

Multnomah County Health Department

# EQUITY PLAN

2026-2027



# Appreciations & Thanks to Guiding Lights

We honor and extend our deepest gratitude to members of our community who have endured health inequities, including those who may not be here to walk this path with us. Your experiences, resilience, and voices resonate and inspire this work in seen and unseen ways. This plan is shaped not only by those at the table, but also by the lived realities of those whose health and wellbeing call us to action.

Sincere appreciation goes to the many contributors who helped shape this Health Equity Plan. Thank you to the Health Department Director Rachael Banks for her steady leadership and bold vision for advancing health equity, and to our project sponsor, Deputy Director of Strategy, Policy, Racial Justice and Equity Angela Henderson, for guiding this plan forward with clarity, intention, and purpose. Their leadership helped anchor this effort and keep us oriented toward our north star of health equity for all communities.

Immense gratitude to the Equity Plan Steering Committee and Employee Work Groups who so generously shared their perspectives, thoughtful insights and questions, and lived experiences throughout the development process. Your sustained engagement, generosity of spirit, and courage to lean into candid — and at times complex — conversations and sit with both challenge and possibility made this work more authentic and impactful. You have been guiding lights — illuminating the path forward as we move together toward a more equitable future.

Lastly, special thanks to every subject matter expert who contributed expertise that sharpened our strategy and strengthened the foundation of this plan. This collective effort reflects the very spirit of shared stewardship and shared purpose that this Health Equity Plan is designed to advance as we continue the journey together.

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# Introduction

## The Horizon Before Us: Our Vision of Health Equity

Our vision is for thriving communities that nurture the health and resilience of all people. Through this plan, the Health Department affirms our responsibility to ensure that every community member — regardless of circumstance, race, gender, or disability— has a fair and just opportunity to achieve their fullest health potential. We also acknowledge that members of our workforce are at different stages along the continuum of learning and practice, and we honor that growth is an ongoing journey. Much of what we seek to change are deeply embedded social systems woven into our culture and institutions — systems that shape policies, practices, interpersonal relationships, and health outcomes — often in ways that are invisible yet profoundly consequential. We see their impact reflected in persistent preventable health differences where systemic health inequities continue to drive inequitable health outcomes across our communities.

Building on this understanding, in 2025 the Health Department advanced its commitment to intentional, sustained equity work by formally establishing the Office of Health Equity (OHE). The creation of the OHE represents more than structural change, it signals a deepened resolve to confront systemic inequities with focus and accountability. It strengthens our capacity to be future-focused, coordinated in our approach, and results-driven in our impact. Through this dedicated leadership and infrastructure, we are better equipped to navigate complexity with clarity, align our internal culture and external partnerships through our inside-outside equity strategy, and ensure that our commitments move beyond intention to measurable outcomes for the communities we serve.

Our new Health Equity Plan is designed to meet today's realities. It prioritizes the strategic use of resources, data-informed action, and shared accountability across the department. Advancing health equity is not the responsibility of a single office or team, it is a collective charge. Every member of our department — regardless of role, title, or tenure — plays a critical part in bringing our vision of health equity to life. This shared responsibility ensures that we not only respond to inequities, but actively work together to restructure the inequitable systems that produce them to improve health outcomes for all communities.

It is important to acknowledge this plan is not the start of our equity journey; it is the next step. For years, our teammates have worked hard to address specific community needs using equity-focused tools, like the [Equity and Empowerment Lens](#) to guide decisions and investments. Milestones like the creation of the OHE, the 2026 Community Health Improvement Plan (CHIP) arriving this summer, and our Comprehensive Local Plan for Behavioral Health also reflect our sustained commitment to ensuring our services are accessible, responsive, and centered on what matters most — the health and well-being of everyone in our community.

Our equity work does not exist in isolation. Instead, we are bringing together ideas from across the department and elevating community voice to create a unified, department-wide approach. We also recognize that a healthy community includes a healthy workforce. When we cultivate a healthy and energized workforce, we build on the strong care we already provide — empowering our teams to deliver even higher-quality, compassionate service to our community and create lasting, meaningful impact.

True equity requires more than just shared goals; it requires coordinated, sustained action. This 16-month roadmap represents the next stage, a focused, near-term guide to align priorities and accelerate progress. It also lays the groundwork for the next chapter — a comprehensive, multi-year strategy designed to deepen and expand our impact. Together, these efforts will ensure we continue to serve the needs of our internal and external community as one.

The Health Department is proud to present this Health Equity Plan as our formal commitment to each other and our community. This document outlines the specific goals, timelines, and measurable actions we will use to hold ourselves accountable to building a more equitable environment. It is also a living document, meant to grow with feedback and adapt to the needs of the people of Multnomah County.

By aligning our internal operations with our external mission, we ensure that every dollar spent and every decision made moves us closer to a healthier, more equitable public health entity. We invite you to join us and see how we are turning our values into results. Together, we are building a Health Department and community where everyone has the opportunity to thrive.

In solidarity,  
Angela Henderson  
Deputy Director of Strategy and Policy

# Methodology

## Guided by Insight

This section provides a high-level overview of our analysis and how it guided our strategic approach. For more detailed insights, please refer to the Appendices.

This Health Equity plan builds on the department's ongoing, intentional equity efforts and serves as a roadmap toward our shared vision of health equity. Although the department already has several equity-focused plans and initiatives, this plan unifies our efforts, charting a collective journey toward greater alignment and impact. As we move forward, we remain committed to creating and nurturing sustainable, responsive, and well-resourced equity strategies, internally and externally, with system-wide accountability to ensure meaningful and lasting change.

The Office of Health Equity, together with our data analysts from across the department, performed a comprehensive review of current practices to develop a Landscape Analysis. By mapping existing equity-focused plans, we made sure our new strategy builds on what is already working while addressing gaps and opportunities for improvement. We recognized some challenges in the process and will apply lessons learned to strengthen future efforts.

To ensure a comprehensive understanding of our current landscape, we drew on multiple sources of information, including:

- 1. Internal Documents and Equity-focused Plans:** Reviewing existing departmental strategies helped us identify what is already working and where opportunities remain to strengthen alignment across strategies. This included examining specific equity goals already in place or under development throughout the department.
- 2. The Countywide Equity Audit Report (CEAR):** We studied the county equity audit, which highlighted the department's progress along their Equity Maturity Model and offered insights into areas for growth.
- 3. Countywide Data:** We reviewed information from the [Workforce Equity Strategic Plan \(WESP\)](#) and the most recent [Employment Trends](#) data to understand patterns, workforce representation, and trends that helped to inform our priorities.

By synthesizing these sources, we were able to identify both strengths to build on and strategies to address, ensuring that our strategy is grounded in evidence, responsive to current realities, and positioned to advance our vision of health equity across the department.

Using the insights gained from our Landscape Analysis to orient us, we organized two main collaborative groups:

- 1. The Equity Plan Steering Committee:** A diverse team of represented and non-represented leaders from across the organization that included both those with formal positional authority and others recognized for their natural leadership, influence, and expertise. The committee worked together to shape our vision and craft outcomes, goals, and related activities included in the plan.
- 2. Collective Impact Workgroups:** Groups of frontline team members who collaborated to review data, share trends, and refine focus areas and specific action items that informed development of the Health Equity Plan. This workgroup functioned as an elevated governance partner, working in concert with the Equity Plan Steering Committee to ensure balanced decision-making.

The Steering Committee and the Collective Impact Workgroups came together in a structured collaborative process to form the department's focus areas, outcomes, goals and activities, ensuring that both strategic vision and practical experience informed the plan.

We also invited all team members to provide their feedback on proposed focus areas, goals, and action items. This input helped determine which actions would be prioritized in this 16-month plan and which would become part of the department's broader multi-year strategy. This collaborative approach ensures that our Health Equity Plan is not only a living document but also a true reflection of staff expertise and our community's needs. By combining insights from the abovementioned sources, subject matter experts, and real-world employee experiences, we have charted a course that is both practical to guide the department toward our vision of health equity and achievable.

Building on this foundation, we will move from understanding to action. The next section, Turning Insight to Impact, outlines the specific strategies, measurable goals, and desired outcomes that will guide the department in advancing health equity. This is where our vision, informed by evidence and community expertise, translates into tangible, accountable steps to drive meaningful change.

# Action Plan

## Turning Insight to Impact

Through four operational Focus Areas and eight strategic goals, this 16-month Health Equity Plan aligns infrastructure, workforce wellbeing, service access and quality, community partnership, transparency, and organizational culture to produce measurable, sustained health equity outcomes.

### Equity Framework

This plan is grounded in:

- Racial, disability, and economic justice
- Community-defined safety, healing, and prevention
- Trauma-informed and restorative justice practice
- Shared accountability between systems and communities
- Transparency, data disaggregation, and continuous improvement

### Strategic Alignment

This plan operationalizes and integrates the Health Department's equity, health, workforce, and systems strategies. It advances the [Multnomah County FY2026-2028 Strategic Plan](#) by translating its commitments to Health; Equity and Justice; Community Partnership & Belonging; Workforce Excellence; and Operational Excellence & Systems Coordination into concrete actions. It aligns with the Community Health Improvement Plan (coming this summer 2026) and the 2026-2027 Comprehensive Local Plan for Behavioral Health by advancing shared population health priorities through coordinated, equity-centered implementation. In addition, it is further anchored in the Multnomah County [Workforce Equity Strategic Plan](#), Phases 1 and 2, and aligns workforce equity, wellbeing, and retention strategies with service quality, access, and culturally responsive practice.

Rather than functioning as siloed efforts, these strategies are intentionally braided into a single implementation framework with shared timelines, aligned metrics, and coordinated governance — ensuring that healthcare, public health, behavioral health, workforce, and community equity priorities reinforce one another in practice. Within these 16 months, this integrated framework is designed to deliver through four Focus Areas, which translate strategic commitments into action:

**Focus Area 1:** Integrated Health Equity & Infrastructure

**Focus Area 2:** Workforce Equity & Retention Strategy

**Focus Area 3:** Community Partnerships

**Focus Area 4:** Health Equity Organizational Health & Culture

These Focus Areas form the delivery infrastructure through which the plan’s equity goals are implemented, monitored, and sustained so that strategic intent translates into measurable, department-wide outcomes.

<b>Focus Area 1: Integrated Health Equity &amp; Infrastructure</b>			
<b>Outcome:</b> A comprehensive, trauma-informed health equity culture supported by an infrastructure that prioritizes workforce wellbeing, accountability, and cohesive strategy across the Health Department			
<b>Goal 1.1: Integrate and coordinate internal and external health equity initiatives across the Health Department to reduce silos and improve alignment</b>			
<b>Activities</b>	<b>Equity Action Lead/Owner</b>	<b>Measures</b>	<b>Timeline</b>
1. Operationalize the Office of Health Equity (OHE) to serve as the central coordinating body for departmental health equity efforts	1. HD Director’s Office	1. A completed and approved formal OHE organizational design (governance structure) with defined core team member roles with a corresponding implementation plan	Months 1 - 6
		2. Feedback requested from 75% of community partners on the proposed OHE design and structure and then incorporated into the design	Months 1 - 6
		3. Quarterly OHE-sponsored cross-division coordination meetings are held and documented	Months 7 -16
		4. Feedback from Health Department employees indicates improved cross-departmental collaboration and communication	Months 7 - 16

**Goal 1.2: Increase the visibility, connection, and impact of Health Equity Liaisons embedded within departmental divisions to strengthen coordination and shared learning across the department**

<b>Activities</b>	<b>Equity Action Lead/Owner</b>	<b>Measures</b>	<b>Timeline</b>
<ol style="list-style-type: none"> <li>1. Launch a Health Equity Community of Practice (CoP) with a formal charter, clear governance structure, and diverse, cross-departmental Health representation to support peer learning, collaboration, and consistent integration and alignment of equity approaches across the department.</li> <li>2. Regularly convene Health Equity Liaisons to showcase divisional health equity work, share challenges and successes, and elevate their role across the department.</li> </ol>	<ol style="list-style-type: none"> <li>1. OHE</li> <li>2. All HD Division Equity Liaisons</li> </ol>	<ol style="list-style-type: none"> <li>1. Approved Health Equity CoP charter with defined governance roles and decision-making methodology</li> <li>2. ≥8 Health Equity CoP meetings held per year</li> <li>3. 100% of Health Equity CoP seats filled across all divisions in the Health Department</li> <li>4. 75% of Health Department Managers/ Supervisors report increased awareness of Health Department Equity Liaisons’ roles and efforts they championed</li> <li>5. 50% of frontline staff report increased awareness of Health Department equity efforts</li> <li>6. ≥ 10 Cross-divisional collaborations or initiatives emerging from the Health Equity CoP</li> <li>7. Increased feelings of connection and support experienced by Health Department Equity Liaisons across Department</li> </ol>	<p>Months 4 – 16</p>

**Goal 1.3: Strengthen cross-system coordination and implementation of Community Health Improvement Plan strategies across the department to improve population-level health outcomes and reinforce accountability to stated health equity goals across all equity-focused departmental plans.**

<b>Activities</b>	<b>Equity Action Lead/Owner</b>	<b>Measures</b>	<b>Timeline</b>
<ol style="list-style-type: none"> <li>1. The Office of Health Equity will partner with division leads to identify, map, and align shared equity priorities, populations, and strategies across departmental plans to strengthen collective impact.</li> <li>2. Implement plan-specific equity strategies and use plan-defined key performance measures to monitor health equity progress.</li> <li>3. Host Department-wide “Health Equity Plan Town Halls” to share the 16-month strategic roadmap and progress, including the planned design for the Office of Health Equity.</li> </ol>	<ol style="list-style-type: none"> <li>1. OHE, HD Division Directors</li> <li>2. BHD (CLP+/CHIP), Director’s Office (WESP/HEP), PHD (PHM Comp Plan/CHIP, HDHR (WESP)</li> <li>3. OHE</li> </ol>	<ol style="list-style-type: none"> <li>1. Implementation leads for each plan have been identified</li> <li>2. Respective leads/divisions report quarterly on all applicable equity-related key performance indicators identified in each plan according to each plan’s reporting schedule, including documentation of resolutions and actions taken when performance is delayed or off track</li> <li>3. 4 scheduled Health Equity Town Hall meetings with leads of respective plans</li> </ol>	<p align="center">Months 6 -10</p> <p align="center">Months 6 - 16</p> <p align="center">Months 6 -16</p>

## Focus Area 2: Workforce Equity & Retention Strategy

### Outcome:

Increased employee retention across the Health Department.

**Goal 2.1: Establish a unified, Department-wide approach to implementing Phase 1 of the County Workforce Equity Strategic Plan 2024-2028 (WESP), with clear roles, timelines, and monitoring to support equitable outcomes across all Health Department divisions**

Activities	Equity Action Lead/Owner	Measures	Timeline
<ol style="list-style-type: none"> <li>1. Form a department-level WESP implementation team led by the Office of Health Equity.</li> <li>2. Implement Phase 1 of the WESP in alignment with the WESP Departmental Implementation Toolkit.</li> <li>3. Map WESP Phase 1 benchmarks to specific Health Department functions, teams, and priorities.</li> <li>4. Create a dashboard and initiate progress tracking for all identified benchmarks.</li> <li>5. Complete evaluation of WESP Phase 1 and adjust before launching WESP Phase 2 expansion.</li> </ol>	<ol style="list-style-type: none"> <li>1. OHE/HDHR</li> <li>2. All HD Divisions</li> <li>3. OHE/HDHR</li> <li>4. OHE/HDHR</li> <li>5. OHE/HDHR</li> </ol>	<ol style="list-style-type: none"> <li>1. Department WESP Implementation Team (WIT) established with a clear governance framework outlining member roles and responsibilities.</li> <li>2. Monthly progress reports submitted to the WIT by the end of WESP Phase 1</li> <li>3. Quarterly dashboard developed and published by end of WESP Phase 1</li> </ol>	<p style="text-align: center;">Months 1 - 2</p> <p style="text-align: center;">Months 1 - 4</p> <p style="text-align: center;">By end of WESP Phase 1 (Month 4)</p>

**Goal 2.2: Establish a unified, department-wide approach to Implementation Phase 2 of the County Workforce Equity Strategic Plan 2024-2028 (WESP), with clear roles, timelines, and monitoring to support equitable outcomes across all Health Department divisions.**

<b>Activities</b>	<b>Equity Action Lead/Owner</b>	<b>Measures</b>	<b>Timeline</b>
1. Implement Phase 2 of the WESP in alignment with the WESP Departmental Implementation Toolkit.	1. All HD Divisions	1. WIT formally announces department wide WESP Phase 2 implementation	Month 5
2. Create and align feedback loops for designated WESP Phase 2 responsible parties within the Health Department to gather and report progress on Phase 2.	2. OHE/HDHR	2. Monthly progress reports submitted to the WIT by the end of Phase 2 and uploaded to the dashboard	Months 6 - 16
3. Map WESP Phase 2 benchmarks to specific Health Department functions, teams, and priorities.	3. OHE/HDHR	3. At least two new evidence-based retention strategies developed and implemented at the Health Department	By end of WESP Phase 2 (Month 16)
4. Identify and implement at least 2 evidence-based retention strategies informed by WESP Phase 1 data	4. HDHR		

**Focus Area 3: Community Partnerships**

**Outcome:**

Sustained trust-based community partnerships that shape programs, policies, and accountability

**Goal 3.1: Strengthen and sustain external partnerships**

<b>Activities</b>	<b>Equity Action Lead/Owner</b>	<b>Measures</b>	<b>Timeline</b>
1. Maintain regular consultation with community partners	1. All HD Divisions	1. Biannual community feedback summaries published	Months 1 - 16
2. Document community feedback and alignment actions across Health Department divisions.	2. All HD Divisions	2. Quarterly documentation of program, policy, or process changes across the department made in direct response to community partner feedback	Months 6 - 16
3. Create a Community Partnership Administration Plan to guide maintenance, retention, and reconciliation efforts with community partners.	3. OHE	3. Community Partnership Administration Plan created, approved, and implemented	By month 16

## Focus Area 4: Health Equity Organizational Culture

### Outcome:

A culture of trust and transparency that fosters synergy and strengthens collective understanding and collaboration across the department

### Goal 4.1: Increase internal health equity communications in the Health Department

Activities	Equity Action Lead/Owner	Measures	Timeline
1. Develop and launch an Office of Health Equity e-newsletter to increase internal communications regarding health equity initiatives, resources, and progress within the Health Department.	1. OHE	1. OHE e-newsletter launched in Fall 2026 2. ≥15% internal staff readership (measured by email open rate) by July 2027.	Months 8 - 16

### Goal 4.2: Establish a trauma-informed Health Equity Restorative Healing strategy that supports workforce well-being, accountability, and growth across the department.

Activities	Equity Action Lead/Owner	Measures	Timeline
<p>1. Leverage existing governance and committees across the Health Department: Partner with existing health equity committees to co-design a department-wide Health Equity Restorative Healing strategy, and promote, and sustain health equity healing circles.</p> <p>2. Trauma-informed Facilitation and Training: Create and implement trauma-informed training, including bystander intervention strategies for health equity healing circle facilitators, grounded in restorative practices and health equity principles.</p> <p>3. Create and implement a department-wide Health Equity Restorative Healing strategy.</p>	<p>1. WESP Implementation Team (WIT), HD Division Equity Committees, OHE</p> <p>2. HDHR (perhaps in consult w/ County Organizational Learning team)</p> <p>3. WESP Implementation Team (WIT), HD Division Equity Committees, OHE</p>	<p>1. A health equity restorative healing strategy is implemented through peer-led healing circles across the department.</p> <p>2. ≥ 5 healing circles held per quarter.</p> <p>3. ≥ 10% participant-reported improvement in belonging, annually.</p>	<p>Months 6 - 16</p> <p>By month 16</p>

# Final Thoughts

## Reflections Along the Way

One of the Health Department's greatest strengths is the diverse voices — grounded in lived experience and deep love for community — that shape our work. The people we serve partner with us to show us what best practices should look like. Together, we built these department-wide goals using data and insight from community partners, clients, and teammates. Because we have invested in trust with one another, we can build on this momentum and continually improve our services.

Our confidence in this plan does not come from the pages of a report. It comes from the people who carry out this work. While responding to the COVID-19 pandemic, the Health Department delivered under extreme pressure, and in so doing, maintained the trust of the communities we serve. Since then, more employees have experienced workplace related stress and burnout, often with few lasting solutions. Even so, they have remained resilient and committed to serving the most vulnerable in our community. We continue to lead with equity, and reach those who need our services most.

We now face different headwinds alongside our community partners. Despite these challenges, our people still show up. They continue to build strong partnerships, strengthen internal processes, and do the essential work of improving health equity.

Over the next 16 months, we will expand our capacity to implement these equity initiatives and more. This plan positions us to operate effectively no matter what the future brings. When new challenges arise, the systems we are building will enable us to respond with strength and agility. We are moving forward with clarity and purpose. We have the data to understand where we've been and where we stand today, and we now have a unified plan to guide where we are going. Together, we are strengthening our Department and, in turn, improving the health and lives of the people we serve — including ourselves.

# Acknowledgements

## Architects of the Journey

### Steering Committee Participants

Anthony Jordan	Kat Stevens
Beth Poteet	Kim Rhodes
Courtney Covington	Maribel Murillo
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### Collective Impact Work Group Participants

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#### Group 2

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#### Group 3

**Members:** Alex Perez-Perez, Crystal Gallaher, Zumana Rahman, Heather Minton, Tatyana Leonchik, Daijon Williams

#### Group 4

**Members:** Michael Walker, Emma Galligan, Nomika Gibson, Willow Buswell, Jonathan Cruz, Christina Toscano

# Glossary

## Shared Language for the Journey

A glossary is a fantastic way to ensure everyone is on the same page. Using a shared language prevents confusion and makes the plan more inclusive.

The Office of Diversity and Equity has a [Workforce Equity Strategic Plan's Shared Language Guide](#) with key terms. Much of what is listed here are more specific to the Health Department and its acronyms.

**Behavioral Health Division (BH or BHD):** If capitalized, this is our internal Behavioral Health Division. Lowercase “behavioral health” refers to mental and emotional health that impact the body.

**BIPOC:** An acronym for Black, Indigenous, and People of Color.

**CEAR (Countywide Equity Audit Report):** A report created by the Multnomah County Auditor that reviews how well the County is meeting its equity goals.

**CHIP (Community Health Improvement Plan):** A long-term plan to address public health in a community.

**CLP+ (Comprehensive Local Plan):** A plan required by the state that sets forth the direction for Multnomah County’s Community Mental Health Program (CMHP) to effect behavioral health system transformation. The “+” shows a renewed, expanded effort to improve how the County delivers these services.

**Equity:** The practice of providing people with the resources and support they need to reach their best self. It is different from “equality,” which gives everyone the same thing regardless of their starting point.

**The Equity and Empowerment Lens:** A set of reflective actions, materials, and tools designed to assess or provide information for discussion, planning, and decision making that leads to more equitable policies and programs.

**Health Equity:** All persons have access to the resources and power they need to attain their full health potential.

**Health Equity Plan (HEP):** A strategic framework that outlines the Health Department's actions and commitment to eliminating unjust and preventable race-based differences in health outcomes. It focuses on advancing workforce equity and fostering an inclusive organizational culture, while also improving external community conditions by addressing the root causes of health inequities so all people can reach optimal health and well-being.

**HD Human Resources (HDHR):** The Human Resources team is responsible for providing targeted services to create a positive, productive, and healthful work environment for Health Department employees. They handle recruitment, onboarding, compensation, benefits, and employee relations.

**Health Inequity:** Systemic, avoidable, unfair and unjust differences in health status, disease prevalence, and mortality rates between population groups, often determined by social, economic, and environmental conditions.

**Landscape Analysis:** An assessment process used to map out current practices, trends, and resources to identify what is already working, and where there are gaps to fill and opportunities to leverage for more impact.

**Office of Health Equity (OHE):** The central group within the Health Department responsible for coordinating health equity efforts inside the department and out in the community.

**Public Health Division (PH or PHD):** If capitalized, this is our internal Public Health Division. Lowercase "public health" refers to the health outcomes of communities as a whole.

**Public Health Modernization Comprehensive Plan (PHM Comp Plan):** A deliverable tied to 2015 legislation (Oregon House Bill 3100), this plan provides a strategic framework designed to transform public health from a reactive system in

**Social Determinants of Health (SDOH):** The conditions and circumstances in which people are born, grow, live, learn, work, age, and play that are key factors in how populations experience health equity or inequity.

**Substance Use Disorder (SUD):** A mental illness where the use of substances leads to problems in a person's life.

**Underserved Neighborhoods:** Areas that face systemic barriers or limited access to essential services or resources, like healthcare, food/grocery stores, education, housing, or reliable transportation.

**WESP (Workforce Equity Strategic Plan):** A plan created by Multnomah County focused on making the workplace fairer for all employees.

# Appendices

## Appendix A: Equity Landscape Analysis

For more details please refer to: [Landscape Mapping Summary](#)

The Equity Steering Committee had a representative from each division within the Health Department. In December the committee was asked to reach out to their divisions and complete an Equity Landscape of any equity activities their division was currently doing. There were 242 equity activities reported and many were overlapping in their main goals and/or outcomes. When separated out between if the equity efforts were internal or external, 88% were external, 8% internal and 4% crossed both internal and external.

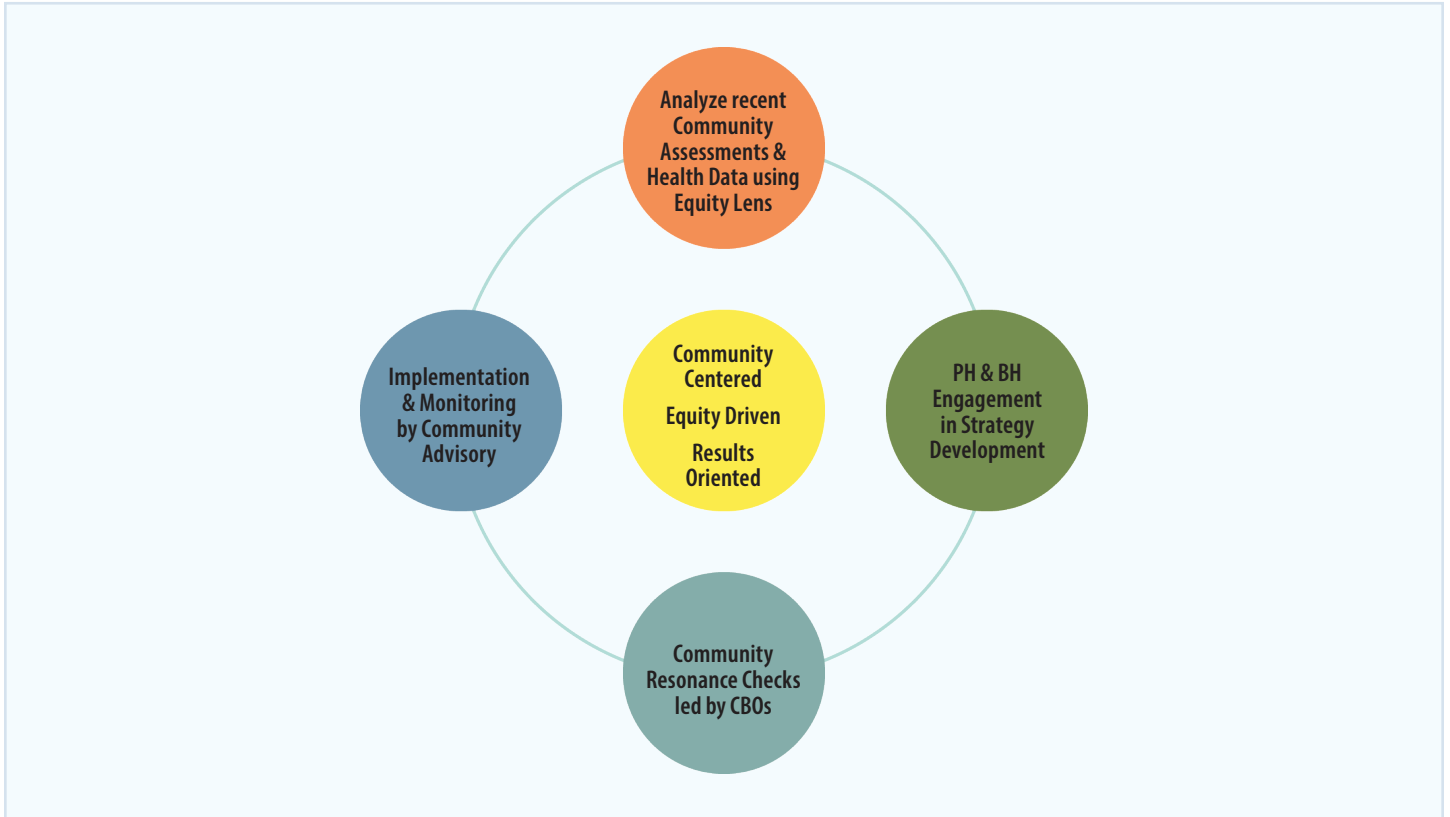
Internal or External	Number of Equity Activities	Percent
External	213	88%
Internal	20	8%
Internal / External	9	4%
<b>Grand Total</b>	<b>242</b>	<b>100%</b>

Five primary themes emerged, providing a strategic foundation for the Health Department’s 16-month Equity Plan and its long-term initiatives.

There were four Collective Impact work groups of frontline team members who functioned as a governance partner and collaborated with the Steering Committee in decision-making.

Summary Common Intersecting Equity Activity	Strategy Topic
<b>Workforce, Culture, and Professional Development</b>	<ul style="list-style-type: none"> <li>» Equity in Hiring &amp; Onboarding</li> <li>» HD Culture &amp; Retention</li> <li>» Employee Training</li> </ul>
<b>Community Health and Clinical Services</b>	<ul style="list-style-type: none"> <li>» Harm Reduction &amp; Fentanyl</li> <li>» Infectious Disease Protection</li> <li>» STI Clinical Services</li> <li>» Healthy Families &amp; WIC</li> </ul>
<b>Environmental Health and Indigenous Sovereignty</b>	<ul style="list-style-type: none"> <li>» Environmental Health Education</li> <li>» Water &amp; Fish Safety</li> <li>» Indigenous Knowledge &amp; Food Access</li> </ul>
<b>Community Advocacy and Urban Planning</b>	<ul style="list-style-type: none"> <li>» CBO Support &amp; Unification</li> <li>» Knowledge Sharing &amp; Trust</li> <li>» Transportation &amp; Built Environment</li> <li>» 50-Year Metro Vision</li> <li>» Legislative Support</li> </ul>
<b>Vulnerable Population Support</b>	<ul style="list-style-type: none"> <li>» Housing Navigation for Underrepresented Populations</li> <li>» Homelessness Mortality Tracking</li> <li>» Mobile Service Mapping</li> <li>» Vector Control</li> </ul>

## Appendix B: Community Health Improvement Plan



### Data & frameworks that inform the CHIP:

- » 24 recent community assessments across MCHD and partner programs
- » Community focus groups and surveys conducted as part of the 2025 Community Health Needs Assessment (CHNA)
- » Prioritized health indicator data
- » Input from public and behavioral health programs
- » Community feedback/resonance checks
- » Strategic plans such as the Comprehensive Local Plan (CLP+), Overdose Prevention and Response Plan, Homelessness Response Action Plan, Health Equity Action Plan, etc.
- » Decisions made during the Federal Response planning
- » 10 Essential Public Health Services
- » Public Health Modernization

### Three priorities for community health were identified through a rich analysis of:

- MCHD's 2016 CHIP that was developed through extensive community engagement led by the Oregon Health Equity Alliance (OHEA),
- Community input and findings from the regional 2025 Community Health Needs Assessment (CHNA),
- Community-identified priorities from 24 recent assessments, and
- Current health outcome data identifying racial inequities and rising trends.

## Multnomah County CHIP

<b>Healthy and Connected Communities</b>	<b>Resources Essential for Health, Well-Being and Stability</b>	<b>Access to Equitable Care</b>
<p><b>Goal:</b> All people have access to Inclusive community spaces and neighborhoods that are physically and socially designed to promote health, safety, and belonging.</p>	<p><b>Goal:</b> All people have access to resources and opportunities that support individual, family and community health, well-being and stability.</p>	<p><b>Goal:</b> All people are able to achieve their full potential for health and well-being across the life span.</p>
<p><b>Strategies:</b></p> <ol style="list-style-type: none"> <li>1. Support and promote inclusive community spaces and opportunities to create belonging.</li> <li>2. Empower and support community centered initiatives that prevent violence and promote community safety</li> <li>3. Identify and mitigate physical and behavioral health risks related to environmental hazards and extreme weather events.</li> </ol>	<p><b>Strategies:</b></p> <ol style="list-style-type: none"> <li>4. Improve access to transitional and permanent housing options that support people on their health journey and path to stable housing.</li> <li>5. Ensure access to resources that prevent and mitigate health hazards in the home environment.</li> <li>6. Connect people with resources that support school readiness, high school graduation, and employment opportunities.</li> <li>7. Increase access to nutritious and culturally relevant food and food assistance.</li> <li>8. Promote access to safe, convenient and affordable transportation options.</li> </ol>	<p><b>Strategies:</b></p> <ol style="list-style-type: none"> <li>9. Reduce barriers to accessing care and services.</li> <li>10. Identify and address gaps in care, strengthen system capacity and coordination.</li> <li>11. Champion and implement prevention and health promotion initiatives.</li> <li>12. Provide reliable health information to communities based on science and data.</li> </ol>

## Appendix C: Behavioral Health Comprehensive Local Plan

- » The Comprehensive Local Plan (CLP) is a required plan that reports back to the state. These are requirements that the State funds. This plan will continue to evolve as the funding changes.
- » The info will also be found in the CHIP and other strategic planning.
- » The County Financial Assistant Agreement SFAA requirements for the State funding.
- » From a draft document of the Multnomah County Behavioral Health Comprehensive Local Plan 2026-2027 OHA Feedback Response:

### Description of Community Needs Assessment/Planning

**Process 1.** Describe the population-based community needs assessment process conducted by the County, including how the County:

- a. Coordinated its local planning with the development of the community health improvement plan under ORS 414.575 by the coordinated care organization(s) serving the area
- b. Involved consumers, advocates, families, service providers, schools, and other interested parties in the planning process
- c. Involved the local MH advisory committee described in ORS 430.630(7)
- d. Coordinated with the local public safety coordinating council to coordinate services among the adult and juvenile criminal legal systems, adult and juvenile correction systems and local BH programs to ensure that person with BH disorders who come into contact with the legal and corrections systems receive needed care and to ensure continuity of services for adults and juveniles leaving the corrections system
- e. Determined the types of BH services needed locally, including developmentally appropriate, culturally and linguistically specific services
- f. Determined the types of housing supports needed locally for individuals with BH disorders and their families, including — but not limited to — capacity development, rental assistance, and other barrier removal assistance

As described in Part I, beginning in the Summer of 2024, BHD began to plan - and begin implementation of — the CLP+ effort to reinvent the BHD’s role as CMHP administrator. The planning process included rich assessment work by the County Health Department’s Community Epidemiology Services (CES) team to gather data regarding the needs of our communities. The team took a two-pronged approach to identifying overarching, recurring themes:

- » Conducted a review and crosswalk of recommendations from 12 prior behavioral health needs assessments conducted in Multnomah County over the past 10 years;
- » Conducted a rapid assessment of the capacity of the organizations in Multnomah County that work across the behavioral health continuum of care to respond to the needs of the substance using population.

This effort utilized the CAST assessment methodology, which produces capacity estimates of existing services to identify areas of need within a local care system. From the expansive review and crosswalk initiative, seven recommendations to improve our services for the communities we serve were identified thematically in the reports:

- 1. Promote equity and invest in trauma informed and culturally responsive services:** Develop and fund culturally and linguistically specific behavioral health services, and ensure providers are trained in cultural competency and trauma-informed care;
- 2. Address workforce shortages:** Prioritize workforce support, including pipeline development, training and retaining behavioral health professionals, and ensuring the workforce reflects the community’s demographics;
- 3. Improve Data Sharing and Analytics:** Invest in data infrastructure to track service utilization, outcomes, and gaps, and use this data to inform policy and funding decisions;
- 4. Improve care coordination:** Streamline care coordination and ensure comprehensive service delivery across the state
- 5. Address social determinants of health:** Focus on upstream factors such as housing access, education, and employment to reduce the risk of substance use disorders and support long-term recovery;
- 6. Enhance communication and community engagement:** Develop communication strategies to reach patients and families, and connect providers to each other;
- 7. Improve behavioral health facility capacity:** Invest in physical infrastructure.

## **Findings from the CAST analysis included:**

- » The assessment found that approximately 127,000 adults and 7,000 youth in Multnomah County needed, but did not receive, SUD treatment in 2024;
- » The 2024 service capacity was highest (i.e., lowest unmet need) for harm reduction approaches like naloxone and fentanyl test strip availability and lowest (i.e., highest unmet need) for Level 3 Recovery Residences
- » The analysis showed that Multnomah County continues to have an unmet need for SUD treatment. Harm reduction approaches have been strengthened over time, but further need exists for higher level recovery residences and behavioral health workforce development.

Once those data gathering efforts were completed, the division then launched a series of convenings with local providers of BH and SUD services, as well as representatives from the CCOs that serve individuals in Multnomah County. Provider convenings were split between those who provide services for Mental Health, and those who offer SUD services. Those convenings — in addition to sharing our learnings from the collective literature assessment and CAST survey — allowed us to gather feedback from critical subject matter experts in this work. We had attendees representing mental health and SUD providers rank their priorities, and top consensus from both groups included:

1. Developing the behavioral health workforce
2. Investing in physical infrastructure
3. Providing linguistically and culturally relevant services

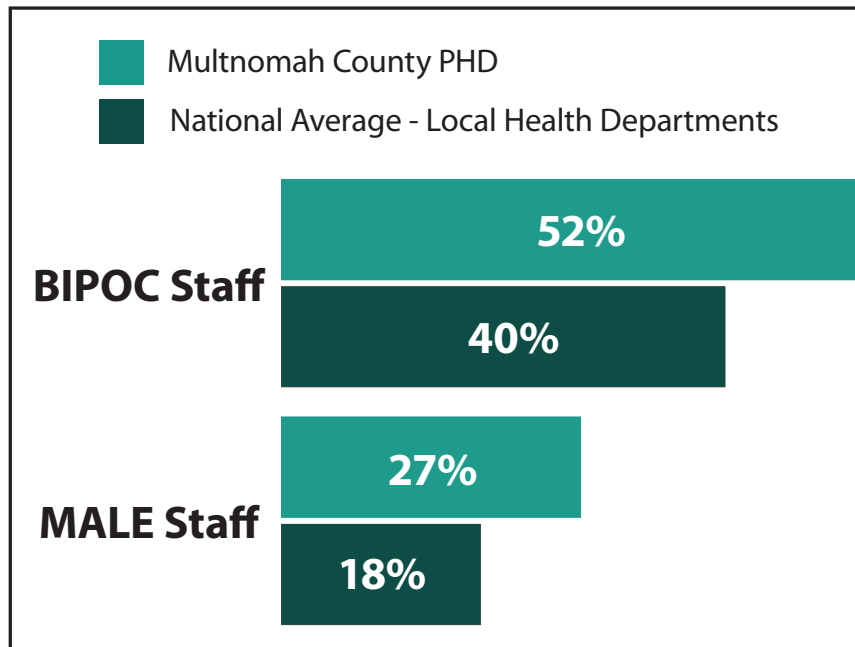
## Appendix D: Public Health Comprehensive Plan (PHD-CP)

In the health equity assessment, both the community partners and internal MCHD-PHD staff agree that MCHD-PHD is moving in the right direction with community outreach and equity efforts. Both community partners and staff also recommend improvements to our systems that will further strengthen community outreach, communication and accountability so that collectively we are implementing health programming that will close the gap in health disparities.

- » In the survey of community partners, partners reported having trusting relationships with Multnomah County Health Department (MCHD) staff (72%)
- » They also reported that the Multnomah County Health Department valued community ideas, provided resources, and communicated openly and honestly (76-63%), generally finding meetings welcoming, comfortable, and easy to attend (94%)
- » Internally, staff voiced frustration that equity efforts lack measurable success and accountability. They pointed to confusing government systems, especially in finance, contracts, and payments, as roadblocks to fair partnerships. They noted that old data systems make it hard to do full demographic analysis and track results. Furthermore, budget cuts to prevention programs were seen as conflicting with stated equity values. Concerns were also raised about unstable leadership, a failure to follow through on new ideas, and confusion among staff about County funding rules, largely due to lack of consistent fiscal training.

In the fall of 2024 MCHD-PHD staff participated in the Public Health Workforce Interests and Needs Survey (PH WINS), a national survey of public health professionals working in state and local public health departments.

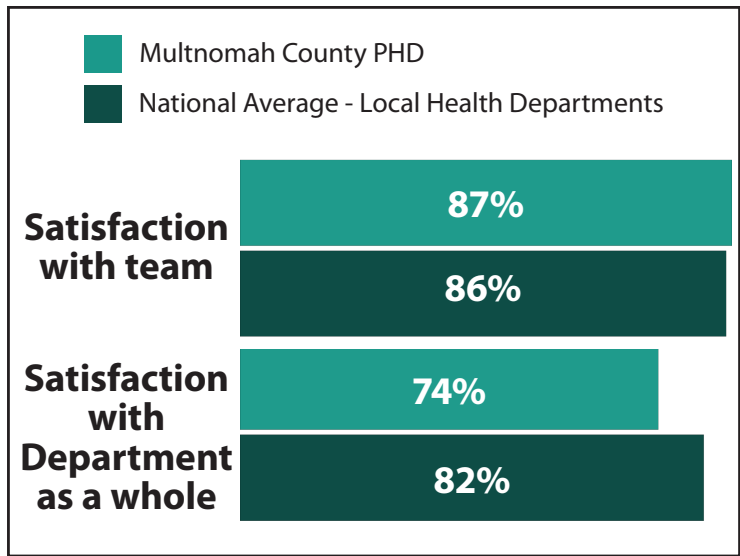
- » Results indicate that MCHD-PHD is more diverse than the national average based on the PH WINS data. Note-as public health is an overwhelmingly female workforce, male gender-identity is also a marker of diversity. This diversity strengthens the division's ability to deliver equitable and culturally-relevant public health services.
- » Staff within MCHD-PHD reported higher levels of unfair treatment than their national peers. Thirty-three percent of BIPOC respondents from MCHD-PHD reported that people (themselves or others) are treated unfairly based on race at work, compared with 17% nationally. That equates to almost twice as much race-based workplace discrimination as the national average.



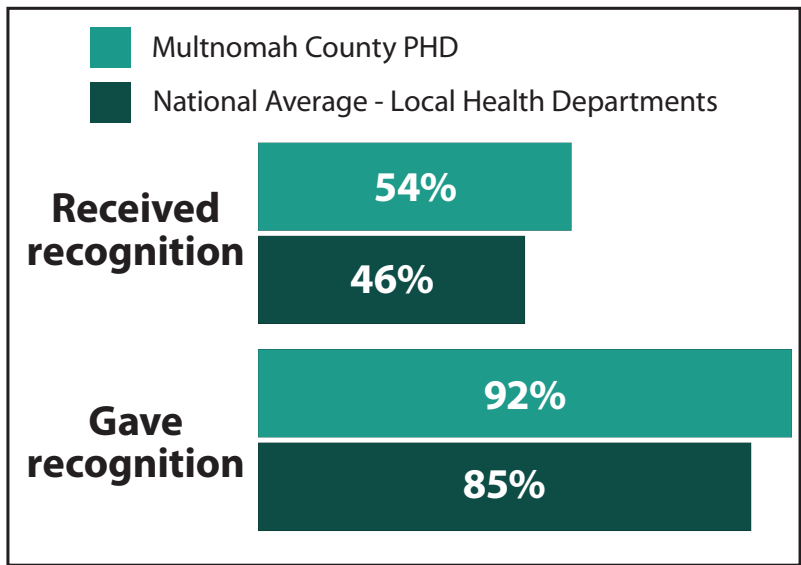
A comprehensive review of the budget and funding requirements defined in the Public Health Modernization manual for each foundational program and capability were reviewed and assessed by MCHD-PHD leadership. The leaders assessed the ability for staff to fulfill each element some or most of the time. The findings suggest that the foundational capabilities with the least amount of capacity throughout the division were in policy and planning and emergency response and preparedness. While the other capabilities were assessed for their technical elements (as defined in the manual), other data suggests a need to increase capacity in leadership and organizational supports specifically in budget and grant management, as well as in employee wellness and retention, and health equity.

The Public Health Workforce Interests and Needs Survey (PH WINS) results provided important information about staff interests, concerns and training needs. For example, less than one-third of MCHD-PHD staff hold a degree in public health specifically, demonstrating the need for foundational public health training across the division to ensure that staff with diverse academic backgrounds share a consistent understanding of core public health principles. The PH WINS results also highlighted unstable leadership and burnout within MCHD-PHD, with those issues driving some staff to want to leave.

- » In addition, while 87% of MCHD-PHD employees reported feeling a sense of belonging within their immediate work units, fewer reported feeling a sense of belonging within the division as a whole (8 percentage points lower than the national average).

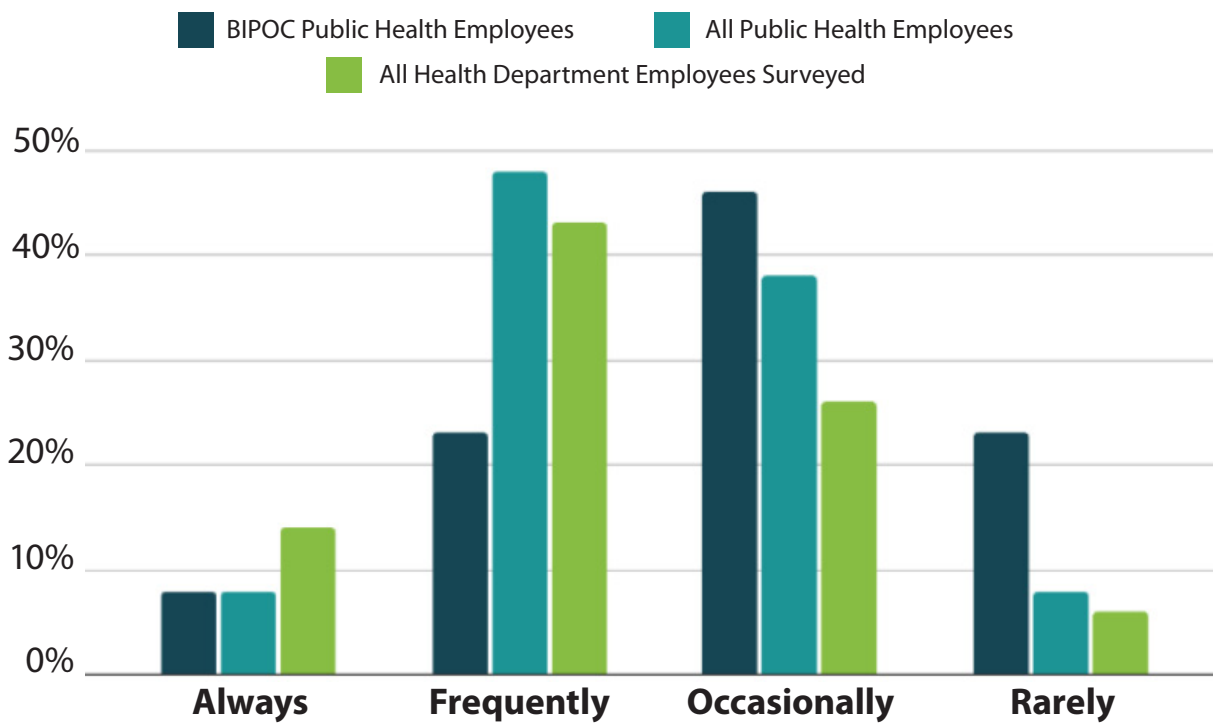


» BIPOC staff reported substantially weaker connections to colleagues than other MCHD-PHD employees (31% of BIPOC employees felt connected to colleagues vs 44% of all MCHD-PHD employees). Employees of color also were less likely to receive recognition for their efforts at work compared to the overall MCHD-PHD employee average. The MCHD-PHD employee experience survey found that BIPOC employees reported both receiving and giving less recognition than the overall employee average.



BIPOC MCHD-PHD employees reported feeling less connected on average than other employees. Specifically, a higher number of BIPOC MCHD-PHD employees reported feeling rarely or occasionally connected to people they work with, compared to all MCHD-PHD employees and all MCHD employees (see chart below). In addition, a lower number of BIPOC MCHD-PHD employees felt ‘always’ or ‘frequently’ connected with fellow employees, as compared with all MCHD-PHD employees and all MCHD employees.

# *“I feel connected to the people I work with in Public Health.”*

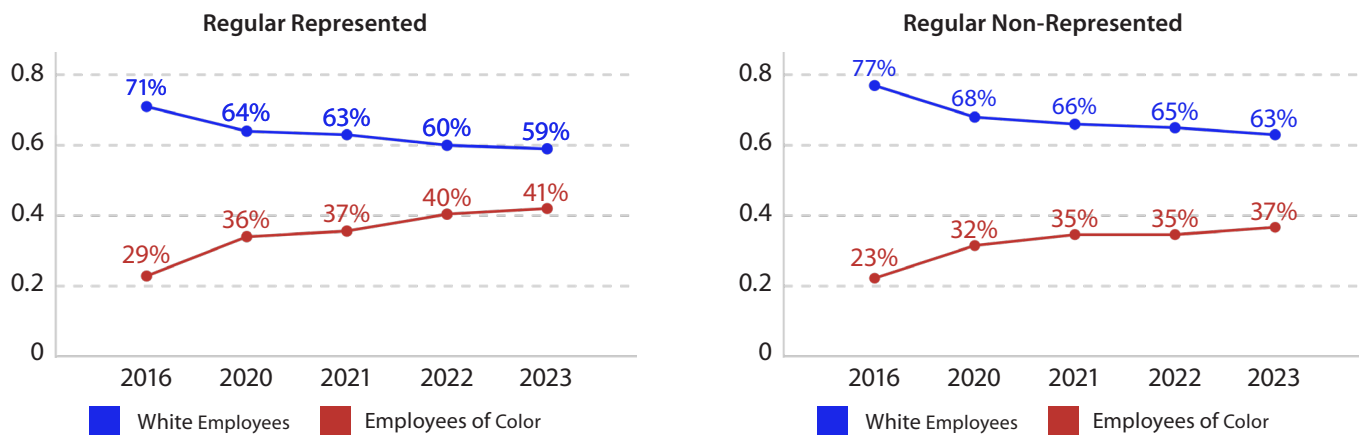


## Appendix E: Workforce Equity Strategic Plan

Please see [WESP-Renewal-2024-v2\(4\).pdf](#) for further details.

The 2019-2022 Workforce Equity Strategic Plan represented a significant shift in our approach to identifying and addressing issues within our organization. As we have implemented that plan over the past few years, we have successfully developed an equity infrastructure that has matured to effectively collaborate and systematically tackle workforce equity disparities. While initially focused on diversifying our organization, we have evolved to confront a broader spectrum of equity concerns, including race, gender, sexuality and ability. Even with our progress, we still struggle to acknowledge and address anti-Black bias within our equity frameworks. Furthermore, the organization’s increasing diversity, including transgender employees, highlights the need for robust support infrastructure for both employees and managers. The increase in diversity does not signify the resolution of issues, but rather necessitates a shift toward culturally specific human resources (HDHR) strategies. This includes targeted training, conflict resolution and support for managers working with a more diverse workforce.

### Changes in Workforce Diversity, Multnomah County Employment Trends



### Many workgroups were established to enhance the WESP work.

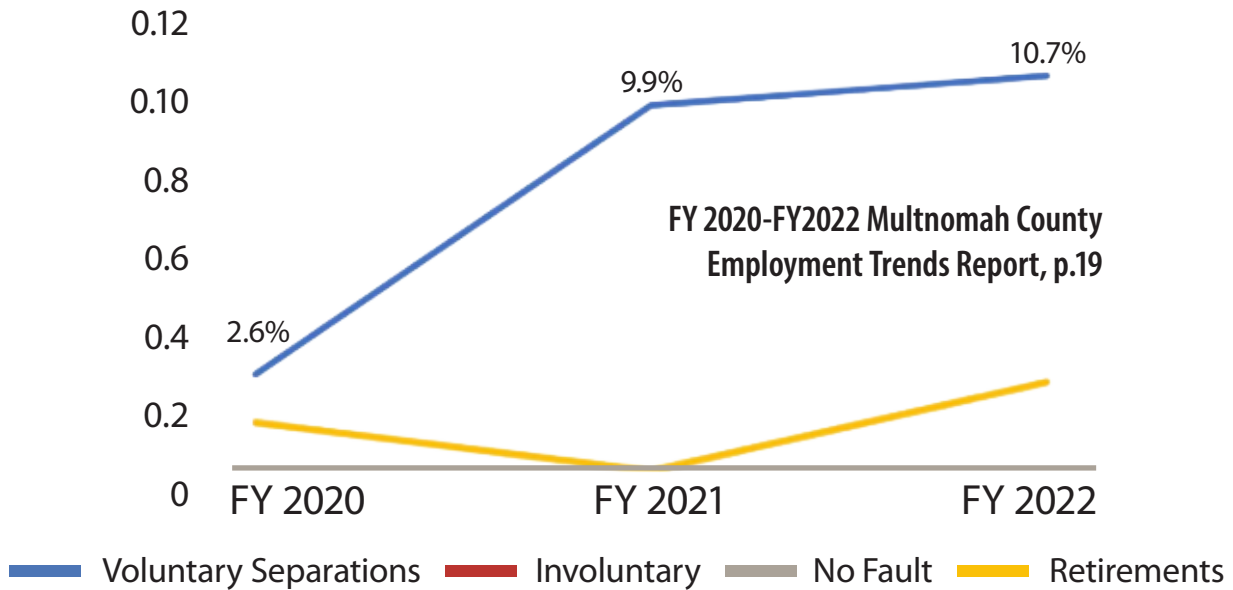
The LGBTQIA2S+ Workgroup Queer and transgender employees of color experience overlapping forms of discrimination in racism, homophobia and transphobia that prevent the LGBTQIA2S+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual or agender, and two-spirit) community from truly feeling a sense of Safety, Trust, and Belonging. Among the recommendations that were created, the group identified the most critical focus areas as Accountability and Retention, because the County cannot retain its transgender staff without having accountability. To that end, the

workgroup felt the most urgent need to improve gender equity at the County is the creation of a Transgender/Gender Diverse Committee, composed of County employees who identify as trans or gender diverse, to oversee the implementation of the WESP benchmarks and other countywide actions that address transphobia. This would ensure that work related to trans employees is guided and directed by trans employees, providing countywide coordination and consistency throughout the departments from the perspective of lived Experience. Other recommendations heavily emphasized the need for gender equity training that is mandatory for all employees, especially executive leadership, managers, and supervisors, to develop skills related to conflict resolution and mitigating microaggressions.

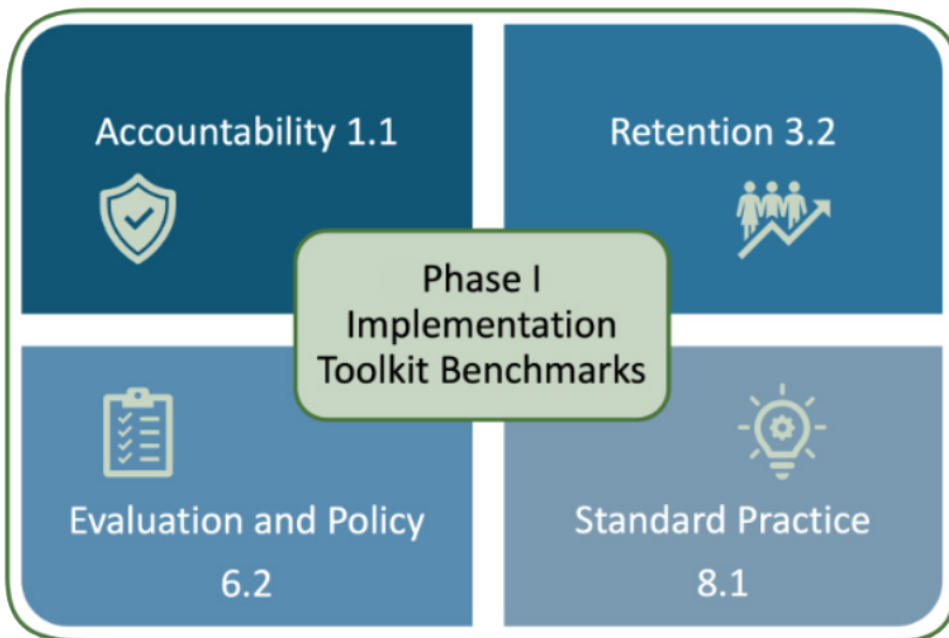
The Disability workgroup was established. 22% of Multnomah County employees who took the Countywide Employee Survey identified as having one or more disabling conditions/disabilities. This is in-line with worldwide numbers that estimate 20-25% of the population have a disability. In contrast to the percentage of employees who indicated having disabilities in that anonymous survey, only 5% of employees identify as disabled in Workday. This discrepancy limits our ability to analyze employment trends data, such as hirings, separations, and promotions due to the small sample size. It especially impacts the opportunity to disaggregate data and better understand the experiences of disabled employees of color and/or disabled LGBTQIA2S+ staff. The most urgent recommendation identified by disabled employees is the need for a centralized HDHR unit to facilitate ADA accommodations.

The Managers of Color workgroup created. A number of recommendations highlighted the need to develop strategies, processes and supports to assist managers of color and improve their retention across the workforce. Specifically, there was a requirement to create a needs assessment tailored for managers of color concerning their training needs and professional development. The needs assessment would identify gaps in learning and development opportunities critical to the success of managers of color. Findings from the needs assessment would inform collaborative efforts between Organizational Learning (OL), Managers of Color (MOC), and ODE in developing learning needs and professional development opportunities, as well as developing retention strategies for managers of color.

## Separation Rate for Regular Nonrepresented Black Employees



The WESP Renewal is broken into phases: Please see [WESP Implementation Action Plan Brief](#) for further details.



## Appendix F: Countywide Equity Audit Report (CEAR)

For more details please refer to [Countywide Equity Audit](#)

### Equity Maturity Model Performance : **Countywide Equity Audit findings**

Phase I: Initiating Equity	Performance	Description
Equity vision	Implemented	HD has an equity vision.
Equity data collection and analysis	Not Implemented	HD does not conduct data collection and analysis of equity data.

Phase II: Readiness	Performance	Description
Equity plan	Not Implemented	HD does not have an equity plan.
Individuals have taken equity trainings	<b>Above Average</b>	75% of HD employees completed training in Workday.
Equity staff	In Process	While HD has recently hired a Deputy Director of Policy, Strategy, and Equity position, the department currently lacks an equity manager.

Phase III: Establishing an Equity Infrastructure	Performance	Description
Comprehensive equity training plan	Implemented	HD has an equity training plan.
Regular tracking of equity initiatives	Not Implemented	HD does not track equity initiatives
Percent who say they have opportunities to provide feedback to their supervisor	Average	The 2023 countywide employee survey found that 87% of HD employees have opportunities to provide feedback to their supervisor.

Phase IV: Sustaining Equity	Performance	Description
Percent who say they feel like they belong in their department	Average	The 2023 countywide employee survey revealed that 82% of HD employees feel a sense of belonging within their department.
Percent who say the workload in their unit is properly distributed	Average	According to the 2023 countywide employee survey, 56% of HD employees indicated that the workload in their unit is properly distributed.
Equity practices are embedded in decision-making processes	Average	HD has embedded equity practices in a few decision-making processes, such as recruitment and budgeting processes.

**Auditors recommend that the Health Department implement the following, no later than March 1, 2026:**

1. Hire an equity manager.
2. Advocate to the Board for funding to build capacity for equity data collection and analysis to inform equity efforts.
3. Develop a comprehensive equity plan that outlines specific goals, strategies, and initiatives for advancing equity.
4. Establish a centralized system for monitoring and evaluating the effectiveness of all equity initiatives. This system should include clear metrics, standardized reporting procedures, and a mechanism for collecting feedback from both employees and the community.
5. Investigate the concerns raised in the countywide employee survey regarding responding to discriminatory behavior and report to department staff on findings and steps for improvement.
6. Embed equity practices in all decision-making processes.

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