CALENDAR YEAR 2023 EQUITY IMPACT PLAN ANNUAL REPORT

BACKGROUND INFORMATION

Department Name: Fairfax County Health Department (FCHD)

Equity Lead(s): Dallice Joyner, Anna Ricklin

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EQUITY IMPACT PLAN REPORT

Review your department's Equity Impact Plan for CY 2023 at Equity Impact Plans | Topics (fairfaxcounty.gov)*. Using that plan, fill in each goal below and describe: 1) what was done to make progress toward the goal, 2) with whom (partners), and 3) how work toward this goal was measured/evaluated and the results. If you have data for the performance measures in your CY 2023 Equity Impact Plan, report them. Add more goals as needed.*

Goal 1: Build Health Department staff capacity to identify, explain and act upon racial bias and support a culture that promotes dialogue and open discussion

1. Progress: Actions taken to advance goal one includes completing the GARE Employee Racial Equity Survey. The survey was conducted in March, and we received the results in September. Two key recommendations were highlighted which the Health Equity Team will present to Executive Leadership for next steps in January 2024. The second cohort of Health Equity Leadership Experience was developed, with a revised curriculum and using internal FCHD staff as facilitators and presenters. The focus was on practical application of equity principles to all aspects of FCHD work.

2. Partners: GARE (for survey); Health Department staff including leadership, workforce development staff, and subject matter experts throughout the department.

3. Measurement: 47% of staff responded to the GARE survey. The experience had better than 90% attendance over 10 weeks and almost no attrition (in comparison to the pilot version conducted in 2022). At the end of the 10 weekly sessions, 29 new equity champions were added to the equity champion network (see Goal 4).

Goal 2: Leverage information from existing data sets, community engagement, etc., to identify gaps and inform policy direction; develop interventions and programs

1. Progress: This goal was addressed through both primary data collection efforts initiated by the Health Department, ongoing community discussions conducted by the Outreach Team, and the review of multiple reports/surveys conducted by external partners. As noted under Goals 2C and

5A, discussions with Outreach Team members and select community representatives were conducted as part of the Community Health Assessment process to gain insights regarding concerns, contributing factors to prominent health issues, and opportunities for addressing community health needs. Similar information was also ascertained through the Health Department-supported Inova community survey included in the most recent Inova Fairfax Community Needs Assessment Report. The Division of Epidemiology & Population Health and the Outreach & Engagement Unit collaborated in conducting several focus groups with community members to assess factors impacting community trust of the Health Department and strategies for improving relationships.

Data from food insecurity screenings with clinic patients and clients of the Maternal Child Health home visiting nurses was regularly reviewed and follow-up resources and service referrals made. The process for conducting screens, implementing follow-up by Family Assistance Workers and providing referrals, and enrolling clients in services has now been established as part of the workflow and institutionalized into the performance management plan with key performance metrics and goals.

Finally, efforts to view existing health outcome datasets through an intersectional lens were successful to a point. Data retrieved from several national, state, and district-level sources for health outcomes (rates/prevalence of chronic diseases, population health indicators, life expectancy, etc.), risk factors, and health behaviors by 1) race/ethnicity, 2) gender, 3) age, 4) place of residency (census tract/zip code), and 5) to some degree, sexual orientation, and transgender status, but data was limited. This data was analyzed to identify disparities and explore the unique health challenges faced by different sociodemographic groups, creating visuals for data in each health topic area (mortality/morbidity, food access and nutrition, physical activity, substance use, etc.). Visuals were presented at an internal data walk. After reviewing the data, a round-table discussion was held with Outreach Team staff to provide insight on the driving forces that they had seen in the community. To collect more qualitative data on the driving factors behind our county's health outcomes, FCHD also hosted a series of 8 interviews with community leaders, including high school students, a representative from a LGBTQ+ coalition, a leader from a non-profit group serving people with disabilities, and a leader for a non-profit serving the Route 1 Corridor (see also Goal 4).

2. Partners: Inova; community members; Health Department staff including staff from Division of Epidemiology and Population Health, the Outreach and Engagement Unit (community information); Maternal and Child Health, Family Assistance Workers, Public Health Nurses (food insecurity).

3. Measurement: The collaboration between the Division of Epidemiology and Population Health and the Outreach and Engagement Unit conducted 5 focus groups of Hispanic and African American residents from identified higher-risk zip codes to understand factors impacting community trust of the Health Department.

   At the start of the year, there was not an established process for food insecurity follow-up; at the conclusion of the year, we have clear processes developed and operating in two different programs (clinic services and MCH home visiting); 55% of clients who screened positive for food insecurity were successfully contacted for follow up within two weeks; >50% of those were connected to resources and/or other services.

   In terms of qualitative data collection on the driving factors behind our county's health outcomes, 8 interviews with community leaders were conducted as well as "person-on-the-street" brief interviews at community-targeted events were collected (total number not available).

Goal 3: Intentionally communicate the importance of racial, social and health equity to internal and external audiences

1. Progress: We developed an outline of an internal communications strategy including web-based and interpersonal information sharing; developed a strategy for ongoing Equity Champion engagement. A senior communications specialist became a member of HE Team in February. The Health Safety Net Resource List is now available online for the public to view; a Spanish language version of the list is in process.
2. Partners: Communications Team, Equity Champions, Inova, Federally Qualified Health Centers (FQHC), and other local HDs (Arlington, Alexandria, Prince William, Loudoun, outside vendor (Reingold).

3. Measurement: Team member added from Communications; six monthly meetings with up to 20 Champions in attendance; new communications strategy developed (to be implemented in 2024).

Goal 4: Build internal infrastructure to operationalize health equity practices

1. Progress: Health Equity Leadership Experience, Phase 3 was conducted from Feb 2023-Apr 2023; six staff were trained as facilitators and all trainees served as facilitators for the 2nd cohort of HELE from September-November 2023. We also added several new staff to the Health Equity Team from Communications, Environmental Health, Health Services, and School Health.

   We collected a point-in-time count of staff demographics in August. Staff did an overall analysis, and the Health Equity team reviewed it. Overall demographic diversity roughly reflects the diversity of the County. When disaggregated by paygrade class, the agency is less diverse at higher grades. When disaggregated by length of service, our agency becomes more diverse as we hire

new staff. Analysis of data by positions and divisions is still pending. This data will be used to supplement the GARE Survey response data to provide context and background.

This year, the Public Health Improvements Initiatives Plan ("PHIIP")'s Coordination Team ("PHICT") was launched. This team is tasked with operationalizing the plan for building internal capacity for and implementing co-creation of health promotion strategies for sustained relationships.

2. Partners: Institute for Public Health Innovation and Workforce Development Team (HELE); HD-Human Resources (HR); Performance Excellence Leadership Committee (internal to FCHD); staff from six divisions.

3. Measurement: 29 staff completed the second cohort of HELE, participating in 90-minute sessions for 10 weeks; they have now been added to the growing Equity Champion Network.

   Seven new members were added to the Health Equity Team from four divisions. We have now institutionalized an annual point-in-time request for staff demographic data with HD-HR each summer to track changes over time.

   PHICT members are from 6 divisions, including a representative from the Health Equity Team. A team charter has been developed and is in the process of being finalized. The team is refining the health improvement prioritization process to select which public health issues the group will work on in the coming year.

Goal 5: Collaborate with customers, clients, and stakeholders to co-create strategies to address health inequities

1. Progress: During the Community Context Assessment (CCA), a portion of the Community Health Assessment, HD staff gathered qualitative information from community residents and leaders in the form of in-depth interviews, brief person-on-the-street interviews, and open-ended surveys. This approach was guided by the Community Health Assessment Advisory Team, made up of community leaders from currently/historically marginalized communities in terms of race/ethnicity, religion, socio-economic status, immigration status, age, sexual orientation and gender identity, and ability status, as well as geographic regions of disparities ("Communities of Opportunity" or "Opportunity Neighborhoods").

   See discussion of PHICT above (Goal 4), for coverage of early strategies to identify and implement methods to sustain relationships that lead to the co-creation of health-promotion strategies.

   Ongoing challenges with specialty care and charity care referrals from the FQHCs is a long term, highly complex issue. In 2023, the Health Department convened community health service

providers to begin discussions about being intentional in how we address this longstanding gap for un- and under-insured Fairfax County patients.

2. Partners: For the CCA, partners include Dar Al Hijrah, Second Story, Loving Hands Touch, Psi Alpha Alpha Chapter of Omega Psi Phi Fraternity, Inc., Gay Men's Health Collaborative, ENDependence Center of Northern Virginia, Boat People SOS, the Korean Communities Services Center, First AME of Alexandria, Mobile Moms, and others.

   Partners for Health Safety Net access and integration work include both HealthWorks and Neighborhood Health Federally Qualified Health Centers, as well as Inova Health System.

3. Measurement

   For the CCA, the work is evaluated by breadth and depth of connection with the different communities. Eight in-depth interviews lasting at least an hour were held with community leaders representing different communities. “Person on the street” interviews were targeted to solicit input from the different racial and ethnic communities, as well as geographic distribution. Online surveys were used to engage communities which were harder to reach given the circumstances and/or were the preferred method of engagement for that community.

   The resulting Community Context Assessment report includes detailed descriptions of community strengths and assets, the built environment's impact on health, and macro forces of change, as well as direct quotes from community. This information provides context for the racial disparities data which are reported elsewhere in the report.

   The complete Community Health Assessment, which includes the CCA, will be released in Spring 2024. {link when available}

Describe other equity-related work completed in CY 2023 (efforts that advance racial and social equity that your department was involved in within the department or countywide) not in the department’s Equity Impact Plan.

- The establishment of the Health Equity Champions network, described above, was not explicitly outlined in our 2023 Equity Impact Plan. It fits broadly with our goals for internal communications and goals to institutionalize conversations about racial equity. Champions are also a way to achieve Goal 4, which focuses on infrastructure – they are our “human infrastructure” for equity and inclusion going forward.