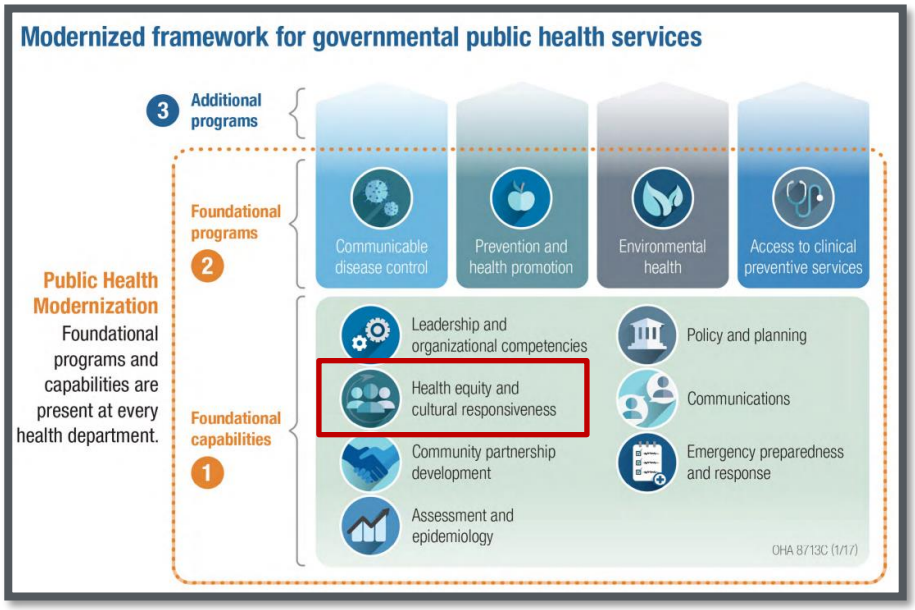



*Figure 2. The Oregon Public Health Modernization Framework* (Oregon Health Authority, 2017)

Within Public Health Modernization, "Equity and Cultural Responsiveness," is a foundational capability (Figure 2). The vision of this foundational capability is to, "Ensure equal opportunity to achieve the highest attainable level of 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).

DCPH has prioritized this work and is 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. Place emphasis on defining a meaningful community engagement and feedback process" (Oregon Health Authority, 2017).

## GOALS

The goal of the report is to understand the distribution of social determinants of health, health behaviors, and health factors within Deschutes County, how Deschutes County Public Health currently works to addresses health equity, how effectively community partners perceive we are addressing health equity, and to identify strategies and recommendations for the future.

# Why Focus on Social Determinants of Health Equity?

*"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)

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.

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 in figure 3 are from several studies that estimated the impact of these determinants on population

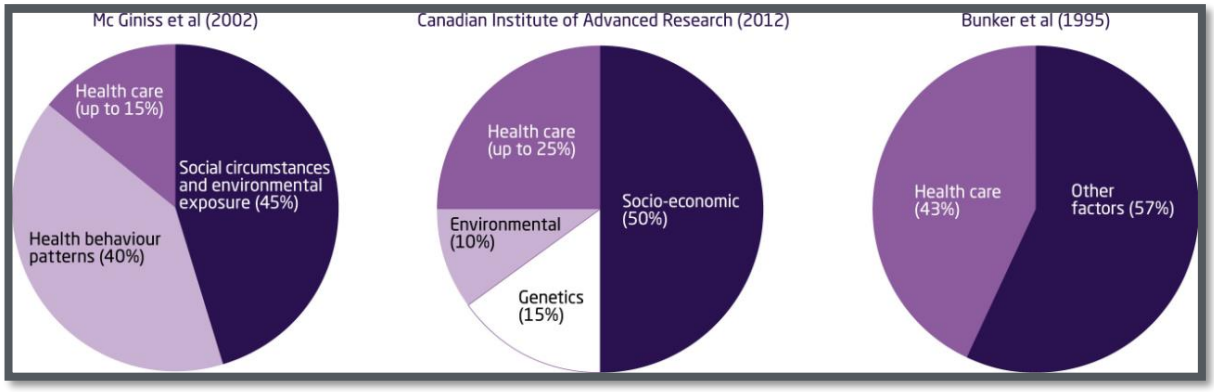



*Figure 3. Estimates of the contribution of the main drivers of health status* (Marmot &

health. Based on these estimates, 60-85% of health status is determined by social circumstances, health behavior, and/or environmental factors (Marmot & Allen, 2014). To improve population health, it is crucial to address social and environmental factors.

The Health Impact Pyramid (Figure 4) 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).

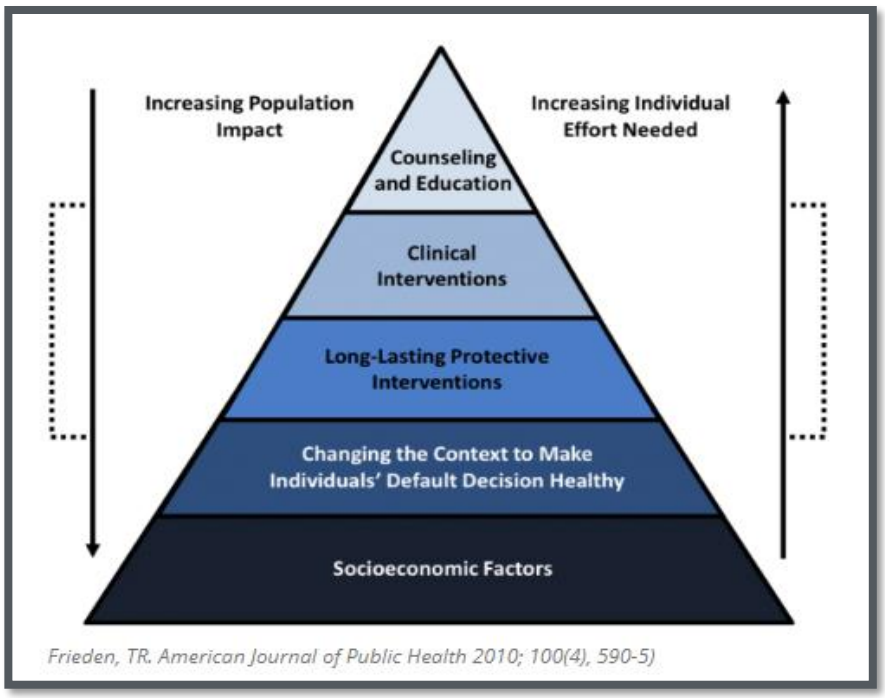



*Figure 4. Health Impact Pyramid* (Community Commons, 2018).

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.

### THE VALUE OF INVESTING IN HEALTH EQUITY

"Because of inequitable access to care, these populations are sicker when they do find a source of care and incur higher medical costs. That 30 percent translates to more than $230 billion over a four-year period. If health disparities among minorities had not existed between 2003 and 2006, direct medical care spending would have been reduced by a whopping $229.4 billion."

(American Pubic Health Association, 2015)

# Community Health Data

## POPULATION GROWTH

*Disclaimer: Some of the National County Health Ranking topics use only one year of data. For Deschutes County, this can create very low sample sizes. This should be considered when reviewing county health ranking data.*

*Additional data on status within Deschutes County and Central Oregon can be found on the Deschutes County Health Services website, www.deschutes.org/healthdata.*

The data included here should by no means be considered a complete or thorough representation of the determinants of health in Deschutes County. Additional Deschutes County specific health data related to equity will be updated and added to the "What Affects Our Health" webpage on the Deschutes County External Website: www.deschutes.org/health/page/what-affects-our-health and the 2019 Regional Health Assessment.

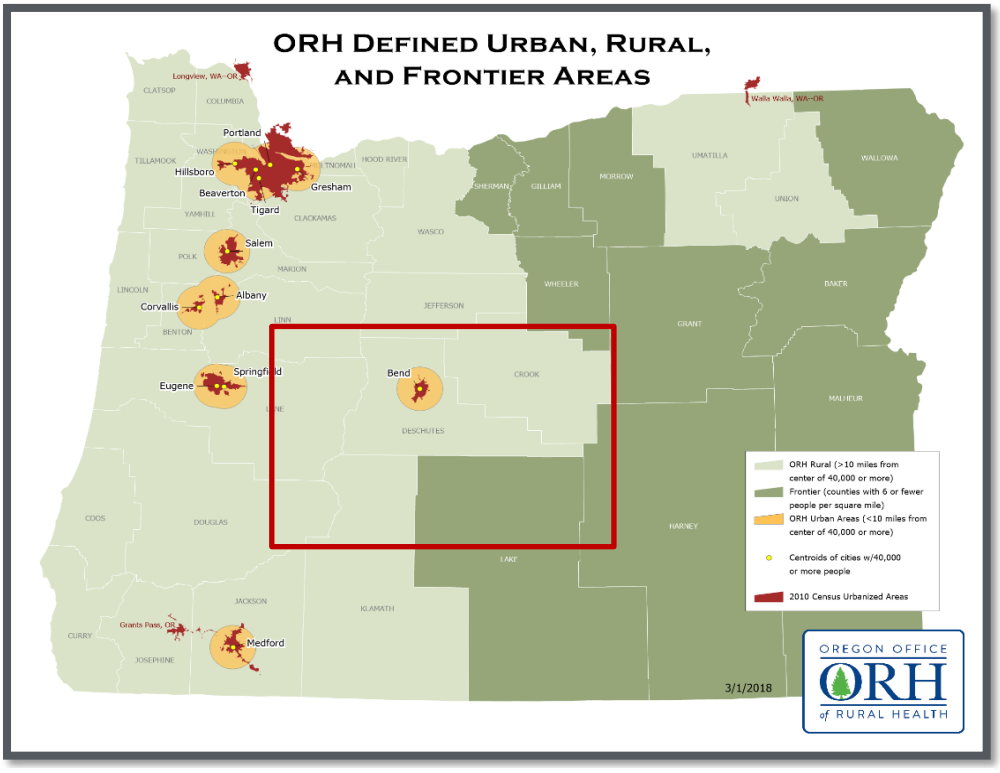



*Figure 5. Image of defined urban, rural, and frontier counties and cities in Oregon*

Deschutes is Oregon's fastest-growing county with a population of 186,875 in 2016, and an 18.5% population change from 2010 to 2017 (United States Census Bureau, 2018). Much of this growth has occurred in the city of Bend, which was listed as the sixth

fastest growing city with a population of 50,000 or more by the United States Census Bureau in 2017 (United States Census Bureau, 2017). Although the cities of Bend and Redmond have experienced rapid growth, the rest of Deschutes County, including the cities of La Pine and Sisters, are both listed as rural in the Oregon Office of Rural Health's 2018, "List of Towns and Cities by ORH Urban/Rural Definition: 10 Mile Radius from a City of 40,000 or More" (Image 5) . The population per square mile in 2010 was 52.3, with a total area of over 3,000 square miles (United States Census Bureau, 2018).

## RACE AND ETHNICITY

As of July 1, 2016, the United States Census showed the Deschutes County population as predominately non-Hispanic white (87.7%) and 94.5% identified as white alone. Overall, Deschutes County has less racial diversity than the overall population of Oregon (United States Census Bureau, 2018). County Health Rankings use an index of dissimilarity to determine racial segregation. In the index, higher values indicate greater residential segregation between black and white residents. A score of "0" would indicate complete integration, and a score of 100, complete segregation. Deschutes County was 78 on the index, which is higher than Oregon's score of 62. Top national performers were at 23 on the scale. The same index is used to score white and non-white segregation. In this category, Deschutes County actually scored lower (better at 24) than Oregon (33), but still worse than top national performers (14) (County Health Rankings, 2018).

*Table 1. Race and ethnicity by population in Deschutes County and Oregon (2016)* (United States Census Bureau, 2018).

| RACE AND HISPANIC ORIGIN | DESCHUTES COUNTY | OREGON |
|---|---|---|
| White alone | 94.5% | 87.4% |
| White alone, not Hispanic or Latino | 87.7% | 76.4% |
| Hispanic or Latino | 7.8% | 12.8% |
| Two or More Races | 2.5% | 3.8% |
| American Indian and Alaska Native alone | 1.1% | 1.8% |
| Asian alone | 1.1% | 4.5% |
| Black or African American alone, percent | 0.5% | 2.1% |
| Native Hawaiian and Other Pacific Islander alone | 0.1% | 0.4% |

County Health Ranking provides a breakdown of some health outcomes by Race and Ethnicity. Although the rate of teen births was lower in Deschutes County than in Oregon, the number of births per 100,000 women aged 15-19 were higher for those who identified as Black (32) and Hispanic (31), than those who identified as White (16). In addition, people who identified as white has a slightly lower percentage (6%) of babies with low birth weights than those who identified as Hispanic (7%) (County Health Rankings, 2018).

## EDUCATION

The vast majority (93%) of people 25 and older in Deschutes County were high school graduates or higher, compared to 90% in the state of Oregon. Thirty-three percent of the Deschutes County population has a bachelor's degree or higher (United States Census Bureau, 2018).

## HOUSING AND LIVING ARRANGEMENTS

Availability and affordability of housing are frequently mentioned as a concern in Deschutes County, with rapid population growth causing an increase in housing costs. Both DCPH staff and community partners mention housing as a key social determinate affecting health. In Deschutes County, 65.3% of residents own their homes, and median owner costs with a mortgage were $1,498 monthly. The median gross rent was $981 monthly.

Only 6.4% percent of people five years or older speak a language other than English at home, compared to 15.1% in the state of Oregon (United States Census Bureau, 2018).

Per County Health Ranking, 21% of Deschutes County households experienced severe housing problems, compared to 20% in Oregon. Top National Performers were at 9%. Severe housing problems were defined as the percent of household with at least one of these: Housing unit lacks complete kitchen facilities, housing unit lacks complete plumbing facilities, the household is severely overcrowded, or household is severely cost burdened.

*Table 2. Housing statistics in Deschutes County and Oregon* (United States Census Bureau, 2018).

| HOUSING | DESCHUTES COUNTY | OREGON |
|---|---|---|
| Owner-occupied housing unit rate, 2012-2016 | 65.3% | 61.4% |
| Median value of owner-occupied housing units, 2012-2016 | $275,300 | $247,200 |
| Median selected monthly owner costs -with a mortgage, 2012-2016 | $1,498 | $1,563 |
| Median selected monthly owner costs -without a mortgage, 2012-2016 | $479 | $477 |
| Median gross rent, 2012-2016 | $981 | $941 |

*Table 3. Living Arrangements Deschutes county and Oregon* (United States Census Bureau, 2018).

| FAMILIES & LIVING ARRANGEMENTS | DESCHUTES COUNTY | OREGON |
|---|---|---|
| Persons per household, 2012-2016 | 2.50 | 2.52 |
| Living in the same house 1 year ago, percent of persons age 1 year+, 2012-2016 | 81.8% | 81.9% |
| Language other than English spoken at home, percent of persons age 5 years+, 2012-2016 | 6.4% | 15.1% |

## INCOME AND THE ECONOMY

The median household income in Deschutes County from 2012 to 2016 was $54,211, and 10.6% of the population was considered in poverty (United States Census Bureau, 2018). Of the population aged 16 and over, 61.4% were in the civilian labor force. 57.1% of this workforce identified as female. On average, workers traveled 18.6 minutes to work (United States Census Bureau, 2018). County Health Rankings indicate a great difference in median household income for white households ($55,400), compared to Hispanic ($43,000), and Black ($19,200). The percent of children in poverty also varied greatly by race, with 53% for those who identified as Black, 32% for Hispanic, and 16% for White (County Health Rankings, 2018).

In Deschutes County, 9% of the population was listed as uninsured, and unemployment was the same in both Oregon and Deschutes County (4.9%). Unemployment remains lower than the top national performers 3.2% unemployment rate (County Health Rankings, 2018).

*Table 4. Income and Employment Deschutes county and Oregon* (United States Census Bureau, 2018).

| INCOME, POVERTY, & EMPLOYMENT | DESCHUTES COUNTY | OREGON |
|---|---|---|
| Median household income (in 2016 dollars), 2012-2016 | $54,211 | $53,270 |
| Persons in poverty, percent | 10.6% | 13.3% |
| In the civilian labor force, total, percent of the population age 16 years+, 2012-2016 | 61.4% | 61.9% |
| In the civilian labor force, female, percent of the population age 16 years+, 2012-2016 | 57.1% | 57.4% |

## POVERTY AND HEALTH: A DEEPER DIVE

The Deschutes County median household income is lower than top national performers ($65,100) but higher than the state of Oregon. Income inequality, the ratio of household income at the 80th percentile to income at the 20th percentile, was 4.4, which is also lower than the State of Oregon, but higher than top national performers (3.7). Using data from the Behavioral Health Risk Factors Surveillance System (BRFSS), DCPH was able to assess the health of people living below the Federal Poverty Level compared to the health of people living above the Federal Poverty Level. Due to low sample sizes, data had to be combined from 2012 to 2015. The results show statistically significant differences for multiple indicators.

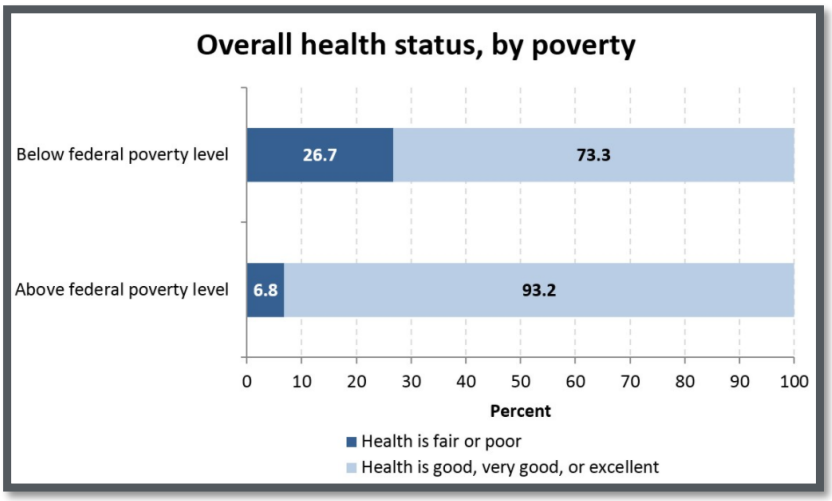



*Figure 6. Overall Health Status by poverty level.*

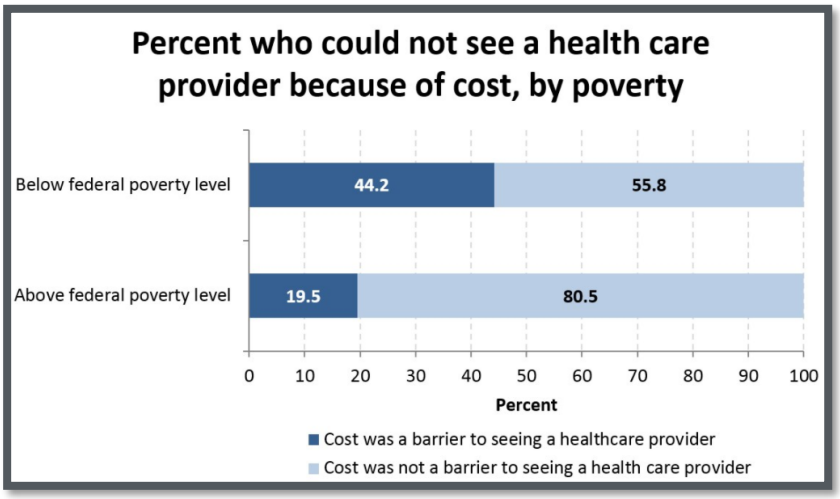



*Figure 7. Ability who could not see a Health care provider by poverty level.*

In Deschutes County, income is related to a person's overall health status. Around 1 in 4 people in our county who live below the Federal Poverty Level report that their health is fair or poor. Among people living above the Federal Poverty Level, only 1 in 15 reports that their health is fair or poor (Deschutes County Health Services, 2018).

A person's income level might impact whether or not they can access health care. For example, some people with lower incomes might have difficulty accessing adequate health insurance coverage or might have difficulty paying for out-of-pocket costs or transportation needed to access care. In our county, nearly half of the people living below the Federal Poverty Level said that they could not see a health care provider because of cost. Among people living above the Federal Poverty level, around 1 in 5 said the cost was an issue that prevented them from seeing a provider (Deschutes County Health Services, 2018).

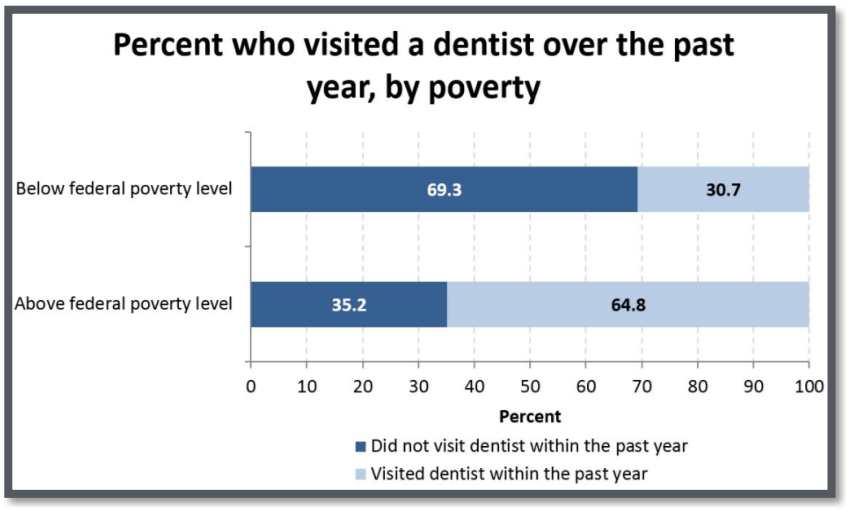



*Figure 8. Dental visit in the last year by poverty level.*

Income might also relate to whether or not a person can access dental care. Some people with lower incomes might not have dental coverage or might have trouble paying costs associated with dental care. In Deschutes County, around 70% of people living below the Federal Poverty Level did not visit a dentist in the past year. Among those living above the Federal Poverty Level, only 35% did not see a dentist in the past year (Deschutes County Health Services, 2018).

Income level might impact a person's mental health for many reasons. People with lower income in our community might be more likely to be exposed to poorer housing conditions, unhealthier working conditions, and higher stress associated with finances. These factors, along with many others, can affect a person's mental health from childhood through adulthood. In our community, the income level is related to whether or not people experience poor mental health days. Half of all people living below the Federal Poverty Level reported at least one poor mental health day in

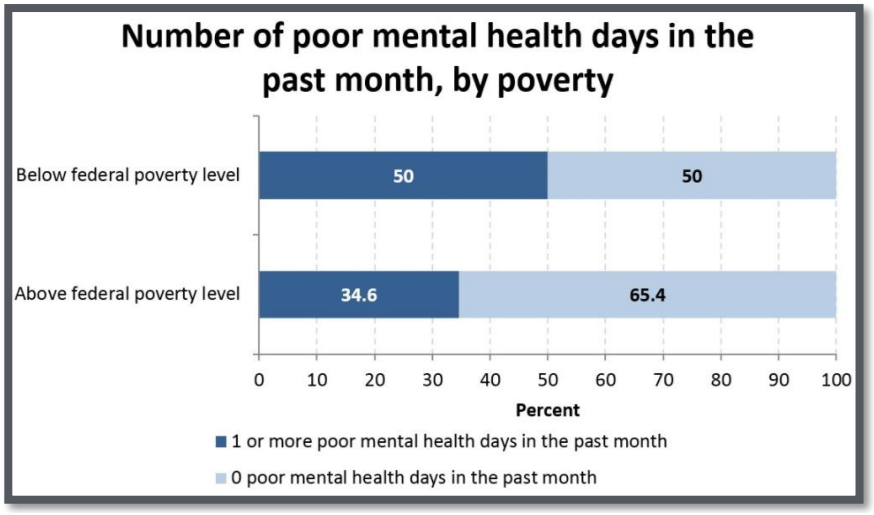



*Figure 9. Poor mental health days by poverty level.*

the past month. Only 35% of people living above the Federal Poverty Level reported at least one poor mental health day in the past month (Deschutes County Health Services, 2018).

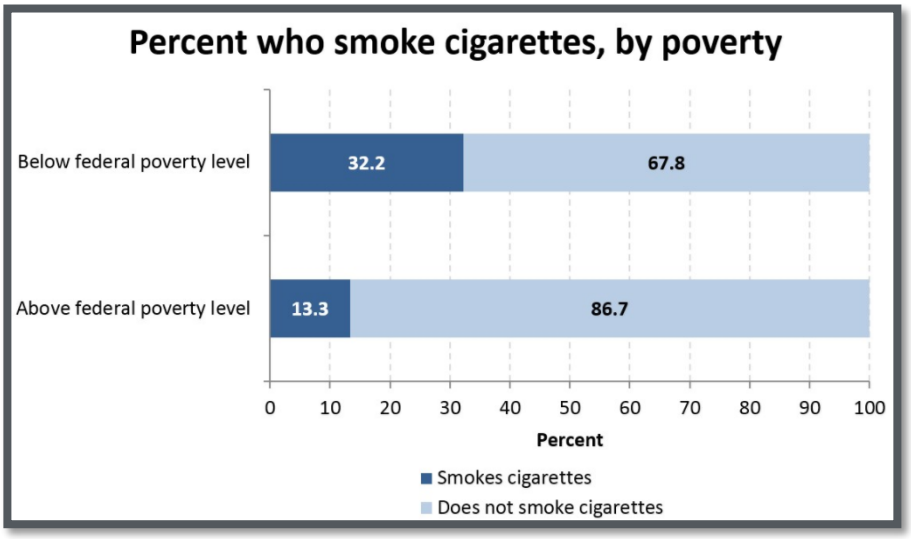



*Figure 10. Smoking by poverty level.*

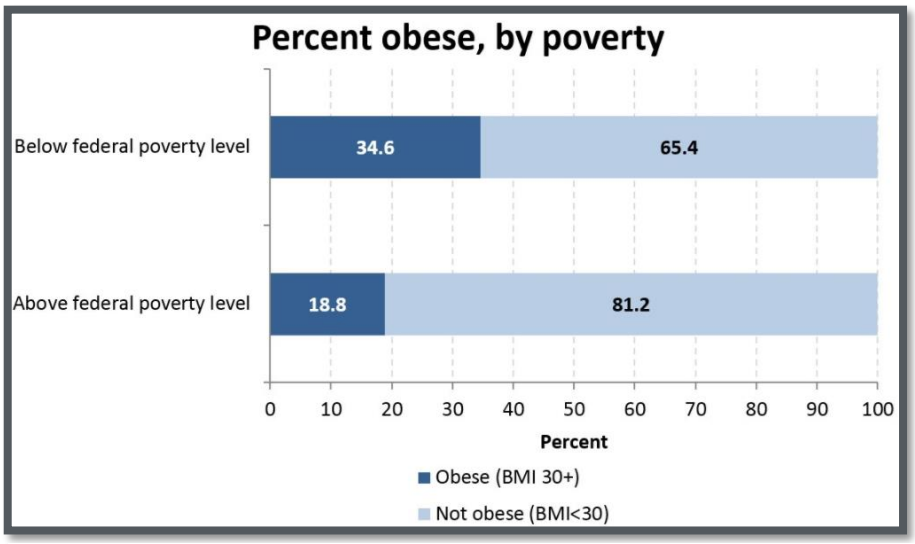



*Figure 11. Smoking by poverty level.*

Income level is related to a person's risk factors for diseases. Risk factors related to disease development might include behaviors such as smoking cigarettes. In Deschutes County, around 32% of people living below the Federal Poverty Level smokes cigarettes. Among those living above the Federal Poverty Level, only 13% smoke cigarettes (Deschutes County Health Services, 2018).

Another disease risk factor that relates to a person's income is obesity. In Deschutes County, around 35% of people living below the Federal Poverty Level are obese. Among people living above the

Federal Poverty Level, only around 20% are obese (Deschutes County Health Services, 2018).

# BAR HII Assessment

## METHODS

### Literature Review and Assessment Selection

In October of 2017, the DCPH equity workgroup, comprised of about nine staff, began researching potential tools to assess intra-organizational equity, provision of equitable services to the community, and prioritize equity strategies.

In 2015, Wilder Research published a review of seven equity assessments/tools, which lead DCHS to select the Bay Area Regional Health Inequities Initiative (BAR HII) health equity assessment tool. This assessment focuses on thoroughly analyzing department work to address inequities created by race, ethnicity, poverty, gender, transportation, lack of access to education, and numerous other social determinants of health (Bay Area Health Inequities Initiative, 2010). In addition, the BAR HII assessment is tailored to health departments and uses public health language, which made it more relevant than other assessment options.

The BAR HII process includes five sub-assessments that look at both internal processes and staff perceptive, as well as input from collaborating partners. The assessments were implemented in the following order:

1. Internal Staff Survey
2. Collaborating Partner Survey
3. Staff Focus Groups
4. Leadership Focus group
   **This replaced the BAR HII Management Interviews.*
5. Internal Document Review and Discussion
   **This was already in progress prior to BAR HII selection and implementation.*

### Modifying and Implementing the Internal Staff Survey for DCHS

After selecting the BAR HII assessment, the Public Health Equity workgroup reviewed and refined the survey questions to assure the language was relevant for DCPH. To do this, each member of the Equity workgroup reviewed a copy of the full list of staff survey questions (BAR HII Toolkit Appendix I, page 47). Staff members noted questions they perceived as essential and those that seemed redundant or less valuable. The Health Equity workgroup members then compared

what they considered the most crucial questions to the BAR HII self-assessment toolkit essential question list (Appendix III). The essential questions aligned very closely, which made it easier for the group to select questions to omit. Out of the 120 possible BAR HII questions, DCPH selected 70 to include in the assessment. The survey took approximately 30 minutes to complete. The goal of streamlining the assessment was 1) to encourage completion rate 2) decrease the amount of staff time taken from other important tasks. Thanks to the Napa County Public Health Department in California, who shared their SurveyMonkey version of the assessment, DCPH was able to save additional staff time by editing as opposed to recreating the survey.

Based on BAR HII recommendations, the equity workgroup decided the survey should be distributed via SurveyMonkey. This was piloted with the workgroup prior to all staff distribution. Because of their involvement creating and piloting the survey, equity workgroup members were able to assist and provide information to their peers when the survey was distributed.

The deputy director of Public Health sent an email to all DCPH staff encouraging staff to take the survey and highlighting the importance of equity and the social determinants in public health work. In addition to the survey link, the deputy director wrote, signed, and attached a letter to the email explaining the value of the assessment and that the results help:

- Understand staff perspective on social determinants of health and what DCPH is doing to address health inequities.
- Inform and guide Public Health division priorities, decision-making, and strategic planning efforts.
- Serve as a baseline assessment to measure progress moving forward.

**Troubleshooting**: DCPH piloted the survey using the recommended BAR HII method, a unique survey link. Through piloting, DCPH learned that some of the surveys were blocked and that staff were not receiving emails from SurveyMonkey. Despite support from the Deschutes County Information Technology department and SurveyMonkey, approving SurveyMonkey servers did not fully fix the problem. Ultimately, DCPH opted to use a general link to distribute the survey to DCPH all staff.

- Help meet requirements for PH Modernization and National Public Health Reaccreditation.

A copy of the letter and email may be found in the appendices.

Leadership support was crucial throughout the process, and leadership was kept in the loop via email, discussion in leadership team meetings, and in-person meetings with the project leads.

To further incentivize staff, everyone who took the survey was entered into a raffle for several prizes (paid for by donations). Four total prizes were purchased: an insulated stainless steel water bottle, two $25 local coffee cards, and a $25 movie gift card. To assure staff could be entered into the raffle drawing and still submit the survey anonymously, SurveyMonkey was set to automatically open a new survey webpage when staff completed the survey. This survey was not linked to the BAR HII survey in any way. The prizes were distributed in a raffle drawing at the end of each successive week the assessment was open.

### Expanding the Survey to the Tri-County Region.

In February, guided by requirements in the Oregon Health Authority Public Health Modernization Grant, DCPH expanded the first two sub-assessments to incorporate Crook and Jefferson Counties. The modified Bar HII staff survey was sent to Crook and Jefferson County via SurveyMonkey. Jefferson County and Crook County began their internal assessments in mid-February.

### Data Analysis and Dissemination

The project leads began analyzing responses for the three counties shortly after the survey closed. For DCPH, program-specific summaries were created for programs containing six or more respondents in order to maintain anonymity. Data dashboards were created for five programs, DCPH as a whole, and a comparison of leadership vs. non-leadership responses. The dashboards are in the appendices. The equity workgroup reviewed the data in late March prior to creating an email summary that was sent to all-staff in early April. The survey was completely anonymous and results were distributed in aggregate. The email is in the appendices. In late May, workgroup staff presented results from the survey at Public Health All-Staff meeting. This allowed the entire department to engage in conversation around the results.

### Modifying and Implementing the Collaborating Partner Assessment

In early February, the Health Equity workgroup repeated the same process to review and prioritize questions for the collaborating partner assessment. The workgroup piloted the survey by 'responding from the perspective of a community partner' prior to distribution.

In February and March, the DCPH Health Equity workgroup, in collaboration with Crook and Jefferson Counties, discussed effective distribution methods for the collaborating partner survey. To increase completion rates, health department employees who maintain relationships and partnerships with organizations and community members disseminated the survey to partners they work with.

Since Crook, Deschutes, and Jefferson counties maintain similar partnerships, a question was added to the survey that allowed respondents to indicate which health department they would like to answer for, or if they would prefer to respond for Tri-County Public Health. This enabled analysis by the health department, as opposed to a blanket regional analysis. Each health department was responsible for disseminating the assessment to their partners. Partners were asked to forward the survey on to others who would be interested in completing the assessment. In addition, DCPH staff presented the assessment to the Deschutes County Public Health Advisory Board in late February 2018. Staff highlighted the survey's potential to improve the health department's provision of equitable services to underserved populations within the county. The project leads asked for the group's assistance in disseminating the survey to community partners. DCPH staff who work with the advisory board distributed the survey to board members who agreed to forward to community partners and others within their organizations. The survey was disseminated via a general SurveyMonkey link from May 1st to 22nd, 2018.

As before, leadership support was crucial for success. Workgroup staff discussed the collaborating partner survey and staff role in dissemination during a monthly public health leadership team meeting and emailed instructions to leadership who worked with their staff to distribute the survey.

During the time the survey was open, workgroup staff sent updates on the number of responses and types of organizations responding to leadership in all three counties. This served as a reminder to continue reaching out and allowed

health department staff to assess whether they were reaching a variety of organization types.

### Data Analysis and Dissemination

Two staff members created result summaries for Deschutes, Crook, and Jefferson County health departments, as well as a regional summary. These summaries were sent to all three counties, and in an email sent to all DCPH staff. The email and the results are in the appendices.

### Focus Groups

The themes gathered from the internal and external surveys, along with input provided during the all-staff meeting, ultimately determined which questions would be asked during the staff focus groups. The health equity workgroup created the list of questions. Focus groups took place with each public health program during team meetings. An additional focus group took place for public health leadership. Leadership was not present during the staff focus groups. The focus groups were voluntary and result disseminated in aggregate as not to identify teams or individual. This was done to encourage open and honest dialogue with staff.

One workgroup member served as a facilitator for all of the meetings. Two others alternated as a note taker. Facilitation staff was non-leadership. Notes were taken on a visible computer screen so that staff could review what was typed to assure the discussion was accurately and anonymously summarized. Focus groups took one and a half to two hours each, with five minutes dedicated to data review at the beginning, and a few minutes at the end to review the meeting notes. The focus groups questions are in the appendices.

## RESULTS

### Summary

Responses gathered from the BAR HII assessment served to inform the creation of strategies and action items for the next few years. Results from both the Staff Assessment and Collaborating Partner Survey suggested that both frontline staff and partner organizations wish to see an expanded role in the program and department-level planning in coming years. Additional survey feedback reflected that internal training and learning opportunities were needed for DCPH staff

members. Information obtained from the six staff focus groups elucidated a need to increase transparency and proactivity with impactful decisions, give experienced frontline staff more of a voice with important decisions, while also improving communication between teams, health service divisions, and collaborating partners.

The information highlighted here provides an overview of the findings from the assessment. The complete data dashboards are embedded within the appendices.

## Staff Assessment Results and Analysis

There was an 86% (65/76) response rate for the BAR HII Internal Staff Assessment. Responses were from eight administrative staff (12%), forty-four front line staff (68%), nine supervisors (14%), and four managers/directors (6%). Of those who responded, 89% identified as Caucasian/White, 5% as Latino/Hispanic, 2% as Native American/Alaska Native, 2% as African American/Black, 2% as Biracial/Multiracial.

The WIC response rate was 92% (11/12), Nurse-Family Support Services was 100% (8/8), Prevention and Health Promotion 89% (8/9), Environmental Health 70% (7/10), Vital Records 100% (3/3), and Perinatal Care 100% (3/3). Due to public health division restructuring during survey implementation, a response rate for the following programs cannot be determined as it is difficult to determine how program staff identified themselves; Clinical Services (7), Communicable Disease (3), Front Office (5)

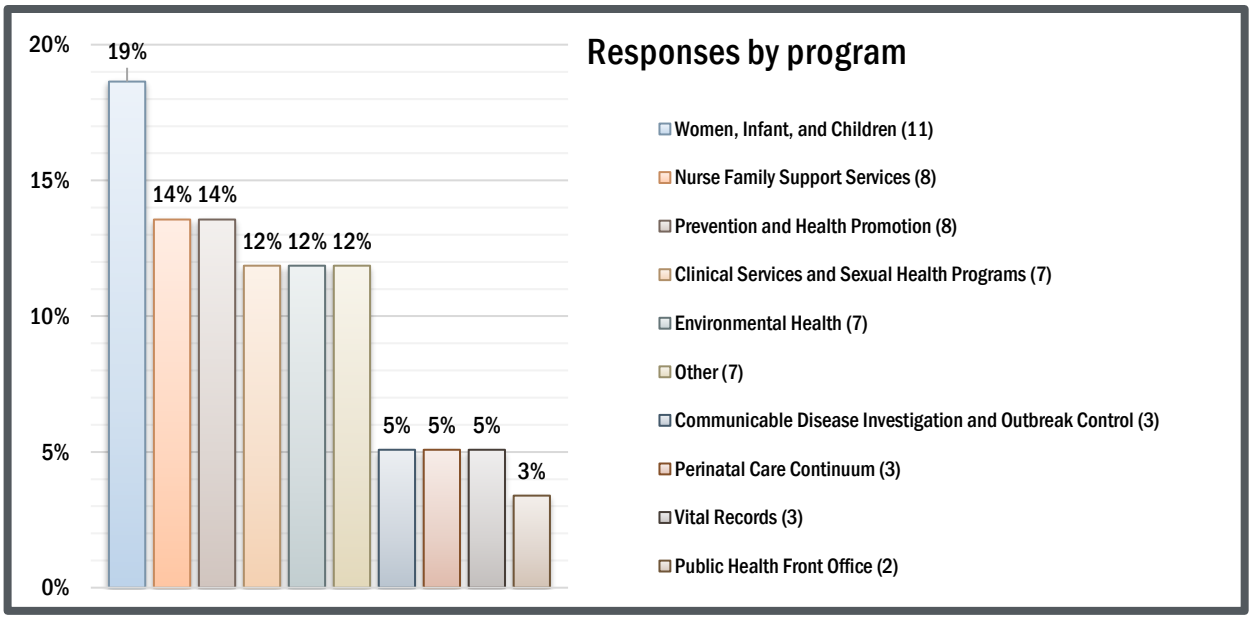



*Figure 12. Number of Reponses by program for the DCHS Internal BAR HII Assessment.*

The majority of both leadership (62%) and a large proportion of non-leadership (50%) felt that there was either too little or no focus on addressing health inequities in our Public Health Department. The top five most important

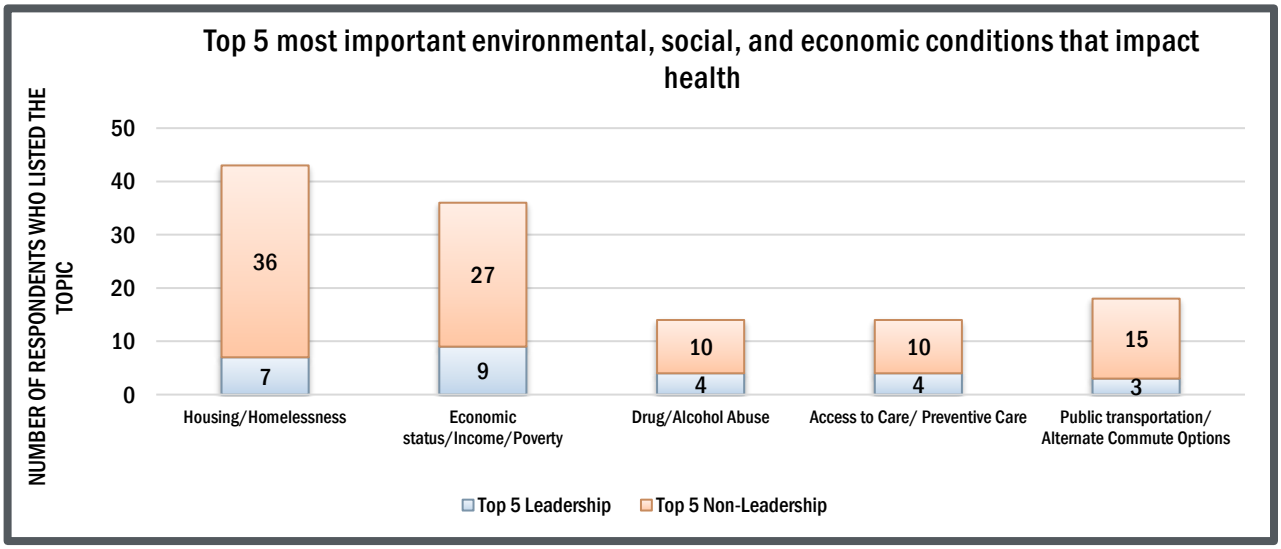



*Figure 13. As shows above, the top five most important environmental, social, and economic conditions that affect health were the same for leadership and non-leadership.*

environmental, social, and economic conditions that influence health were the same for leadership and non-leadership, including housing/homelessness, inadequate income/poverty, drug/alcohol abuse, access to primary/preventive care, and public transportation. Fifty percent of non-leadership staff indicated there is either no focus or not enough focus on addressing health inequities, compared to 62% of leadership.

Over 80% of staff believe that the health department and programs currently address health equity and the social determinants of health. Close to 38% of staff, believes the organization demonstrates a commitment to addressing the environmental, social, and economic conditions that affect health. Twenty-three percent of staff indicated that DCPH has strategies in place to advocate for policies around these topics. Fifty-two percent indicated that there is either no focus or not enough of a focus on health inequities.

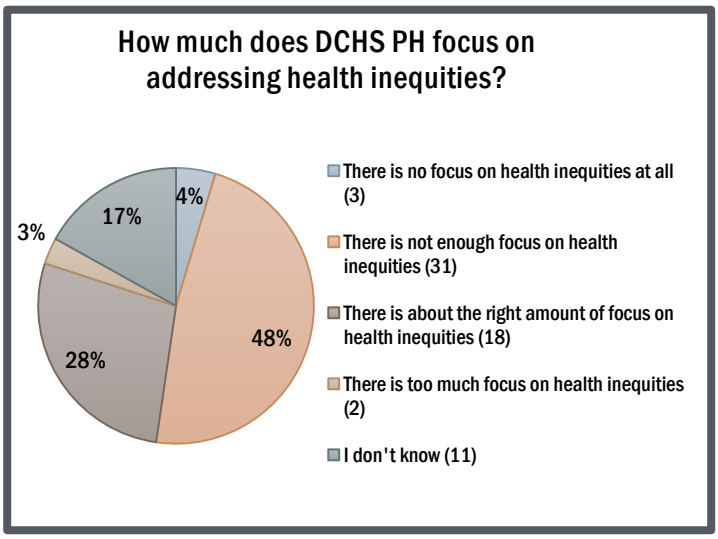



*Figure 14. As illustrated in the above figure, less than half of staff feel that there is enough current focus on addressing health inequities within DCPH.*

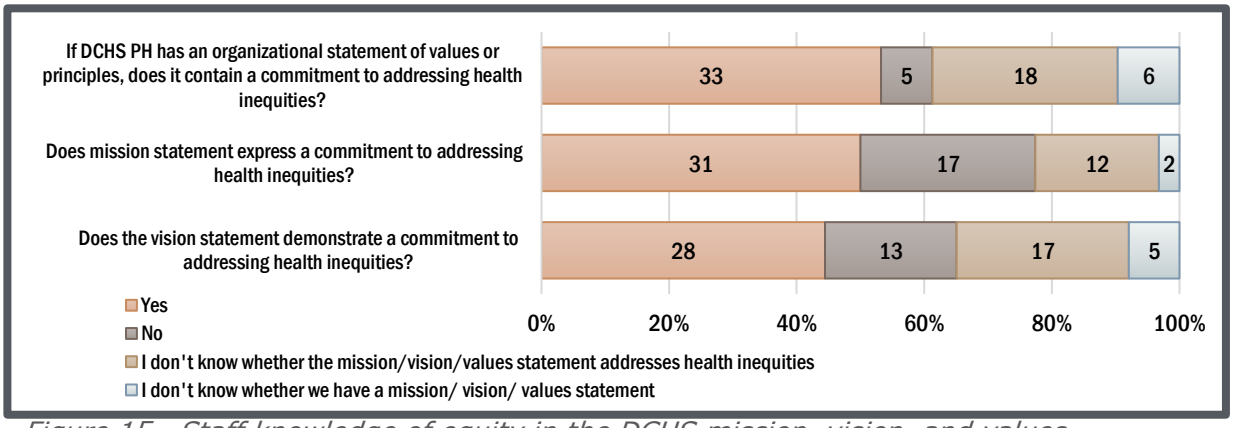



*Figure 15. Staff knowledge of equity in the DCHS mission, vision, and values.*

Seventy-eight percent of staff indicated that either they have no role in DCPH decision-making, or that they do not have a role in seeing their input incorporated into decisions. Sixty-one percent indicated that they usually or always understand the reasoning behind program and agency level decisions affecting their job. Ninety-two percent of respondents work directly with the community in their position. Sixty-three percent work with community groups. Most staff indicated that at least some input is solicited from partners when planning.

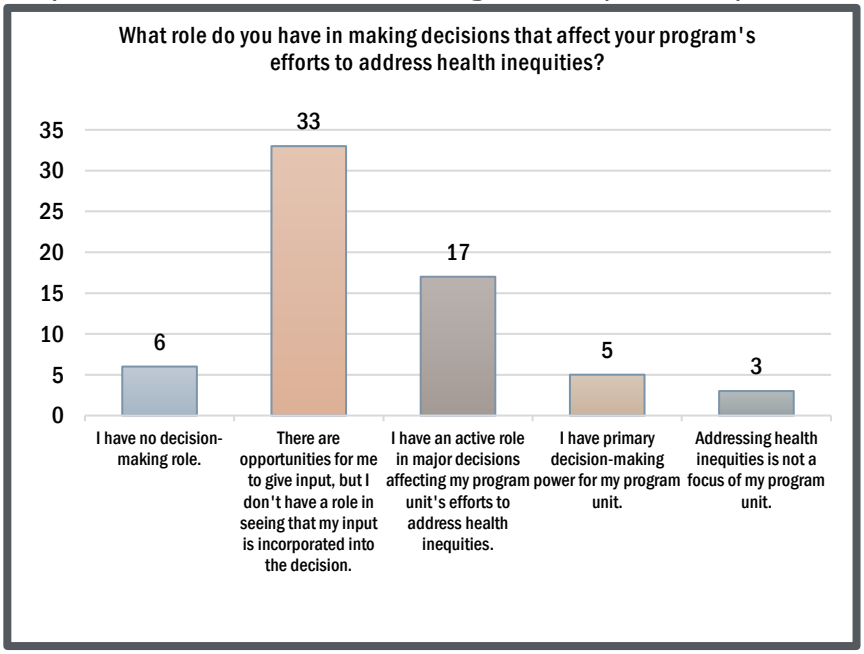



*Figure 16. Staff's perception of their role in program-level decisions aimed at reducing health inequities*

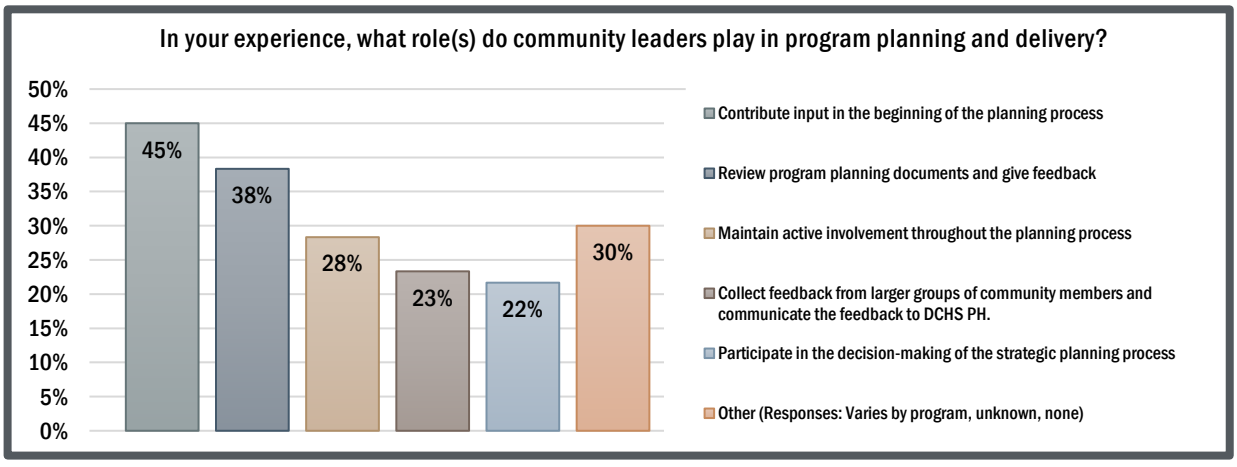



*Figure 17. Staff perception of community leader involvement in the program planning and delivery process. Many staff observed some partner involvement in early planning stages, but few perceived this involvement as continuing throughout the planning*

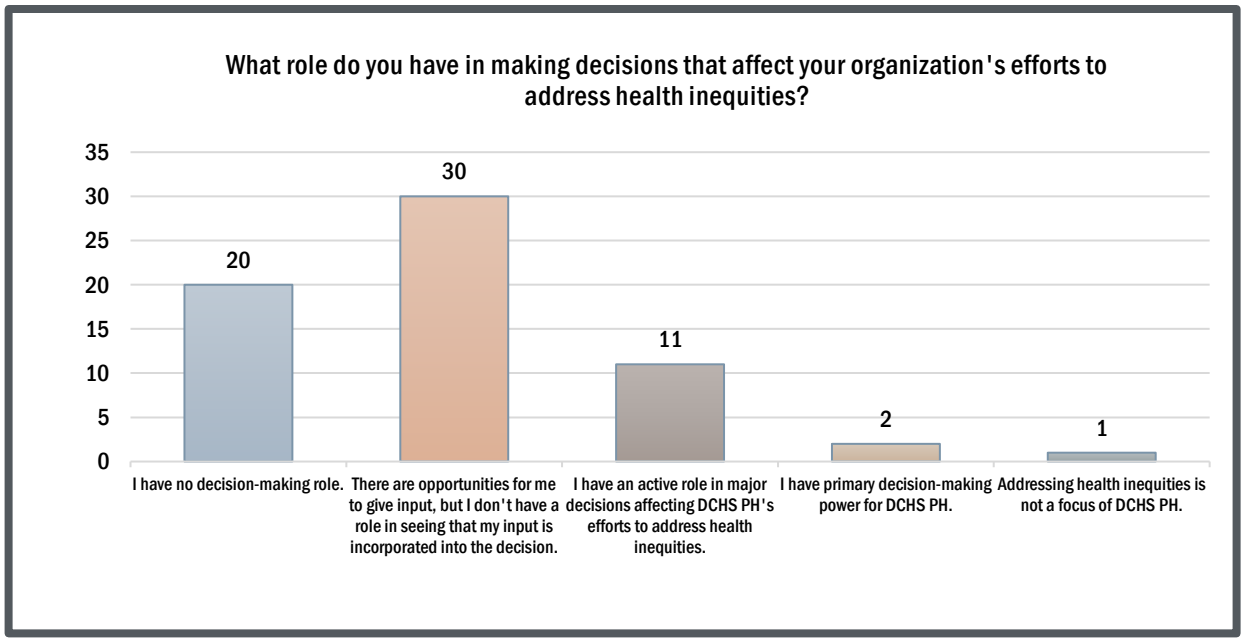



*Figure 18. Staff perception of their role in department-level decisions aimed to reduce health inequities.*

Fifty-nine percent received training on ways public health can address the environmental, social, and economic conditions that impact health. The majority agreed that they have opportunities to talk to their supervisor and engage in a peer discussion about social determinants of health.

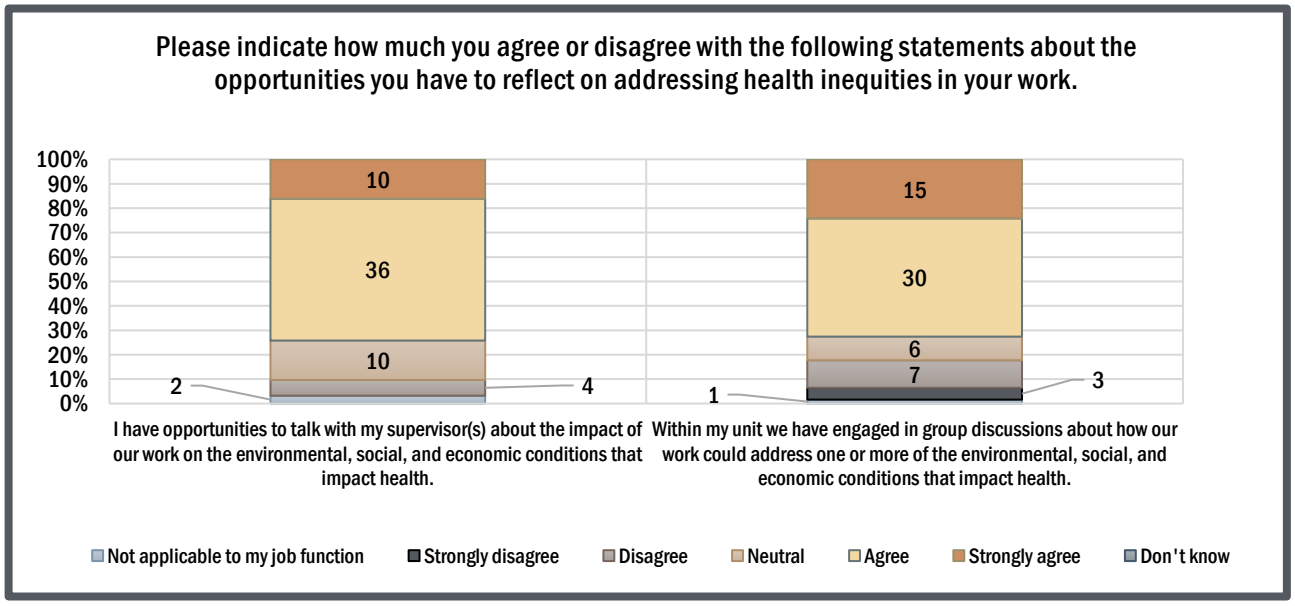



*Figure 19. Staff perception of their ability to talk to supervisors and peers about environmental, social, and economic conditions that impact health.*

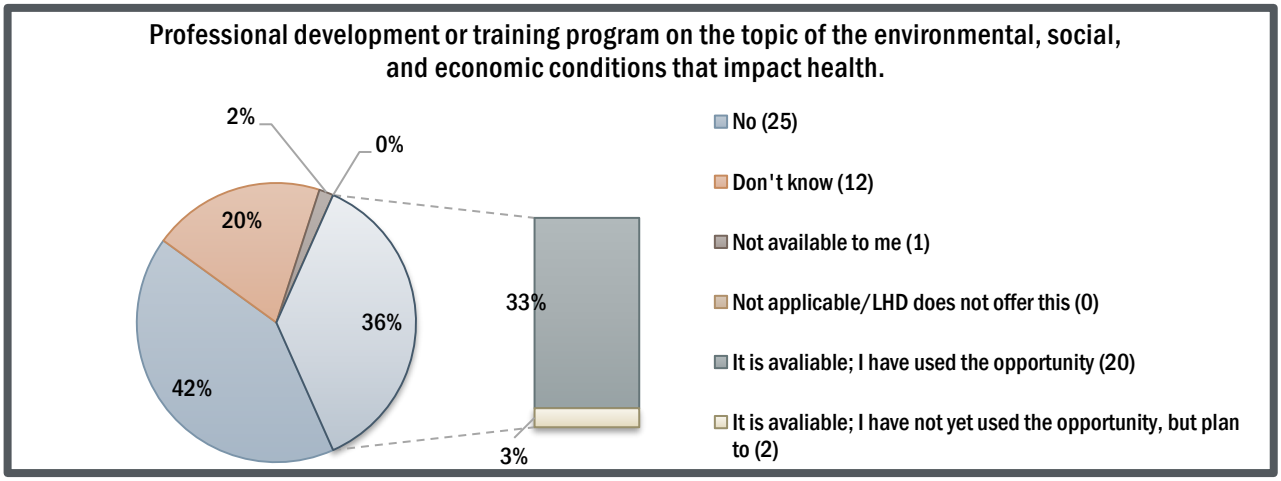



*Figure 20. Professional development opportunities for staff.*

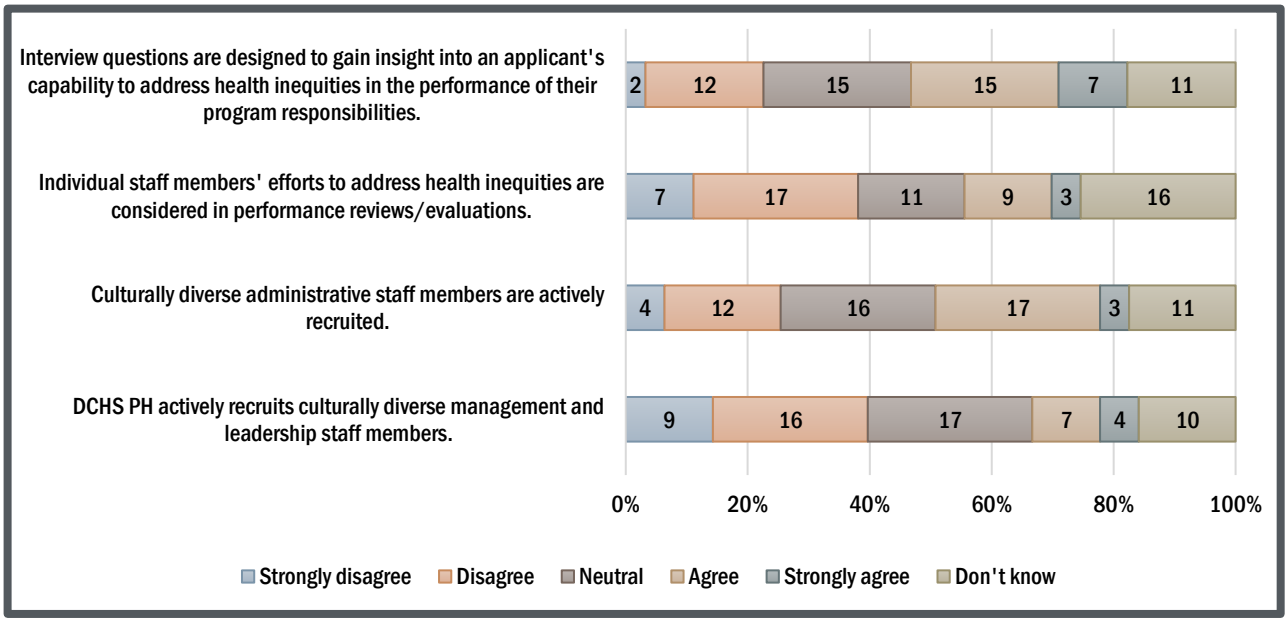



*Figure 21. Staff perception of equitable hiring and staffing practices.*

**Top Opportunities for Improvement:**

- Involve non-leadership staff during planning and decision-making.
- Promote internal practices to promote equity in hiring and staffing.
- Increase overall training, awareness, and focus on health inequities.

## Collaborating Partner Assessment Results

There were 34 responses for Deschutes County, 108 regionally. Most respondents worked for community-based organizations, public agencies, or academic institutions/schools. While the majority of respondents indicated they are front-line staff, responses were from a range of positions. Seventy-nine percent of respondents indicated their organization has worked with the health department for five years or more.

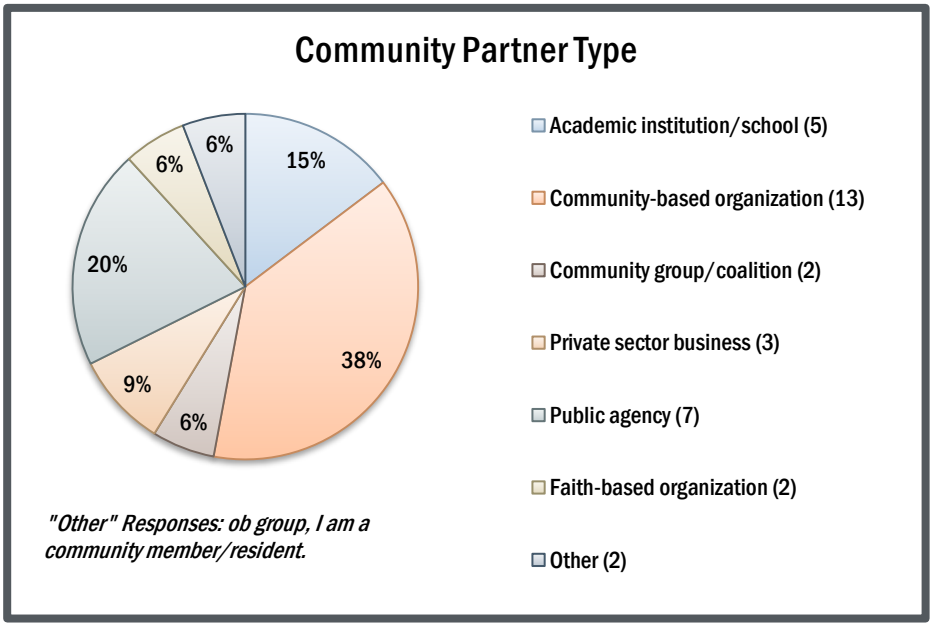



*Figure 22. Responses by partner organization type.*

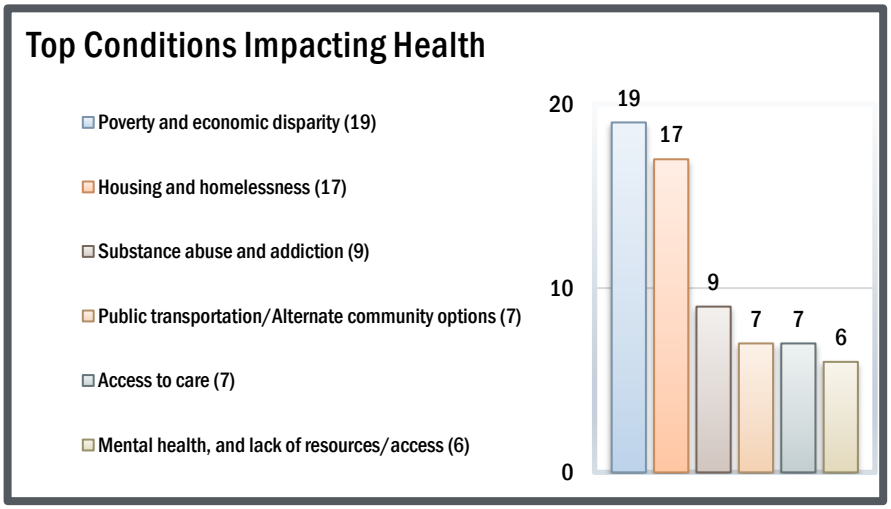



*Figure 23. Community partner perspective of the top environmental, social, and economic conditions that impact*

The most frequently mentioned environmental, social, and economic conditions that impact health in Deschutes County were poverty and economic disparity, housing and homelessness, substance use and addiction, public transportation/ alternate community

options, access to care, and mental health and lack of mental health resources/ access. Responses did not vary greatly by organization type or respondent position.

Seventy-six percent of respondents agree that their organization works with the health department to address the environmental, social, and economic conditions that affect health. Fifty-nine percent indicated that addressing these conditions are a high priority in organizations like theirs. Another 35% indicated they are moving in that direction.

One hundred percent of respondents strongly agree or agree that the health department should play a significant role in addressing the environmental, social, and economic conditions that impact health.

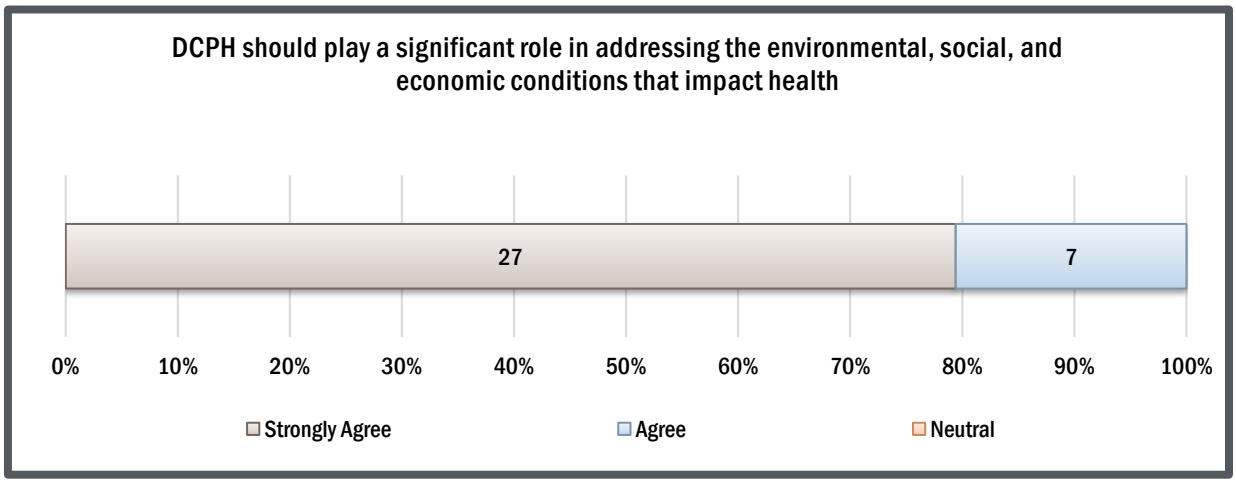



*Figure 24. Partner perspective of DCPH's role in addressing social determinants of health.*

Seventy-four percent of respondents think the health department demonstrates a commitment to addressing the environmental, social, and economic conditions that influence health, and 79% think that Public Health staff understand the major causes of health inequities in their county.

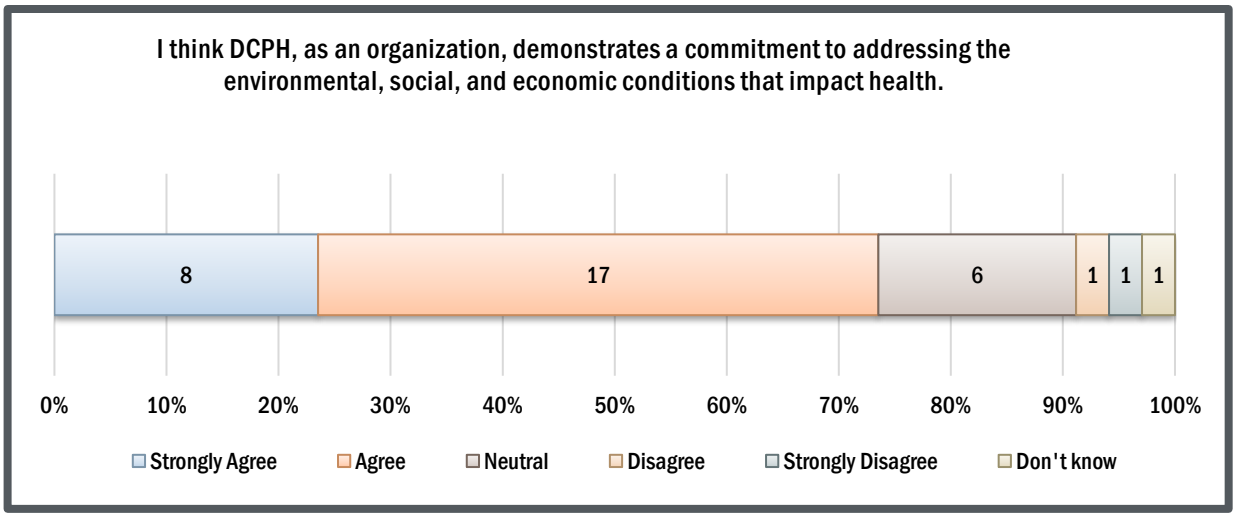



*Figure 25. Partner perspective of DCPH's current commitment to addressing social determinants of health.*

**Top Opportunities for Improvement:**

- Work closely with partners during program and agency planning.
- Go to collaborate locations instead of having partners come to the health department.

## Focus Group Results

The following themes were discussed during focus groups with DCPH teams. The themes are ordered based on the frequency of response, with themes mentioned more frequently appearing first.

**The public health all staff is beneficial but needs modification**. The meeting should focus on celebrating frontline staff, highlight what other programs are working on, explain what to expect in the coming months, how staff can be involved, and be as transparent as possible. It should be a safe place to share information without fear of reprimand or judgment. The DCHS director should be present to answer questions and explain agency level decisions. When decisions are made that do not fit the style of the leader explaining them, it is obvious the decision came from higher up. Whenever possible, the person who makes the decisions should be there to answer staff questions. Teams should be involved in creating the all staff agenda. DCPH should invite crucial non-public health staff to the PH all staff meeting (ex: MMH) to increase collaboration.

DCHS needs to modify its project management process, and involve **subject matter experts and impacted staff early in the planning process**. This process should include research on the front end to determine what programs will be impacted by the change. The project manager should ask the staff who else they think will be impacted, and compile a comprehensive list. These **impacted staff are often front-line subject matter experts, and should be consulted early and included throughout the process**, to determine how changes may affect them, other programs, partners, clients, and the community. When communicating with staff, face-to-face communication is appreciated. In addition, before decisions are made, client and community feedback should be collected to see what they want and need. All changes should be data informed and/or evidence-based. Project leads need to keep staff in the loop about what is happening. Email to all (relevant) public health staff should be sent to let everyone know what is coming down the pipe, and who their representative is on the workgroup. Before implementing, changes should be piloted with all impacted programs. If improvements are needed, changes should be made before implementation. The pilot should be an evaluation of how well the change works, and revoking or changing the process should be considered based on results from the pilot. **Consulting staff subject matter experts early in the process demonstrates respect, values the skillset subject matter experts bring to the table, empowers staff, and improves morale**.

The admin update (emailed newsletter) and similar communication is beneficial and is something staff would like to see continue. **Transparent consistent**

**communication is very valuable**. Leadership at all levels should aim to be as transparent as possible, with the same information going to all public health programs at approximately the same time to prevent misinformation and uncertainty. In addition, **Meeting minutes should be kept for important meetings and workgroups.** They should be distributed to staff regularly (monthly email), to increase staff knowledge and ability to provide input in agency activities. This includes meeting minutes for Public Health All Staff, Workforce Development, Equity and Inclusion, Public Health Equity, the Quality Council, and leadership and management team meetings. Sensitive information may be redacted when necessary. For transparency between teams, each public health section should pilot a quarterly group meeting to discuss what people are working on and how to collaborate/ improve processes between programs (Ex: Healthy People Healthy families, Advancement and Protections, Healthy Communities). Staff should choose what to talk about in these meetings, and management should be present in these meetings. Another way to promote transparency is the creation and dissemination of a five and ten-year plan, with a **simple and clear goal/ vision**. This will help clarify priorities for the organization and keep everyone on the same page. In addition, organizational goals and performance metrics need to be accessible and created with input from frontline-staff expertise.

**Upper management and directors need to be strong program advocates**. This should be the number one responsibility of managers. In addition, they should involve their subject matter experts in program advocacy and planning. Advocacy includes demonstrating program need and assuring program sustainability. DCHS/DCPH should also **advocate and invest in health equity** and have dedicated staff to work on health equity.

Draft agendas for coming meetings should be accessible to all staff, and **staff should be allowed to propose topics to discuss at meetings**. This can be done for team meetings as well as the public health of all staff. In addition, DCHS should revisit the meeting cadence to assure meetings are still aligned appropriately.

DCHS/DCPH needs to create a **decision matrix** to identify what type of decisions are being made, and how staff can or should be involved in decision-making: Level 1 decisions-High level, Level 2 decisions- Staff input wanted but ultimately leadership decision, Level 3- Democratic process. This would ensure staff awareness of decision-making protocol, particularly within leadership. Relating to this, there should be a comprehensive listing of job descriptions within our organization that explain what people do, including the differences in leadership positions (director, deputy, manager, supervisor).

**DCPH needs to improve the phone tree and front office process** to assure timely communication for all clients, including Spanish-speaking community residents.

**What We Heard is Going Well!**

Leadership who do the following were praised:

- Make nonhierarchical decisions and bring staff into planning and advocacy.
- Allow staff to determine, create, and modify agendas and items to discuss in meetings.
- Remain available for questions when decisions are made that affect their program, including being present at team-meetings and having an open door policy.
- Advocate for programs and public health at the DCHS and County level.

We also heard:

- Within teams, staff are supportive of one another and collaborate well.
- Joint team-meetings with programs that collaborate closely are beneficial.
- Regular communication to staff about what is going on is appreciated.
- The public health all staff can be a good platform to share information and collaborate with other teams.

**Top Opportunities for Improvement:**

- Revise project management and decision-making process to include consultation from impacted staff.
- Modify and improve public health all staff meetings.
- Create a matrix for decision-making and explain staff role in decision-making.
- Record and disseminate meeting minutes to staff for all key meetings and workgroups.
- Focus on evidence based decision-making at all levels of the organization.
- Improve and increase opportunities for team-to-team, program-to-program communication.
- Invest in dedicated health equity staff.

# Recommended Actions and Next Steps

| Five Year Plan (2019-2023) | |
|---|---|
| DESCHUTES COUNTY PUBLIC HEALTH GOALS<br>Promote transparent communication<br>Achieve nonhierarchical decision-making<br>Create a simple, clear, and achievable vision for public health | COMMUNITY GOALS<br>Promote health in all policies<br>Assure access to health services<br>Integrate climate resilience in planning<br>Integrate built environment considerations in planning |
| 2019/2020: Integrate Health Equity into Agency Practices<br>2019/2020: Proactively include Climate Resilience Considerations in Equity Work<br>2020/2021: Create and Sustain a Health (Equity) in All Policies Community Task Force (HiAP)<br>2021: BAR HII Equity Assessment<br>2022/2023: Hold for BAR HII Strategy implementation<br>2023/2024: Integrate Climate and Built Environment in DCPH Strategies and the HiAP Task Force | |

| TIMELINE (2018) | DUE |
|---|---|
| Plan and prepare for assessments | 1/31/2018 |
| Prioritize Strategies from the Health Equity Guide (https://healthequityguide.org/strategic-practices/) | 2/28/2018 |
| Conduct BAR HII Internal Assessment | 5/31/2018 |
| Conduct BAR HII Community Partner Assessment | 6/30/2018 |
| Conduct focus groups (all teams and leadership) | 9/30/2018 |
| Workgroup and PH leadership creates and prioritizes additional strategies based on the assessment plus those we reviewed from the health equity guide | 10/31/2018 |
| Get input from DCPH staff on proposed strategies (all staff and report/ email) | 12/31/2018 |
| Disseminate Health Equity Report to staff | 2/28/2019 |
| Get input from community partners on proposed strategies (staff and managers/deputy reach out to partners) | 9/1/2018 |
| Finalize and disseminate Health Equity Report | 1/31/2019 |

**Per the BAR HII assessment results, many of the strategies are internally focused. Before DCPH can adequately advocate for Health Equity ideals in the community, we want to embody them within the agency.*

**STAFF PRIORITY:** The top three priorities as identified during the 11/27/18 all staff are highlighted in yellow in the action plan.

| STRATEGIES (2019-2021) | DUE | LEAD |
|---|---|---|
| **Internal Collaboration and Communication** | | |
| Revisit meeting cadence with leadership to assure order is still correct for public health. | 9/30/2018 | DONE |
| Post operational plan metrics on performance boards (Courtney downstairs) and recommend that be discussed at team meetings. | 1/31/2019 | DONE |
| Phase 1: Create, establish and maintain a centralized location in the PH Admin Shared Files for Internal programs and workgroups to share all staff meeting minutes and other workgroup information. Will require each group to provide updates.<br>Phase 2: Work with programs and workgroups to explore the feasibility, capacity, and willingness to maintain meeting notes that are available to staff, how to start this process, and where to post meeting minutes.<br>Phase 3: Create and maintain InsideDC workgroups/ PH information page (Title idea: "What's Going on in Public Health) that includes workgroup information and links to applicable shared files for meeting minutes, agendas, updates, and other materials. After PH all staff meeting, an email will be sent with meeting minutes. It will include a link to insideDC page and different ways to find information about what happening in the division. | 9/30/2019 | H. Saraceno & C. Lindsay |
| Consider and implement a way to share work using program factsheets to help teams learn about one another. | 7/1/2019 | M. Feld |
| **Community Engagement** | | |
| Share equity report learnings/results and action plan with key partners | 4/30/18 | Workgroup |
| Incorporate Health Equity in RHA/RHIP Process. | 6/30/2019 | RHA Steering Committee |
| Explore implementation of Health (Equity) in All (HeiAP) Policies Task Force including opportunities for community collaboration and exploring readiness. | 12/31/2021 | Workgroup & T. Kuhn |
| **Staff Training** | | |

| | | | |
|---|---|---|---|
| | Create a presentation, with staff input, to educate staff on historical context & how it drives current data/ trends around Equity in our community. Include Health in All Policies in the training. Consider if this can be tied to Trauma-Informed Care (TIC) Power Training.<br>**Training to be provided In PH team meetings and posted on Relias* | 1/1/2020 | Workgroup (Possible TIC collaboration) |
| | Consider opportunities to integrate HiAP in DCPH functions and advocate/educate staff. Guidelines for local health may be found here. | 6/30/2020 | Workgroup |
| | **Leadership** | | |
| **Staff Priority #3* | Modify public health all staff meeting:<br>1) *Meeting Focus:* Celebrate frontline staff, what other programs are working on/accomplishments, how staff can be involved, and be as transparent as possible about what's happening.<br>2) *Additional attendees:* Recommend that the DCHS director is present for discussions involving agency level decisions, and present at least once a year. DCPH should invite crucial non-public health staff to the PH all staff meeting (ex: MMH), to increase collaboration.<br>3) *Staff input*: Post agenda in advance of the meeting. Let staff have input on what to include on the agenda (ex: two question survey) and what they would like to hear about. Also use clickers to see if staff agree with recommendations *(ex:* meet every other month, make web-based option). Consider an all staff (once a year) dedicated to a public health section to talk about what they are doing, help plan, etc.<br>4) *Meeting minutes:* Meeting minutes should be taken for the PH all staff meeting.<br>5) *Meeting frequency:* Reconsider meeting frequency and need for all staff vs. other combined team meetings. | 11/31/2019 | P. Ferguson and H. Saraceno.<br>PH All staff planning group? |
| | Each public health section should be encouraged to pilot a quarterly group meeting to discuss what people are working on and how to collaborate/ improve processes between programs, where it makes sense. Hillary should be invited to these meetings as well. At the all-staff, each section can provide a brief synopsis of what's going on within their section. | 1/31/2019 | H. Kaisner, T. Kuhn, & P. Ferguson |
| | Create an overview of leadership roles and responsibilities<br>• Describe the role of director, deputy, managers, and supervisors so that staff has a better understanding of position and decision-making role.<br>• Number one job of managers: program advocate (demonstrating program need and assuring program sustainability). | 5/31/2019 | H. Saraceno |

| | | | |
|---|---|---|---|
| | Advocate to use established and agreed upon guidelines for process and project implementation | | |
| **Staff Priority #2* | Review and create guidelines for process/project implementation. At the front end, determine what programs and staff will be impacted by the change and make sure there is representation of those impacted in the process. Include consultation with impacted staff – "nothing about (impacting) you without you." Explain how this will happen. | 5/31/19 | H. Saraceno, C. Lindsay, & all leadership |
| **Staff priority #1* | Create and establish agreed upon guidelines for and commitment to, the inclusion of staff in PH decision-making processes and levels of authority. Include staff in creation. Avoid top-down decision-making where possible.<br>*Recommended Approach:* Establishing an agreed upon decision-making matrix that defines levels of decision-making, communicates how staff can be involved in decision-making and providing input ("nothing about (impacting) you without you."), and PH Communication philosophy and Guidelines.<br>Leadership at all levels should aim to be as transparent as possible, with the same information going to all public health programs at approximately the same time to prevent gossip. Hierarchical communication does not work well. Leadership face time with staff is important). Communicate all of this to staff and implement. | 6/30/2019 | H. Saraceno |
| | Integrate health equity considerations into PH policies and practices as well as the contracting, grant, and RFP processes (Examples questions in appendices). | 6/30/2020 | C. Smallman, & T. Kuhn |
| | Review and assure representation on key community workgroups and organizations to align with the HiAP framework. Also, Identify, support, and work collaboratively with the leadership of grassroots and civic organizations whose activities and campaigns advance health equity<br>*Ask: How can we leverage meetings to better tackle health equity? Are there meetings we should participate in but do not?* | 7/31/2019 | H. Saraceno, H. Kaisner, T. Kuhn, & P. Ferguson |
| | Assure staff is intentional in going to collaborate locations instead of having partners come to the health department. This should be a Standard Operating Procedure and PH value. | Ongoing | Leadership |
| | Emphasize public health program work links to the overall vision/ goals for DCPH. | Ongoing | H. Saraceno |
| | Apply participatory budget tools and/or processes to health department programs and decision-making to enable community decision-making suggestions on where funding should be allocated. | Ongoing | C. Smallman and Deputies |

| | | |
|---|---|---|
| Let all PH staff know that they have the opportunity to go through the New Employee Orientation Training to Learn more about DCHS. | 1/1/2019 | Dianne Capozzola |

# 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.

**Definition used by DCPH shaded*

## SOCIAL DETERMINANTS OF HEALTH DEFINITIONS

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)

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. (Healthy People 2020, 2018)

The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

(World Health Organization, 2018).

Factors such as where we live, how much money we have, and our education level have been clearly linked to our health, well-being, and how long we live.

(Robert Wood Johnson Foundation

## HEALTH EQUITY DEFINITIONS

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)

Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

(Robert Wood Johnson Foundation,

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

(World Health Organization, 2018)

Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

(Healthy People 2020, 2018)

## SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

DCPH has adopted the CDC's Social Determinants of Health Framework (below). This framework 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)

| | 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<br><br>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<br>• Ensure water sources meet required standards<br>• Ensure brownfield sites Identify hazardous waste that might contaminate a community<br>• 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<br><br>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<br>• Housing authorities<br>• Law enforcement<br>• Schools<br>• 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<br>• Safe and affordable housing that can reduce risk for asthma, lead poisoning, homelessness<br>• Full-day kindergarten that can reduce adverse health prospects such as teenage pregnancy<br><br>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<br>• Housing and health codes to prevent childhood lead poisoning.<br>• Batterer intervention program laws to prevent violence against women and children |

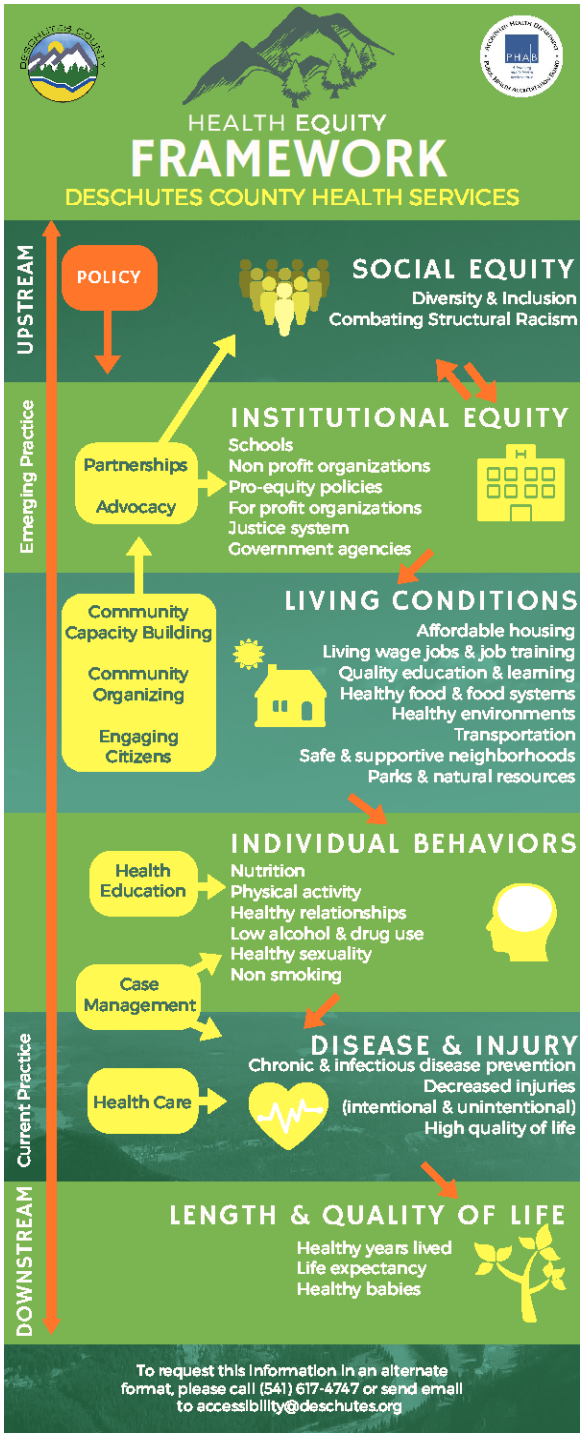
| | | |
|---|---|---|
| 7. | Link people to needed personal health services and ensure the provision of health care when otherwise unavailable | Educate community members about their eligibility for and access to entitlement programs<br>• Medicaid, including its medical, mental health, and housing benefits<br>• TANF<br>• SNAP<br><br>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<br><br>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<br><br>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)<br><br>Use community-based participatory research designs<br><br>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.

*

*https://www.cdc.gov/stltpublichealth/publichealthservices/pdf/Ten_Essential_Services_and_SDOH.pdf*

## DCHS HEALTH EQUITY FRAMEWORK




*In 2017, DCHS finalized a Health Equity Framework. This framework and other DCHS Equity tools and resources may be accessed by DCHS staff through InsideDC here.*

**The framework (left) is an embedded PDF. Double click to open.*

## HEALTH IN ALL POLICIES FRAMEWORK

### What is Health in All Policies?

DCPH 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.

### HiAP Framework


(Center for Disease Control and Prevention, 2018)

**For more information HiAP, this link will redirect you to a guide for state and local governments.*

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# Appendices

## BAR HII EMAILS TO ALL STAFF

**January 31, 2018**
**Subject Line: All PH Staff ~ Determinants of Health Assessment**

Dear DCHS Public Health staff,

In the next day or two you will be receiving an internal Social Determinants of Health survey via an email with a link to *SurveyMonkey*. As part of Public Health Modernization and Accreditation, we are required to conduct an organizational assessment to determine how well we are addressing the root causes of health inequities within the communities we serve. This survey is completely anonymous; none of your responses will be linked to you individually.

***Please complete the survey by February 28th.**

***A few things to note:***

1) This assessment should take approximately **20-30 minutes** to complete.
2) Each staff member will have their own unique link to the assessment, therefore it is important you do not forward your survey link to others or use a co-worker's link to access the survey.
3) If you would like to return to the link to finish at a later time or to change any responses, you can do so.
4) Your responses will be saved each time you click the "next" button on each page of the assessment. If you need to leave the assessment before you complete it, just hit "next" at the bottom of the last page completed and close the browser. When you return to the assessment, you will automatically be taken to the page where you left off.

**Thank you very much for taking the time to complete the assessment.**

Your perspective on the determinants of health within the Deschutes County Public Health Division is extremely valuable and greatly appreciated!

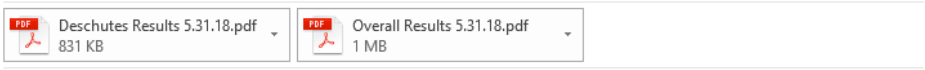
**ADDED INCENTIVES:**
We are aiming for an 80% response rate. In an effort to encourage and reward those who participate, we are offering an opportunity to win a Hydro-flask, a $25 Strictly Organic coffee card, or a $25 movie gift card. After the assessment, you will be redirected to a one-question survey to be entered into the raffle. Your response to this question will be separated from your survey.

**First drawing for incentive prizes will be held on Valentine's Day. Therefore, if you get your survey done on or before 2/14 you will have the most chances of winning ☺**

If you do not receive your survey link by end of the week and/or if you have trouble accessing the survey or have any other questions, please contact Drew Docter at Andrew.Docter@deschutes.org or call (541) 322-7401 (or X 7401).

Hillary Saraceno

In partnership,
Hillary Saraceno, MS
Health Services Deputy Director, Public Health Division




**Thank you all for helping distribute the Regional Collaborating partner Social Determinants of Health Assessment!**

**108 people responded, 34 for Deschutes County.**

**Deschutes County Results:**

- **Respondent Information**
  - Most respondents worked for community-based organizations, public agencies, or academic institutions/schools.
  - While the majority of respondents indicated they are front-line staff, responses were from a range of positions.
  - 79% of respondents indicated their organization has worked with the health department for five years or more.

- **Overview of Results**
  - The most frequently mentioned environmental, social, and economic conditions that impact health in Deschutes County were poverty and economic disparity, housing and homelessness, substance use and addiction, public transportation/ alternate commute options, access to care, and mental health and lack of mental health resources/ access.
  - 76% of respondents agree that their organization works with the health department to address the environmental, social, and economic conditions that affect health.
  - 59% indicated that addressing these conditions are a high priority in organizations like theirs. Another 35% indicated they are moving in that direction.
  - 100% strongly agree or agree that the health department should play a significant role in addressing the environmental, social, and economic conditions that impact health.
  - 79% think that Public Health staff understand the major causes of health inequities in their County.

- **Some Opportunities for Improvement**
  - Working closely with partners during planning.
  - Going to collaborate locations instead of having partners come to the health department.

**The results are attached!**

**Next Steps**

1) Implement internal Focus groups. *More information to come.*
2) Use this data during agency and program planning.
3) Use this data to create/modify the Public Health Equity project work plan.
4) Use the qualitative data as part of the Regional Health Assessment MAPP process.
5) Use the data to meet PH Modernization grant requirements.
6) Use the report for National Public Health re-Accreditation.

**Want to be involved?**

1) Let me know if you have any questions or ideas.
2) Join the PH Equity Workgroup or talk to Equity Workgroup staff to learn about progress *(You can also join by WebEx! Ask to be invited).*
3) Check out our Inside DC Health Equity Page: http://insidedc/health/Pages/Health%20Equity.aspx
4) Learn more about "What Affects Our Health" in Deschutes County: https://www.deschutes.org/health/page/what-affects-our-health

**Thank you all for providing feedback for the Social Determents of Health Assessment!**

**86% of Public Health Staff Responded** (Four Raffle Prizes were awarded).

- **Leadership and Non-Leadership listed the Same Top Community Health Concerns**
  - Housing/Homelessness
  - Economic status/Income/ Poverty
  - Drug/Alcohol abuse
  - Access to care/preventive care
  - Public transportation/alternate commute options.
- **>80%** of respondents said the health department and programs address health equity/the social determinants of health either some or a lot.
- **About 38%** of staff believe the organization demonstrates a commitment to addressing the environmental, social, and economic conditions that affect health.
- **23%** of staff indicated that DCHS-PH has strategies in place to advocate for policies around these topics.
- **52%** indicated that there is no focus, or not enough focus, on health inequities.
- **78%** of staff indicated they have no role in DCHS-PH decision-making, or that they do not have a role in seeing their input incorporated into decisions.
- **61%** of staff indicated that they usually or always understand the reasoning behind program and agency level decisions affecting their job.
- **92%** of respondents work directly with the community in their position.
- **63%** work with community groups.
- **59%** of staff indicated they received training about the different ways public health can address the environmental, social, and economic conditions that impact health.

**The results may be found here!**

- DCHS PH Overall
- Clinical Services & Sexual Health
- Nurse Family Support Services
- Prevention and Health Promotion
- WIC
- DCHS Leadership and Non-leadership comparison *(to be added soon)*
- Environmental Health *(to be added soon)*

**Next Steps**

1) Implement the Community Partner Assessment Regionally (Crook, Jefferson, & Deschutes), and other steps in the BAR HII Assessment. *More information to come.*
2) Create an equity report including this information, partner results, and community data.
3) Use this data during agency and program planning.
4) Incorporate Health Equity discussion in operational planning.
5) Use this data to create/modify the Public Health Equity project work plan.
6) Use the qualitative data as part of the Regional Health Assessment MAPP process.
7) Use the data to meet PH Modernization grant requirement.
8) Use the report for National Public Health re-Accreditation.

**Want to be involved?**

1) Let me know if you have any questions or ideas.
2) Join the PH Equity Workgroup or talk to Equity Workgroup staff to learn about progress.
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**Channa Lindsay, MPH** | Quality Improvement Analyst
Deschutes County Health Services
(541) 322-7632

## BAR HII STAFF EQUITY ASSESSMENT RESULTS

### Overall

**Deschutes County Health Services Public Health Equity Staff Survey Results**

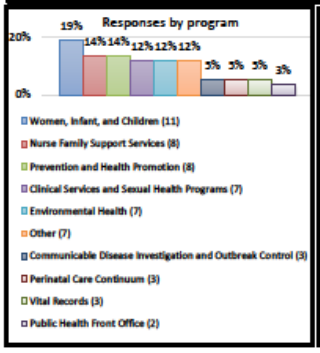
**Reponses Rate and Demographics:** 86% (65 out of 76) of staff responded to the assessment. Responses were from eight administrative staff (12%), forty-four front line staff (68%), nine supervisors (14%), and four managers/directors (6%). Of all respondents, the average time spent at Deschutes County Health Services Public Health (DCHS-PH) was >8 years, with a cumulative of 525.75 years. 89% of respondents identified as Caucasian/White, 5% as Latino/Hispanic, 2% as Native American/Alaska Native, 2% as African American/Black, and 2% as Biracial/Multiracial.

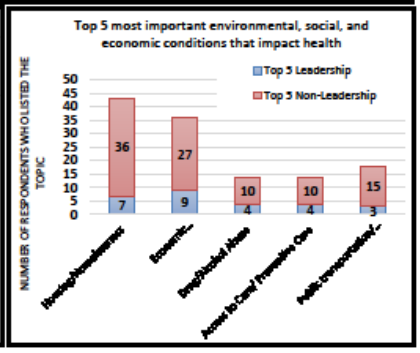
**Top Health Concerns:** Top concerns most frequently listed by staff included, housing/ homelessness, economic status/income/ poverty, drug/alcohol abuse, access to care/preventive care, and public transportation/alternate commute options.

**Department and Program Equity Work:** The majority of staff (>80%) believe that the health department and programs currently address health equity and the social determinants of health either some or a lot. 40-60% indicated that the mission, vision, and values demonstrate a commitment to health equity. Close to 38% of staff believe the organization demonstrates a commitment to addressing the environmental, social, and economic conditions that affect health, and only 23% of staff indicated that DCHS-PH has strategies in place to advocate for policies around these topics.

**Community and Staff Input during Planning:** Responses around the role of community leaders, residents, and organizations in agency and program planning was varied, but most staff indicated that at least some input is solicited from partners when planning. Seventy-eight percent of staff indicated that either they have no role in DCHS-PH decision-making, or that they do not have a role in seeing their input incorporated into decisions. Sixty-one percent of staff indicated that they usually or always understand the reasoning behind program and agency level decisions affecting their job.

**Equity in Employee Work:** Ninety-two percent of respondents work directly with the community in their position. Sixty-three percent work with community groups (e.g. groups made up of community members rather than institutions or agencies within the community). 59% of staff indicated they received training about the different ways public health can address the environmental, social, and economic conditions that impact health. 52% indicated that there is no focus, or not enough focus, on health inequities. Most employees indicated that they engage in various types of work that address the social determinants of health.



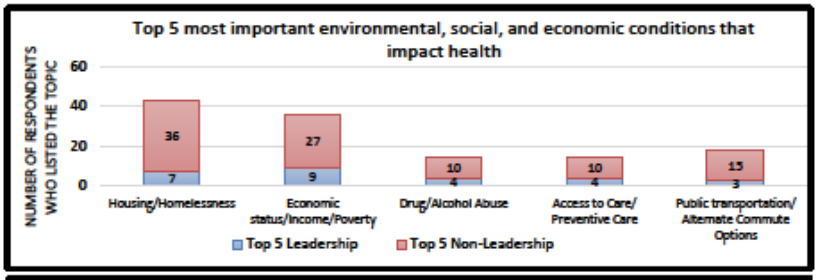



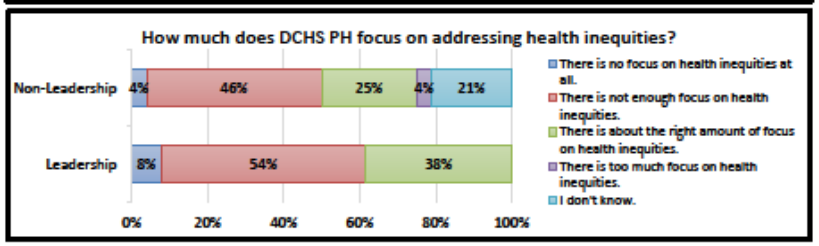

**Embedded PDF. Double click to open. Programmatic responses available by request.*

## Leadership and Non-leadership Comparison

**DCHS Public Health Equity Assessment Results by Position**

**Leadership:** Thirteen (20%) respondents indicated that they are a supervisor, manager, or director (leadership). Of these, 100% self-identified as Caucasian/ White. 77% percent of leadership staff work directly with the community in their position, and 85% indicated they work with community groups.
**Non-Leadership:** Fifty-two (80%) respondents indicated they are either front line or administrative services (non-leadership). 2% self-identified as African American/Black, 87% Caucasian/White, 7% Latino/Hispanic, 2% Native American/Alaska Native, 2% Biracial/Multiracial/Other. 96% of non-leadership staff work directly with the community, and 57% indicated they work with community groups.
**Shared Views:** The majority of both leadership (62%) and a large proportion of non-leadership (50%) felt that there was either too little or no focus on addressing health inequities in our Public Health Department. The Top 5 most important environmental, social, and economic conditions that impact health were the same for leadership and non-leadership, include Housing/homelessness, Inadequate income/poverty, Drug/alcohol abuse, Access to primary/preventive care, and Public Transportation. 50% of non-leadership staff indicated there is either no focus or not enough focus on addressing health inequities, compared to 62% of leadership.
**Workforce Equity:** Of non-leadership respondents, twenty-three (46%) felt that staff of diverse ethnic, racial, and cultural backgrounds were not equitably promoted in the department. Four (25%) responses from leadership staff indicated that they felt staff from these backgrounds were not equitably promoted. Thirty-nine (74%) of non-leadership were either unsure or disagreed with the notion that DCHS PH actively recruits a culturally diverse staff to provide direct service to clients compared to twelve (75%) of leadership responses.
**Community and Staff Input in Planning:** Leadership staff generally percieved that community leaders, members, and organizations had a larger role in strategic planning and program planning processes in comparison to views held by non-leadership. 75% of leadership staff responded that these community partners provide input at the beginning of program planning, while only 38% of non-leadership felt this was true. In terms of internal staff input, 54% of leadership felt they had an active role in decisions affecting the department's ability to address health inequities in the community, while just 8% of non-leadership felt that they were able to contribute to these decisions.

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## BAR HII COMMUNITY PARTNER EQUITY ASSESSMENT RESULTS

### Overall

**BAR HII Collaborating Partner Survey Regional Results**

**There were 108 responses to the survey, 24 for Crook County, 34 for Deschutes County, 34 for Jefferson County, and 16 for Tri-County Public Health.**

**Most respondents worked for community-based organizations, public agencies, or academic institutions/schools. While the majority of respondents indicated they are front-line staff, response were from a range of positions. The vast majority of respondents indicated their organization has worked with the health department for five years or more.**

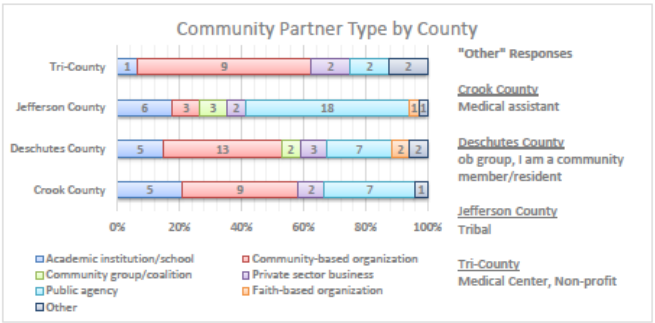
**The most frequently mentioned environmental, social, and economic conditions that impact health in Central Oregon were poverty and economic disparity, housing and homelessness, substance abuse and addiction, access to care, mental health and inadequate resources/ access, and lack of education.**

**Seventy percent of respondents agree that their organizations work with the health department to addresses the environmental, social, and economic conditions that affect health. Sixty-six percent indicated that addressing these conditions are a high priority in their organization. Another 28% indicated they are moving in that direction.**

**Ninety-five percent of respondents strongly agree or agree that the health department should play a significant role in addressing the environmental, social, and economic conditions that impact health.**

**Seventy-seven percent of respondents think the health department demonstrates a commitment to addressing the environmental, social, and economic conditions that influence health, and 83% think that Public Health staff understand the major causes of health inequities in their County.**

**Opportunities for improvement include working closely with partners during planning, going to collaborate locations instead of having partners come to the health department, and advancing focus on the determinants of health.**

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## Deschutes

**BAR HII Collaborating Partner Survey Deschutes Results**

There were 34 responses for Deschutes County.

Most respondents worked for community-based organizations, public agencies, or academic institutions/schools. While the majority of respondents indicated they are front-line staff, response were from a range of positions. Seventy nine percent of respondents indicated their organization has worked with the health department for five years or more.

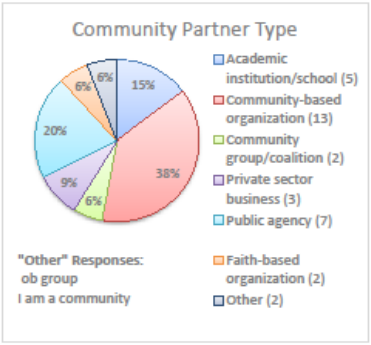
The most frequently mentioned environmental, social, and economic conditions that impact health in Deschutes County were poverty and economic disparity, housing and homelessness, substance use and addiction, public transportation/ alternate community options, access to care, and mental health and lack of mental health resources/ access. Responses did not very greatly by type of organization who responded, or position. In general, responses did not vary much by the respondent's position.

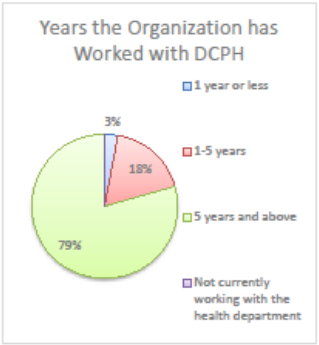
Seventy-six percent of respondents agree that their organization works with the health department to addresses the environmental, social, and economic conditions that affect health. Fifty-nine percent indicated that addressing these conditions are a high priority in organizations like theirs. Another 35% indicated they are moving in that direction.

One hundred percent of respondents strongly agree or agree that the health department should play a significant role in addressing the environmental, social, and economic conditions that impact health.

Seventy-four percent of respondents think the health department demonstrates a commitment to addressing the environmental, social, and economic conditions that influence health, and 79% think that Public Health staff understand the major causes of health inequities in their County.

Opportunities for improvement include working closely with partners during planning, and going to collaborate locations instead of having partners come to the health department.

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## BAR HII STAFF FOCUS GROUP EQUITY ASSESSMENT

### Focus Group Questions

1. What suggestions do you have to promote inclusion in program-level planning and input?
2. What suggestions do you have to promote inclusion in department-level planning and input?
3. Communication includes staff meetings, meeting cadence (explain if needed), emails, the admin update, and one-on-one communication with leadership.
    1. What is working for public health?
    2. What could we do to improve?
4. How do you or your team communicate with other programs or DCHS teams? Is this working?
5. What information do you think should be shared that you feel like you haven't been getting?
6. Is there anything else you think is important to share?

We would also like some feedback from an external survey

7. What is your team currently doing to meet the population or clients where they are (physically, economically, etc.)? What else might you do in the coming years to sustain or improve those efforts?
8. Is there anything else you think is important to share?

## FOCUS GROUP RESULTS CONNECTION TO STRATEGIES

**PH all staff modification**.

- Allow staff to propose, create, and modify agendas items.
- Focus on celebrating staff.
- Increase opportunities for team-to-team communication.

**Leadership Recommendations Based on Staff Feedback:** Modify public health all staff meeting:

- Celebrate frontline staff, explain what to expect in coming months, what programs are working on, how staff can be involved, and be as transparent as possible.
- Recommend DCHS director be present for discussions on agency level decisions. Invite crucial non-public health staff.
- Let staff have input on agenda items. Use clickers to see if staff agree with recommendations.
- Take meeting minutes.
- Reconsider meeting frequency and structure using staff feedback

**Modify and improve the project management process.**

- Involve and include consultation with subject matter experts and impacted staff early and throughout the process.
- Determine who is impacted and make sure there is representation from them in decision-making and throughout the process.
- Project leads need to keep staff in the loop about what is happening. Face-to-face communication is where possible.
- Pilot/ test changes before implantation. Make adjustments based on staff feedback.

**Leadership Recommendations:**
Review/create guidelines for process/project implementation using feedback on left.

**Upper Management and Leadership Roles**

- #1 responsibility: Advocate for program need & sustainability. Include subject matter experts in program advocacy/planning.
- Explain the differences in leadership positions.

**Leadership Recommendations Based on Staff Feedback:**
Create an overview of leadership roles and responsibilities: Describe the role of director, deputy, managers, and supervisors, their differences and decision-making roles. Make the number one job of manager is program advocacy.

**Inclusive decision-making process**

- Include consultation with impacted staff.
- Define staff role in decision-making.
- Create agreed upon inclusive decision-making process/ matrix.
- Collect client and community feedback before decisions made.
- Changes should be data informed/ evidence based.

**Leadership Recommendations Based on Staff Feedback:**

- Create and establish agreed upon guidelines for and commitment to, inclusion of staff in PH decision-making processes and levels of authority.
- Consider participatory budget tools and/or processes in funding/ decision-making.
- Review/ assure representation on key community workgroups and organizations.
- Identify, support, and work collaboratively with the leadership of grassroots/civic orgs. that advance health equity
- Assure staff are intentional in going to collaborate locations.

**Consistent, transparent, communication**

- Determine if meeting cadence is working.
- Record and disseminate meeting minutes for all key meetings and work groups.
- Each PH section should pilot a quarterly meeting to discuss what people are working on and how to collaborate and improve processes.

**Leadership Recommendations Based on Staff Feedback:**

- Public health sections encouraged to pilot a quarterly "program integration and awareness" meeting to discuss what people are working on and how to collaborate/ improve processes between programs. Invite Hillary/ manager.
- Emphasize how public health program work links to the overall vision/ goals for DCPH.
- Revisit meeting cadence.

**Workgroup Recommendations Based on Staff Feedback:**

- Create, establish and maintain centralized location to share meeting minutes and other information. After PH all staff meeting, email out meeting minutes and link to centralized location.
- Post operational plan metrics on performance boards and on InsideDC. Discuss metrics at team meetings.
- Incorporate Health Equity in RHA/RHIP Process.
- Share equity report learnings/results and action plan with key partners.
- Create presentation on historical context, and ways it drives current data/ trends around Equity in our community.

**Other Needs**

- Invest in health equity/ staff.
- Improve the phone tree/ front office process.

**Leadership Recommendations Based on Staff Feedback:**

- Phone Tree modified in fall 2018. Front office process improvements under exploration.
- Health Equity Advocate: Integrate health equity considerations into PH policies and practices as well as the contracting, grant, and RFP processes.

**Workgroup Recommendations Based on Staff Feedback:**

- Explore Community Health in All (HiAP) Policies Task Force and consider integrating HiAP in DCPH functions.

## EXAMPLE EQUITY QUESTIONS TO CONSIDER

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?

## ACDP HEALTH EQUITY MINI-GRANT REPORTING 2019 – DESCHUTES COUNTY

**Data**:

*Quantitative*

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.

*Qualitative*

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 have training on health equity.
- Provide access to more community-level health equity data.
- Support access to services using an equity lens.

**Reflection Narrative**:

Deschutes County Public Health (DCPH) hosted two community meetings, one in Bend and the other in Redmond. Forty-nine participants from twenty-three organizations attended the meetings. The Board of County Commissioners had planned to attend but due to a last minute change in the FY20 county budget approval process, the Commissioners were unable to attend. The DCPH Deputy Director, Hillary Saraceno, and Healthy Communities Manager, Thomas Kuhn, presented the Health Equity Report, including BAR HII results, to the commissioners on June 24, 2019. The presentation included an overview of the 2018 Deschutes County Health Equity Report followed by a lively discussion about the role of public health in addressing the social determinants and health equity. The commissioner's feedback and defined scope for public health work on the social determinants was used to help guide the conversation during the community partner meetings.

*The community meetings goals were threefold:*

1) Provide community partners with brief training on the social determinants of health and health equity, followed by an overview of the BAR HII assessment results including:
    a. What the top six social determinants of health (SDOH) issues are in Deschutes County as perceived by staff, by community partners and by community members representing vulnerable populations who participated in 30 different focus groups.
    b. How effectively DCPH is addressing health equity as perceived by staff and as perceived by community partners.

2) Increase understanding of the ten essential public health services and how the SDOH and health equity fit within those essential services and the local public health role, statutes and planning.
3) Engage community partners in small group discussions to identify: a) the health equity needs DCPH should prioritize within its scope; b) the recommended strategic approaches for addressing the prioritized needs, and c) common interests and opportunities for collaboration.

*What went well?*

- Partners appreciated the overview of how the results of the BAR HII and the outcomes of the community meetings, fit within the context of other work being done in the community (i.e. the Regional Health Assessment, Regional Health Improvement Plan and the local Public Health Strategic Plans).
- Despite the time of year and other competing needs, the number of people attending the two community events were at, or near, capacity for the location.
- The local Public Health Advisory Board members attended the Bend meeting, participated in the small group discussions, and listened to community partner feedback and recommendations.
- There was a lot of interest in, and energy around, the topic of health equity and the SDOH. Community partners were very engaged during the meeting and in the discussion and many volunteered to collaborate on several of the identified priorities.
- Partners appreciated the respect for their time and appreciated how much we were able to accomplish within the amount of time we had allocated.
- Based on feedback from participants, while we went in assuming most of the attendees had a good understanding of public health, the information we included on the role and scope of public health and the SDOH was needed much more than we anticipated.

*Feedback from partners during the meetings was valuable:*

The top four priorities identified by community partners during the two meetings for local public health to focus on were:

1) **Cultural, language awareness/availability and stigmas:**
   Partners prioritized the importance of regularly scheduled staff trainings especially on LGBTQ+, cultural responsiveness, language access, and effective facilitation among people who are marginalized.
2) **Access to care:**
   DCPH should continue to focus on improving and assuring access to preventive health services, especially with an equity and SDOH lens.
3) **Behavioral and Mental Health*:**
   Substance abuse prevention and addiction, mental health promotion and early intervention needs to be prioritized, especially within the Latino population.
4) **Youth Health and Safety:**

Need to focus on young children, youth and young adults, especially in areas of adverse childhood experiences, youth mental health, and substance abuse prevention.

*Other learnings and general recommendations identified by community partners were:*

- **Perceptions related to Mental Health Service Needs:** While staff and community partners identified mental health as the sixth highest SDOH need in the BAR HII assessment, vulnerable community members participating in the 30 focus groups identified it as the top SDOH need in Deschutes County.
- **SDOH Data:** A top priority focus area identified for public health is to provide access to data, including the impact of SDOH and health inequities on health, and on how to use the data.
- **Local Public Health Role:** There is a need to better define and educate the community about DCPH's scope of work, role and responsibilities, especially as it relates to the SDOH and health equity.

*As always, there were also a few challenges:*

- **Time of year impacted community meeting attendance:**
  - Summer vacations, end-of-year work closure and/or fiscal year wrap-up needs.
  - Partners in the education system (P-12 and higher ed) are generally very engaged partners in Deschutes County. However, "use-it-or-lose-it" leave time requirements and a variety of other competing events and trainings during the week of the community partner meetings, resulted in only one education partner being able to attend a partner meeting.
- **The mini-grant timeline did not align with our performance management system timeline**. While the information partners provided during the meeting was useful and will assist in local public health strategic planning, our regional health improvement plan will not be published until January 2020. It is difficult to commit to large projects or initiatives without knowing our Regional Health Improvement Plan priorities and strategies.
- **The role of public health in addressing the social determinants of health is not well understood** by many of our community partners. Our partners expressed an interest in public health playing a larger role as convener, catalyst and organizer – using the Collective Impact model – to bring people together to work on addressing the SDOH and health equity.

Moving forward, DCPH is committed to integrating health in all policies, to continuing to incorporate health equity into internal programs, policies and processes, and to including the community feedback in DCPH's strategic planning efforts. Resources to help DCPH explain the role and scope of public health, programs, and activities as it relates to health equity would help DCPH with needed capacity for external facilitation, communication, and planning efforts with partners. To measure and assess progress, DCPH will continue to use the BAR HII health equity assessment.