OCTOBER 2022

PHD Workforce Development Plan

2022 – 2027

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
POPULATION HEALTH DIVISION

PHD Workforce Development Plan

San Francisco Department of Public Health

Population Health Division

This plan has been approved and adopted by the following individuals:

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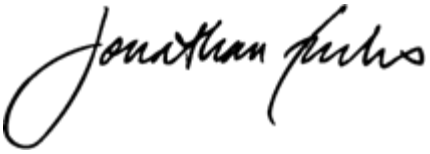

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Adopted on October 1, 2022

Record of Review and Revisions

Revision Date	Section of Plan Revised	Revised by

PHD Workforce Development Plan

A. Introduction

As we mark our fifth year as an accredited local health department and prepare for our first reaccreditation process, the SFDPH aims to meet or exceed the associated domain standards and measures, including the 10 Essential Public Health Services. As a requirement of Domain 8, this **Workforce Development Plan** has several goals including 1) describing the makeup of our current public health workforce, 2) sharing the frameworks that underpin our approach to recruiting, retaining, sustaining and training a diverse and talented staff, 3) summarizing available data on the capacity and capabilities of our workforce as well as the current state of our Division's efforts to advance equity, and 4) articulating a number of data informed strategies and activities that will help to address key gaps in capacity, capabilities, and equity.

This plan is closely aligned with our Division's strategic priorities (**Appendix A**), in which we have identified **7 True North goals** that describe the ideal direction and purpose of PHD while serving as the basis for defined organizational targets and goals. Among them are a focus on **Workforce** by *creating an environment that respects, values, and invests in all our people* and **Equity** by *combatting institutional racism through organizational change*.

Figure 1: SFDPH Population Health Division's 7 True North Goals

Within PHD, three branches work hand-in-hand to organize and coordinate Division-wide efforts to advance workforce development through an equity lens: **the Center for Learning & Innovation** (CLI), **PHD Operations**, and the **Office of Anti-racism and Equity (OARE)**. Each have gathered insights from several sources and partnered with Division leadership, PHD staff, and SFDPH Human Resources to put forward a series of feasible and impactful activities to develop our people—our most valuable resource to help us achieve our collective vision of making San Francisco the healthiest place on earth.

It's important to acknowledge that we have formulated this plan at an extraordinary time in the history of public health. Our comprehensive and ongoing response to the COVID-19 pandemic and Monkeypox (MPX) outbreak, the profound burden of fentanyl-associated overdose deaths, the complex health needs of our unhoused population, and more frequent and extreme heat events have placed unprecedented demands on our core infrastructure and have revealed vulnerabilities in both the capacity and capabilities of our workforce. SFDPH has recently managed three simultaneous activated departmental operations centers (DOCs) and PHD has provided key leadership as subject matter experts, coordinated the public health emergency responses, and hired temporary exempt staff or deployed established staff from PHD's existing Branches, Programs and/or Operations. In fact, over 50% of PHD's workforce has been deployed through these emergency activations. It is through this lens that we take stock of

PHD's incredible achievements over the past several years while reflecting on how we can better support and prepare staff as we face current and future public health challenges.

B. Location and Populations Served

San Francisco is a 7x7 mile urban jurisdiction located in the wider Bay Area, the fourth largest city in California. According to the most recent census, San Francisco has a population of 873,965 residents and is the second densest city (people per square mile) in the United States.[1] It is also known to be one of the most racially and ethnically diverse cities in America with significant income inequality and persistent health disparities across a wide range of conditions as described in the Community Health Needs Assessment (**Appendix B**). While our department focuses on the health of every San Franciscan, we have an expressed commitment to provide health promotion, disease prevention, and health care delivery services to populations that have been marginalized due to structural racism and thus, have limited access to these resources.

C. Governance

San Francisco is the only consolidated city and county in California and operates as a charter city. The city is governed by the Mayor and Board of Supervisors. The San Francisco Public Health Commission is composed of commissioners appointed by the Mayor who govern and make policy for SFDPH. The San Francisco Health Commission is mandated by City and County Charter to manage and control the City and County hospitals, to monitor and regulate emergency medical services and all matters pertaining to the preservation, promotion, and protection of the lives, health, and mental health of all San Francisco residents.

D. Organizational Structure

SFDPH is an integrated health department with two primary roles and two major divisions to fulfill its mission: 1) Protecting the health of the population, which is the primary responsibility of PHD; and 2) Providing healthcare and promoting the health of our patients, which is the primary responsibility of the San Francisco Health Network (SFHN). SFDPH's central administrative functions, such as finance, human resources, information technology, and policy and planning, support the work of SFDPH's two divisions and promote integration. The total SFDPH workforce is approximately 8,000; at PHD, the workforce is significantly smaller with approximately **540 employees**, comprised of permanent civil service, temporary exempt and/or contract staff. Susan Philip, MD, MPH, the Director of PHD, also serves as the County Health Officer. The organizational chart for the SFDPH and PHD can be found in **Appendix C.**

E. Current Capacity

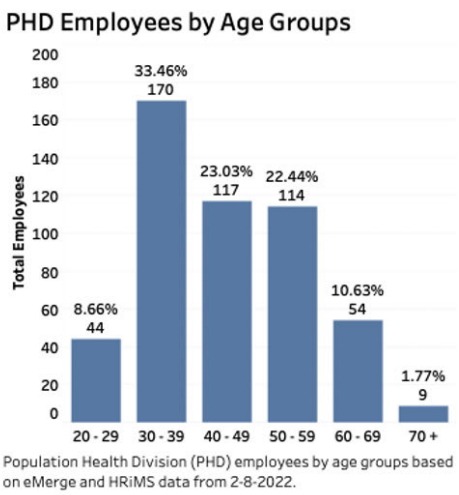
There are several data sources to evaluate our current capacity and benchmark to other health departments. These include data from SFDPH HR as well as the **Public Health Workforce Interests and Needs Survey (PHWINS)** conducted in the Fall of 2021, the results of which were made available to us in Summer 2022. We have chosen to benchmark our local data to the PHWINS summary measures from the Big Cities Coalition (BCC), reflecting 35 large urban health departments in the United States. Our response rate for PHWINS 2021 was 32%, somewhat higher than the BCC (28%). In addition to summarizing our data, we will highlight some key strengths and gaps shared by Directors and Managers during one-on-one structured interviews and focus groups conducted in mid 2022. These gaps will be a key focus of our workforce development strategies and activities to bolster capacity over the next 5 years.

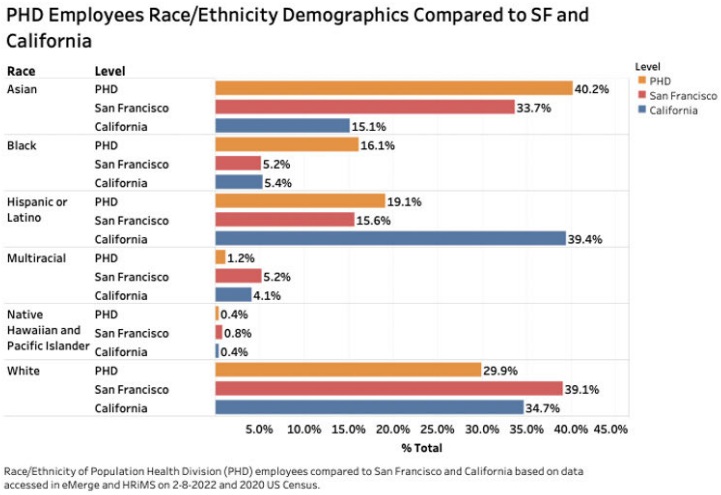
E.1 PHD Workforce profile

E.1.1 Demographic profile

Data on workforce demographics have been obtained from SFDPH Human Resources (HR) and reflect our civil service employees, both permanent and temporary. Approximately two thirds of Division staff identify as women, and as seen in **Figure 2A**, one third are 30-39 years of age, while approximately 13% are over the age of 60, suggesting a significant proportion of the PHD's current workforce are approaching the age of retirement- an important consideration for workforce and succession planning. **Figure 2B** shows the racial and ethnic breakdown of staff in comparison to the population of San Francisco, and of California. Overall, PHD's staff is diverse, with 70% self-identifying as Black, Indigenous, People of Color (BIPOC), and for most groups, the proportion is higher than in San Francisco except for those who identify as multi-racial or Hawaiian and Pacific Islander. Of note, the number of Native American-identified staff is not reflected in the figure due to small numbers.

Figure 2: Demographic characteristics of the PHD workforce by A) Age and B) Race/Ethnicity



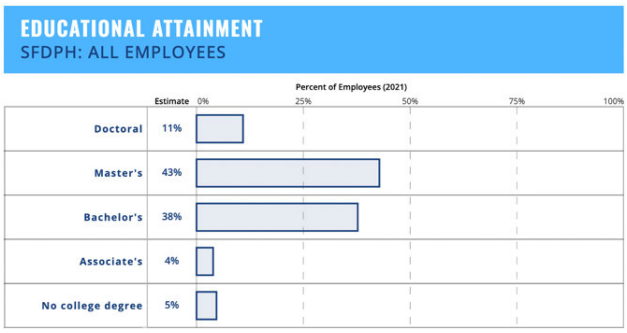


The demographics of our workforce are like that of the BCC (approximately half between the ages of 30-50, and 68% BIPOC-identified) however women represent a larger proportion of the BCC workforce overall compared to PHD (76% vs 63%).

E.1.2 Educational attainment

Data on educational attainment were derived from PHWINS 2021. As noted in **Figure 3**, 54% of our workforce has an advanced degree whereas 46% of the BCC respondents noted this level of educational attainment (38% with a Master's degree and 8% with a Doctoral degree). In addition, 26% of PHD staff have a specialized public health degree compared to 20% of the BCC cohort.

Figure 3: Educational attainment of PHD Employees



E.1.3 Supervisory Status/Job Role

According to PHWINS 2021, 64% of PHD staff are in a non-supervisory role compared to 71% of BCC staff. In addition, 52% of staff are in public health sciences classifications (compared to 44% of BCC jurisdictions) which include program staff, epidemiologists, and contact tracers, among others.

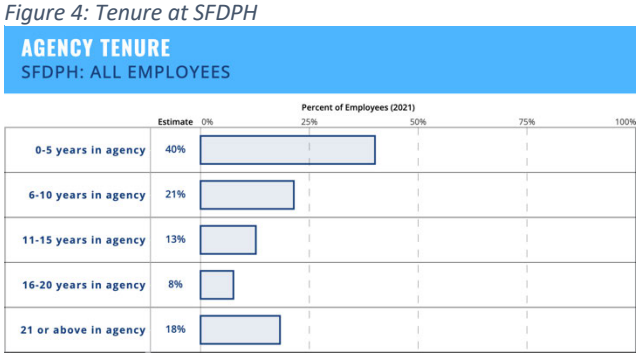
E.1.4 Program Areas

PHWINS respondents identified relevant program areas in which they were employed. The top 4 categories include communicable disease (27%); other health care, including immunizations and substance use services (28%); chronic disease and injury (17%); and organizational competencies such as administrative support, workforce development and other business services (11%). This breakdown is consistent with other BCC jurisdictions.

E.1.5 Tenure at Agency

Among San Francisco PHWINS respondents, 40% reported working for the department for 5 years or less (**Figure 4**) compared to 50% of respondents reporting this tenure across BCC jurisdictions. On the other hand, 18% of San Francisco employees have served 21 or more years at the department compared to 13% of employees at BCC-affiliated agencies. Based on the age distribution of our employees, and the long tenure for many SFDPH employees, focused efforts to plan for succession are a high priority for PHD.

Figure 4: Tenure at SFDPH



E.1.6 Intent to leave/stay

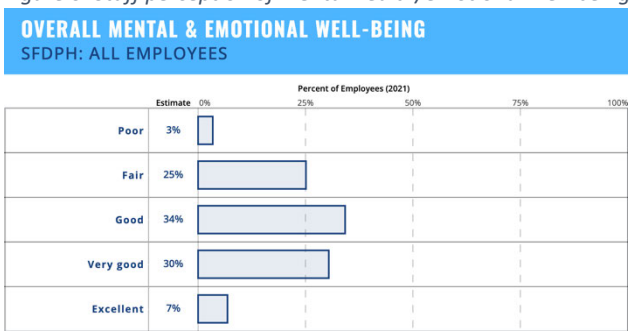
The capacity of our workforce is heavily dependent on our ability to retain talent. Among PHWINS respondents, 17% reported they were planning on retiring in the next 5 years while **29% of respondents shared they were planning on leaving in the next year**, not due to retirement-- a rate similar (30%) to that of other BCC jurisdictions. Understanding these employees' reasons for leaving is critical for improving recruitment and retention. As seen in **Figure 5**, the top reasons for leaving include perceived **lack of advancement opportunities**, organizational culture, work overload/burnout, stress, and lack of recognition. Work overload and burnout as well as stress (41% and 37%, respectively) were also top reasons among BCC staff who intend to leave. While in San Francisco the percent of those reporting a perceived lack of advancement opportunities as a reason to leave in the next year declined compared to 2017, it is still the primary factor threatening loss of staff outside of retirement and must be the focus of concerted efforts to retain staff.

Figure 5: Top reasons for those intending to leave SFDPH

E.1.7 Staff well-being

Capacity of staff to perform their work is highly dependent on mental and emotional wellbeing--domains assessed by PHWINS. In the most recent survey (**Figure 6**) approximately **28% of respondents reported that their mental health and emotional wellbeing could be characterized as "poor" or "fair"**, consistent with other BCC health departments. Across all agency types, executives reported worse mental health than other employees (data not shown). Predictors of fair to poor mental health were not elucidated in PHWINS reporting, however, it's notable that 29% of respondents reported that they had experienced 3 or more symptoms consistent with probable post-traumatic stress disorder related to the COVID-19 pandemic and our public health response.

Figure 6: Staff perception of mental health/emotional well-being



E.2. Strengths in capacity

Our response to the COVID-19 pandemic required a dramatic increase in our capacity to conduct case investigation and contact tracing activities. Strong partnerships with UCSF and community groups were instrumental in expanding this capacity over the course of the pandemic.[2] With supplemental funding from the CDC, our Disease Prevention and Control branch established a new program called the **Reserve for Accelerated Disease Response (RADR)**. The goal of RADR is to ensure we can rapidly scale our Disease Investigation Services (DIS) response by cross training PHD's DIS staff across HIV/STI partner services and linkage, communicable disease, TB Control and Surveillance, and Communicable Disease Prevention Unit staff within the Adult Immunization and Travel Clinic. This new capacity was tapped during the MPX outbreak as we needed to rapidly scale case investigation and contact tracing as part of the response. Another recent example of efforts to increase staff capacity is a new Ending the HIV Epidemic-funded community health worker training program launched in collaboration with the San Francisco AIDS Foundation. **The San Francisco Community Health Academy** is a free training program offered in Spanish and English to enlarge this vital workforce and strengthen their population health skills. More information on these two programs can be found on the CLI-hosted Learning Management System, learnsfdph.org, where curricula for these and other programs are deployed.

E3. Gaps in capacity

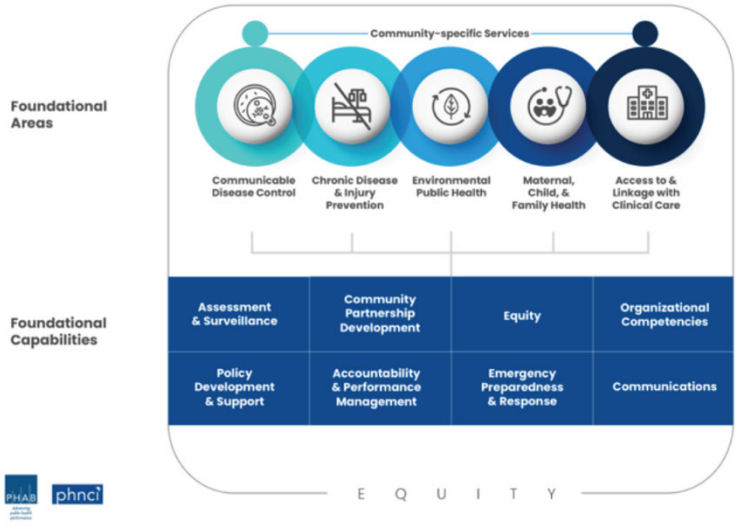
Our most significant gap in current capacity is a **critical 27% civil service position vacancy rate across PHD** which burdens an already taxed extant workforce and contributes to staff burnout. Fortunately, through the FY22-23 budget allocation process, PHD has received 50 new FTE to staff a wide range of critical positions and an additional 14.5 FTE will be hired through CDC OE22-2203, locally known as **Project INVEST** (**IN**ovations that **V**alue **E**quity and **S**trengthen **T**eams). Project INVEST seeks to bolster PHD's infrastructure in training, operations (liaisons to facilitate hiring, grants management, contracting), data visualization, communications, and equity. As will be discussed in Section H, **addressing hiring inefficiencies**, and a **revamping our New Employee Orientation (NEO)** are steps needed to rapidly hire and onboard new and vacant positions – a 20% increase in the PHD workforce over the next year. Finally, our workforce data and loss of several PHD leaders over the past 3 years

have underscored the acute need for careful **succession planning** and to fortify **advancement opportunities** to strengthen retention.[3] [4]

F. Current Capabilities

The SFDPH is dedicated to developing a sufficient number of qualified staff at all levels (non-supervisory, supervisors, managers, and executives) to deliver the **10 essential services of public health** (**Appendix D**). We have adopted the **Foundational Public Health Services (FHPS)** framework which was developed in 2013 to reflect the unique responsibilities of governmental public health. As seen in **Figure 7,** equity was added as an eighth Foundational Capability in 2022, elevating its importance as a cross-cutting skill and capacity needed to advance community health, particularly among those facing structural barriers that impede health promotion, disease prevention, and the ability to prepare for, and respond effectively to emergencies.

Figure 7: Foundational Public Health Services Framework

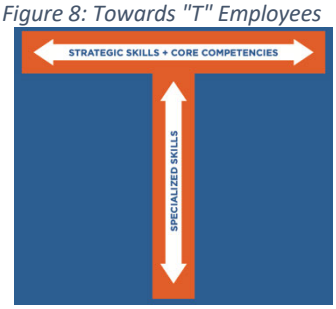


Assessment questions from PHWINS 2021 are directly linked to the **Core Competencies for Public Health Professionals** developed by the Council on Linkages between Academia and Public Health Practice (Council on Linkages). The Core Competencies reflect foundational or crosscutting knowledge and skills for professionals engaging in the practice, education, and research of public health. In addition to these core competencies, we have adopted the **Racial Justice Competencies for Public Health Professionals**, developed by a collaborative group from the Public Health Training Center Network (PHTCN), and published in October 2022 (**Appendix E)**. These will be integrated into future training needs assessments. In addition, the SFDPH has **several mandatory trainings** for all staff covering locally adopted capabilities including, but not limited to, trauma informed systems, consistently collecting sexual orientation and gender identity (SOGI) data, and harm reduction principles (**Appendix F**). Finally, listening session data from Directors and Managers also inform perceived strengths and gaps in capabilities that will be the focus of our countermeasures.

F.1. Training Needs/Skill Development

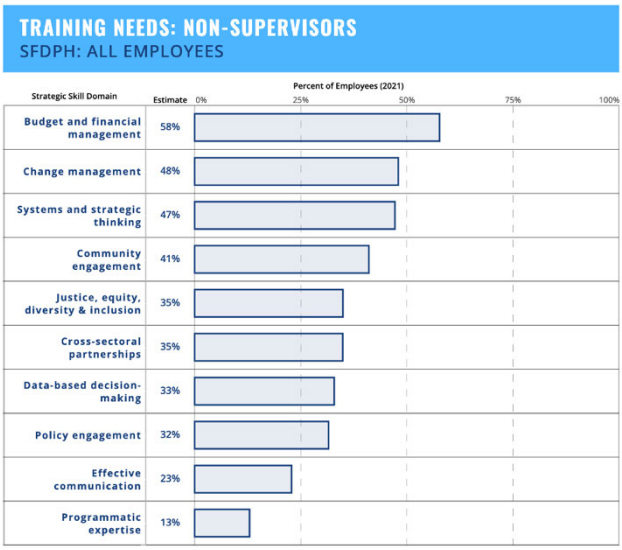
PHWINS 2021 respondents were asked to rate the day-to-day importance of, as well as their own proficiency with 25-26 skill items tailored for their supervisory level. Skills were collapsed into **10 strategic skill categories**. A training need is a skill item reported as having high importance, but low proficiency. According to a recent report by the de Beaumont Foundation, “Adapting and Aligning Public Health Strategic Skills” (March 2021), identifying training needs can help support strategies to produce “T-employees”—those that have depth in technical skills and breadth in strategic skills (**Figure 8**).

Figure 8: Towards "T" Employees



As seen in **Figure 9**, non-supervisory staff have prioritized development in several strategic skill and core competency areas including: 1) budget and financial management, 2) change management, 3) systems and strategic thinking, 4) community engagement, and 5) justice, equity, diversity and inclusion. These are consistent with training needs identified nationally across all supervisory levels. The top 5 areas of training needs among PHD supervisors, managers and executives closely parallel those identified by all staff and they include 1) budget and financial management (66%), 2) systems and strategic thinking (61%), 3) community engagement (59%), 4) policy engagement (49%), and 5) cross-sectoral partnerships (44%). These areas also have been prioritized by agencies at the national level.

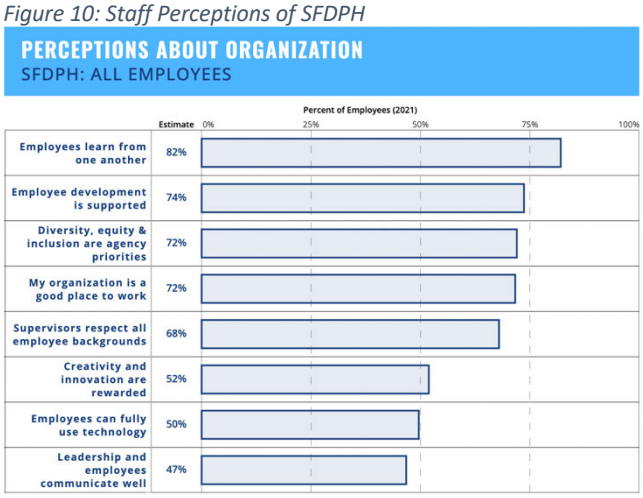
Figure 9: Prioritized Strategic Skills for Non-Supervisory Staff



F.2 Perceptions of the Organization

In addition to the training needs questions, PHWINS 2021 assessed several perceptions of the organization that have implications for our efforts to strengthen capabilities. As seen in **Figure 10**, overall perception of PHD employees is positive, with over 82% reporting that they learn from another and three fourths report that employee development is supported. However, there are several areas with significant room for improvement: less than **half of respondents reported leadership and employees communicate well** and staff **cannot fully use technology**, mirroring results from PHWINS 2017.

Figure 10: Staff Perceptions of SFDPH



F.3. Strengths in Capabilities

San Francisco has been at the forefront of **engaging community partners** to drive the planning and implementation of our HIV treatment and prevention response—an integral part of what is known globally as the San Francisco Model. These partnerships have been leveraged and strengthened during our COVID-19 and MPX public health responses, leading to one of the lowest COVID-19 mortality rates of any metropolitan areas in the U.S.[5] and effective containment of the MPX outbreak with the ending of the public health emergency on October 31, 2022. In addition, staff point to the strength of our health department's **data-driven approach to inform programs and policies** and ability to **conduct cutting edge research**. Trauma informed systems, SOGI, cultural humility, harm reduction, and Lean methodologies were universally praised by staff during formal listening sessions. Finally, PHD teams co-lead several **cross-sector partnerships** in the areas of HIV/AIDS[6] (*Getting to Zero*), pedestrian safety (*Vision Zero*), food security (*Food Security Taskforce*) and preterm birth among Black/African American and Pacific Islander women and birthing people (*Expecting Justice*), among others. In 2018, CLI

convened a DPH-wide Collective Impact Community of Practice so staff leading these cross-sector efforts could share best practice and lessons learned.

F.4. Gaps in Capabilities

Listening sessions underscored the need to **strengthen internal communications** while also focusing on our need to **improve external communications** by bolstering PHD **staff capabilities to work with multi-language media**. During the COVID-19 pandemic, few front-line staff with Spanish and Chinese language capabilities received formal training in messaging and working with these media channels. Media training that applies best practices in communication science is needed. In addition, during the COVID-19 activation, several new software applications were introduced without formal, organized training including Microsoft Teams, Zoom, and Sharepoint, further exacerbating the concern by many staff that they **can't fully use technology tools** at work. Finally, several training gaps were identified through PHWINS 2021, including topics such as **budget and financial management** for which the department currently lacks formal training for both front line and management staff.

G. Equity

G.1. Equity assessments

Efforts to advance racial equity continue to be at the forefront in PHD. Every department in San Francisco city government is required to submit a **Racial Equity Action Plan (REAP),** started in December 2020 and implementation began in 2021. Six domains of the SFDPH Office of Health Equity-led REAP focus on workforce development priorities (e.g., hiring and recruitment, retention and promotion) (**Appendix G**). The findings from three equity assessments can be found in **Appendix H**: 1) the Governmental Alliance for Racial Equity survey, 2018 2) the 2019 Press-Ganey SFDPH Employee Survey on staff engagement, and 3) the Racial Equity Self-Assessment, 2021.

In 2018, we urged future iterations of PHWINS to assess employee perceptions of anti-racism efforts in their respective organizations[7] and were heartened to see several questions integrated into the 2021 survey. It's notable that the vast majority of PHD respondents (92%) believe addressing racism as a public health crisis should be part of their daily work at the health department, however 28% report little or no personal engagement in these efforts. Further, **over half (55%) shared that additional training is needed** to support this goal.

For each of our staff-wide assessments, we should strive to stratify data by race and ethnicity to provide a more complete picture of current gaps in our approach to mitigate racism both internally and externally. For example, in our SFDPH 2019 Staff Engagement survey (**Table 1**), Black/African American staff were the least likely to report feeling comfortable talking about race and racism in the

Table 1: Staff perceptions of racial equity efforts, 2019

Question	PHD	Asian	Black	Latinx	White
I feel comfortable talking about race and racism in the workplace	50% n=382	44% n=137	38% n=50	60% n=52	56% n=132
My department is taking active steps to improve racial equity.	58% n=368	55% n=126	41% n=49	60% n=52	65% n=130
Managers in my department treat staff from all racial/ethnic groups with respect.	75% n=389	76% n=142	59% n=51	76% n=55	78% n=130
Staff in my department treat community members from all racial/ethnic groups with respect.	76% n=385	78% n=139	53% n=51	76% n=55	80% n=129

% Diff -30.6% 30.6%

The percent Population Health Division (PHD Employees that Responded Favorably (4-agree or 5-strongly agree) to questions on the 2019 SFDPH Employee Survey.

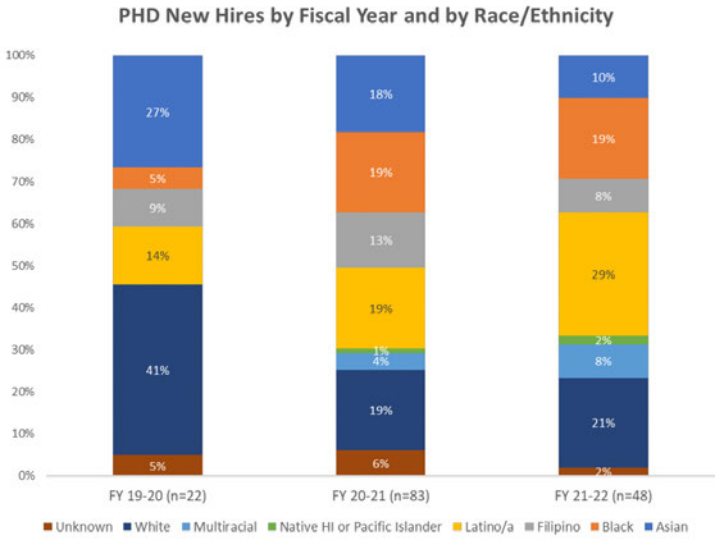
workplace and that the department is taking active steps to improve racial equity.

Based on these data and ongoing concerns about anti-Black racism across the department, PHD established the Office of Antiracism and Equity (OARE) in 2021 to organize internal equity-focused efforts. Again, we also turn to key themes that emerged from our listening sessions to highlight key strengths and areas for improvement.

G.2. Strengths in Equity

We have observed an **increase in the racial and ethnic diversity of PHD hires** over the past three years (**Figure 11**), particularly for Black/African American and Latinx employees. These increases correspond to concerted efforts to recruit from diverse communities through the COVID-19 response. In addition, the SFDPH Office of Health Equity hosts a weekly learning opportunity through the **Black African/American Health Initiative (BAAHI)**. These are well attended and highly valued. Participation in these sessions help DPH staff meet their minimum of 4 hours of equity-focused training per year. In addition, PHD branches host several **internship programs** focused on high school, undergraduate and graduate trainees from historically underrepresented groups in public health, many of whom go on to join the SFDPH workforce [e.g. FACES for the Future, the NIH-funded Summer HIV/AIDS Research Program (SHARP), and the CDC-supported Population Health Scholars program]. Finally, our hyperlocal community-based COVID-19 vaccine sites[8] located in neighborhoods with the highest burden of COVID cases have been instrumental in our **vaccine equity response**, contributing to some of the highest vaccination rates in California among BIPOC populations.[9]

Figure 11: Increasing racial/ethnic diversity of PHD hires, 2019-22



G.3. Gaps in Equity

During our listening sessions, many BIPOC staff have reinforced the lack of advancement opportunities overall and **relatively few staff of color in key leadership positions** within PHD. **Threats to emotional safety** require new support mechanisms for BIPOC staff facing interpersonal racism in the workplace. Additional training and targeted coaching are needed for white staff and other staff with white privilege to mitigate microaggressions that compromise safety for BIPOC staff. Respondents to PHWINS expressed interest in additional training to prepare them to advance anti-racism efforts, which will involve active promotion of existing training in the department (e.g., the BAAHI Learning Series), developing new training and skill building opportunities in PHD, and pointing staff to high quality external training resources.

H. Action Plan

H.1 Theory of Action

Through this workforce development plan, we aim to accelerate efforts to recruit and retain diverse talent. We have adopted the following theory of action that underpins our workforce development strategies **(Figure 12)**

1) Create **robust pipelines and pathways** into PHD through meaningful internships and navigating promising candidates from the diverse communities we serve to employment opportunities within the department;
2) Provide **professional development opportunities** that span training, coaching and mentoring, and focused career development responsive to individual goals;
3) Offer multiple ways to **engage staff** through wellness programs, digital and face-to-face communications, and team building; use data from engagement surveys to guide future interventions; and
4) Seek **promotive opportunities** from within the organization by using a wide range of incentives, including permanent civil service jobs.

Figure 12: Theory of Action to support robust recruitment and retention of diverse talent

H.2. Countermeasures to enhance Capacity, Capabilities, and Equity

Below we outline priority activities to address gaps in workforce capacity, capabilities, and equity, informed by the assessments above, including PHWINS 2021, leadership and frontline staff consultations, and our People Development A3 (**Appendix I**).

H.2.1 <u>Strengthen Capacity</u>: Recruit, retain, and sustain

H.2.1.a. <u>Accelerate hiring efforts</u>. Our highest priority to strengthen capacity is to **fill existing vacancies** with diverse talent. This is critical to meet the ongoing demands on our workforce and to reduce staff burnout. PHD Operations is assembling a task force to work closely with HR and hiring managers to implement several process improvements to expedite hiring.

H.2.1.b. **Enhance our New Employee Orientation (NEO).** Evidence suggests effective staff onboarding predicts retention over time.[10] With over 65 FTE new hires to be onboarded this fiscal year in addition to filling existing vacancies, PHD Operations and CLI are developing an interactive NEO to welcome new staff.

H.2.1.c. Promote career advancement opportunities. At the center of the assessment and staff development process is the **PPAR** (Performance Plan and Appraisal) which is used to **assess training needs** and **set forth professional development goals** for all civil service staff. An equivalent mechanism is in place for contract staff. Unfortunately, the average annual PPAR completion rate across the Division over the last 4 years is 42%. CLI will partner with DPH HR to improve PPAR completion rates by offering training to supervisors through the **PHD Manager Community of Practice**, track PPAR completion rates, and provide regular reminders to supervisors to complete PPARs by the deadline. In addition, CLI and DPH HR team leads can offer **targeted coaching to staff** interested in meeting minimum qualifications for new positions. Recommended strategies can include, but are not limited to, short term placements or stretch assignments to build the qualifications needed for advancement.

H.2.1.d. Develop succession plans. CLI and PHD leadership will adopt a systematic approach to succession planning that will include annual consultation with Branch leadership to identify potential vulnerabilities in key functions should staff leave, and strategically plan pathways for staff, especially staff of color, to advance to leadership positions.

H.2.1.e. Catalyze the collection and use of workforce data to guide workforce planning, development, management, and forecasting. Data on our workforce currently sit within multiple databases. Further identification of key vulnerabilities in our collective capacities and capabilities are needed to inform workforce development efforts. Using funding from Project INVEST, we will partner with our longstanding collaborator, the Oakland-based Public Health Institute (PHI), to conduct a mixed methods gap analysis, integrating stakeholder interviews and HR data review to make recommendations that will guide future workforce investments.

H.2.2 Strengthen Capabilities: Fortify internal/external communications; offer training

H.2.2.a. Host monthly virtual Town Halls. Given remote work through the pandemic for many PHD staff and the need to strengthen communication between senior leadership and frontline employees, PHD Operations will continue to host a monthly virtual town hall to provide key operational updates and feature high impact public health activities. On average, approximately 175 PHD staff participate in these monthly sessions led by our PHD Director and Deputy Director. Session recordings will be stored on a new PHD Operations-organized Sharepoint site to encourage future viewing for those unable to attend.

H.2.2.b. Publish a twice monthly PHD Newsletter. The PHD Operations Branch develops a twice monthly online newsletter to communicate major updates to the Division. The “click through” rate is approximately 40%, suggesting additional strategies are needed to encourage all staff to read the newsletter and access vital content.

H.2.2.c. Coach managers and supervisors on facilitating daily/weekly huddles. SFDPH has adopted Lean Daily Management methodology which provides proper support and leadership to those who are closest to processes. It has been used extensively during the COVID-19 activation, but not all staff have been exposed to it or trained in the methods. We believe we can help address communication gaps between senior/mid-level management and front-line staff through this approach. **CLI has launched a PHD manager community of practice** and will collaborate with the Performance Improvement group in PHD Operations to devote sessions to review techniques and provide one-on-one targeted coaching for leaders seeking to strengthen their skills.

H.2.2.d. Develop a one-stop-shop Training and Professional Development Sharepoint site. Staff strongly endorsed having an up-to-date website that can house a wide range of internal and external training resources. To date, a PHD-driven resource to communicate training opportunities has been lacking. CLI will host a Sharepoint site—a recommendation that came out of our Developing our People A3 process, that will link staff to training policies and procedures as well as low- and no-cost training options focused on **maximizing use of technology to support our work** (e.g., Teams, Mural, and Excel, among others), and courses available through the CDC TRAIN and the network of Public Health Learning Centers on topics identified through PHWINS 2021 including **budgeting and finance**.

H.2.2.e. Provide media training for multi-lingual PHD staff. The COVID-19 pandemic underscored the need to convey complex science and public health concepts to diverse external audiences. In 2023, through Project INVEST, we will **hire a PHD-dedicated communications specialist** that will be housed in our Public Information Office to expand this capacity. Once onboarded, this new staff person will provide formal training to multi-lingual PHD staff who are often tapped to engage Spanish and Chinese language media but lack formal **training in communications science and working with media outlets.**

H.2.3 Strengthen Equity – Advance equity and anti-racism in PHD

H.2.3.a. Promote BAAHI Learning session attendance. This weekly learning series, hosted by the SFDPH Office of Health Equity, sparks conversations about historical and present-day anti-Black racism and its impact on health and wellbeing for our staff and the communities we serve. We will track PHD participation and promote staff attendance to meet the SFDPH-required 4 hours per year minimum of equity-focused learning.

H.2.3.b. Host equity-focused workshops and healing sessions. OARE and CLI will collaborate to host a series of equity-focused participatory workshops that will span a wide range of topics and formats, including traditional healing practices (e.g., drumming, Tai Chi) and skill building in mitigating microaggressions in the workplace. The goal of these sessions is advance the educational and operational framework of the Racial Justice Competency Model for Public Health Professionals.

H.2.3.c. Promote participation in Employee Affinity Groups (EAGs). There is growing appreciation for the value of enclave dialogue groups to promote inclusion and

participation by historically marginalized groups.[11] Structured dialogue groups using guides such as *Me and White Supremacy*, by Layla Saad, also can help foster an environment of belonging as white staff deconstruct white supremacy culture. To advance the REAP, the SFDPH Office of Health Equity released in October 2022 a policy and tools to support the formation and sustainability of EAGs; OARE and CLI will provide technical assistance to PHD staff interested in starting and/or maintaining EAGs.

H.2.3.d. Host workshops on communication across cultures. The Department of Human Resources (DHR) hosts a new workshop series that can be offered to teams on proven strategies to enhance communication across cultures. The program was highly rated by one of our clinical programs that implemented it for its team. CLI will engage DHR to offer these interactive workshops for multi-racial and ethnic teams to strengthen team dynamics and effectively manage conflict.

For each of the proposed activities above, **Appendix J** summarizes key objectives, the team(s) leading implementation, and projected timelines for completion.

I. Monitoring and Evaluation

We will use a number of strategies to monitor and evaluate the activities above such as: 1) review HR data (e.g., time to hire, staff retention rates, demographic background of senior level leadership), 2) conduct post-training or community of practice session evaluations, and 3) host listening sessions with senior leadership, managers and frontline staff. In addition, CLI convenes a Division-wide People Development Working Group (PDWG) comprised of staff from each Branch committed to training and professional development. This group will review process and outcome evaluation data and recommend any necessary changes to specific sessions and/or the overall strategies employed. The PDWG also will review the results of future Division-wide staff engagement and PHWINS surveys and consider modifications to the Workforce Development Plan. Finally, the PDWG will conduct an annual review of progress towards the Workforce Development Plan's stated objectives to ensure the Division is on track to meet its workforce capacity, capability and equity goals, and make any adjustments as needed to the strategies and activities.

J. References

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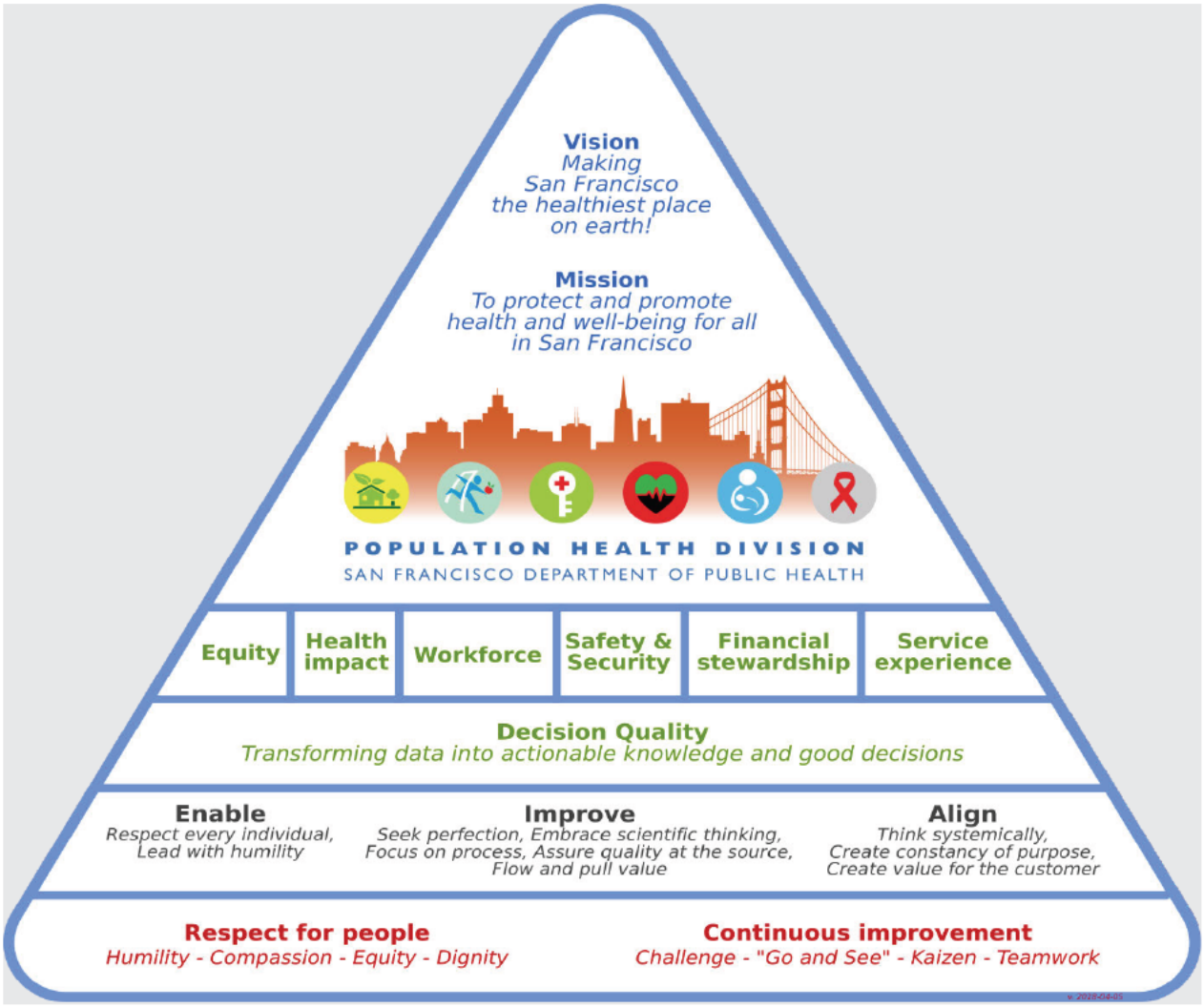
Appendix A. SFDPH Population Health Division's Strategic Priorities

The DPH Triangle communicates our Vision, Mission, 7 True North Priorities, and Core values and principles for how we approach our work and shape our culture.



Major Findings
Foundational Issues

Poverty

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Income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self care—and the ability to avoid health hazards—like air pollution and poor quality housing.

Low income groups are at greater risk of a wide range of health conditions than higher income groups, and have a shorter life expectancy.[1]

People who live in communities with higher income disparity are more likely to die before the age of 75 than people in more equal communities.[2]

More than half of new jobs in San Francisco are expected to be low wage (<$54,000/year), service sector jobs.[3-4]

Household Income

Almost 1 in 4 (22%) San Franciscans live below 200% of the federal poverty level.[3]

For a family of four, 200% of the Federal Poverty Level is $50,200.[4]

A family of four in San Francisco, requires an income of greater than $120,000 to meet all of their needs.[5]

40% of new jobs in San Francisco are expected to be low wage (<$54,000/year) jobs.[6,7]

18% of children under 6 years of age in San Francisco live in poverty (<200% FPL).[8]

Employment Disparities

San Francisco has significant disparities in employment rates between Whites and Black/African Americans.[3]

96% of White San Franciscans are employed.

Only 83% of Black/African Americans are employed; Black/African American males have the lowest employment rate in San Francisco (81%).

Black/African Americans are a third as likely as Whites to have a Bachelor's degree or higher and 5 times more likely to have less than a high school education.[3]

Median Income

In San Francisco, there is significant inequality in household income between races.[9]

White household median income is over **$111k**

Black/African American household median income is **$28k**

Income Inequality and Health

San Francisco has the highest income inequality in California.
The wealthiest 5% of households in SF earn 16 times more than the poorest 20% of households.[9]

Low income impacts lifetime health, beginning with pregnancy and birth.
Lower-income children in San Francisco experience higher rates of asthma, hospitalization, obesity, and dental caries.[10-12]

Low-birth weight is highest among low-income mothers.[13]

http://www.sfhip.org/wp-content/uploads/2020/06/CHNA_2019_Report_Final.pdf

Racial Health Inequities

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Two types of racialized social interaction, interpersonal and structural racism, play a role the racial health disparities seen in San Francisco.

Racial discrimination in interpersonal behavior, often called everyday racism or bias, sets the kind of experiences that make up the social lives of people of color. The accumulation of those experiences has been associated with increased hypertension, preterm birth and other conditions mediated by stress.

Long-standing social and institutional rules, both historic and current, determine which spaces and resources are available to marginalized groups. The disparate treatment of children based on race in schools and courts is an example of these forces. So are the historic differences in family wealth that stem from government housing policy and private banking rules. These forces are often intertwined and reinforcing as they occur over the life-course.

Racial inequities are not just a matter of unfortunate history, but of on-going, correctable injustice.

Improvements

For Black/African Americans improvements are seen in some social determinants and some health conditions. However, the improvements do not always impact the inequity as other groups may experience greater gains.

Indicator	Who Better for...
Teen Birth	Between 2007 and 2016 the teen birth rate for first time moms decreased from 34% to 10% among Black/African American women in San Francisco.[2] In that same time, the proportion of mothers who had a college education when they delivered their first baby increased by 16 percentage points.[2]
Mortality	Mortality rates decreased for all in San Francisco. However, rates decreased the most for Black/African Americans (15%) (vs. 11% for Pacific Islanders, 12% for Whites, 14% for Asians and Latinx). Decreased rates among Black/African Americans were primarily due to decreases in ischemic heart disease, lung cancer, assault, and HIV.[17] Life expectancy also grew for all San Francisco with the largest gains seen by Black/African Americans. (+3 years between 2005–2007 and 2015–2017 vs +2 years for others).
High School Graduation	Graduation rates increased for all between 2012 and 2017. The biggest gains were seen among Black/African Americans (8%), and Pacific Islanders (12%) while rates for Latinx (4%), Whites (3%) and Asians (4%) were more modest.[3]
Childhood Caries	Between 2007–2012 and 2012–2017, rates of untreated tooth decay among kindergarteners decreased the most for Black/African Americans (26% to 19%).[8]

Population Loss

Between 1990 and 2005, the Black/African American population **decreased by 41%** from almost 79,000 to less than 47,000.

Between 1990 and 2005, the proportion of very low income households increased from 55% to **68%**.[18]

The strong association between poverty and health would suggest that the poorer remaining Black/African American population is more likely to have poor health than the previous more mixed-income population.

Major Findings
Foundational Issues

Racial Health Inequities

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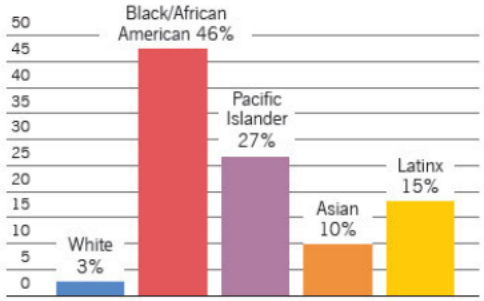
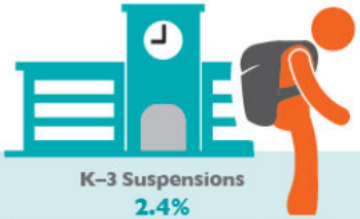
Basic Requirements for a healthy life span	Prebirth/Infancy	Childhood	Adolescence
	Healthy diet Prenatal care	Adequate income, Engaged with school, Social network, Adequate housing, Healthy diet, Safety	Mistakes corrected Schools well-resourced School success

Children 0–18 Living in Poverty[3]





K–3 Suspensions

2.4%
suspension rate for Black/African Americans

vs 0.1%
for White SFUSD Students [4]

Student Proficiency

Black/African American Students
13% are proficient or above in mathematics,
19% in English language arts.[5]

Latinx students
22% of are proficient in mathematics,
28% in English language arts.

Pacific Islander Students
19% of are proficient in mathematics,
25% in English language arts.

White Students
70% are proficient in mathematics,
77% in English language arts.

Hurdles to a healthy life start early in San Francisco

Full-Term Birth
Full term birth more likely for Whites (**93%**) than Black/African Americans (**86%**).[2]

Food insecurity among pregnant women in San Francisco[1]

26.5% among Latinx women

19.5% among Black/African American women

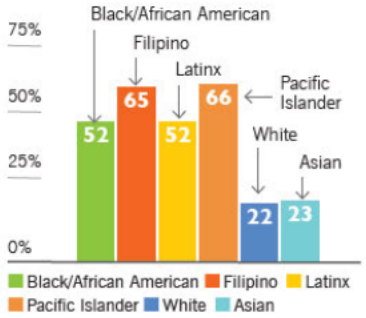
6.6% among Asian and Pacific Islander women

Almost no White women in San Francisco report food insecurity during pregnancy.

Nutrition

Black/African American and Latinx SFUSD students are 2–3 times more likely to consume fast food (**64%**, **73%**), or soda (**44%**, **36%**) at least weekly, as compared to White students (fast food (**35%**) and soda (**17%**).[6]

5th Grade Obesity[4]



Major Findings
Foundational Issues

Racial Health Inequities

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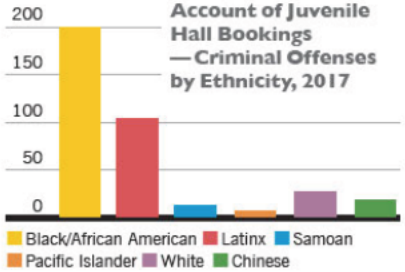
Basic Requirements for a healthy life span	Adolescence	Adulthood	Old Age
	Mistakes corrected Schools well-resourced School success	Employment, Stable housing Active, Healthy childbearing Freedom	Active lifestyle Independence Long life

Juvenile Detentions

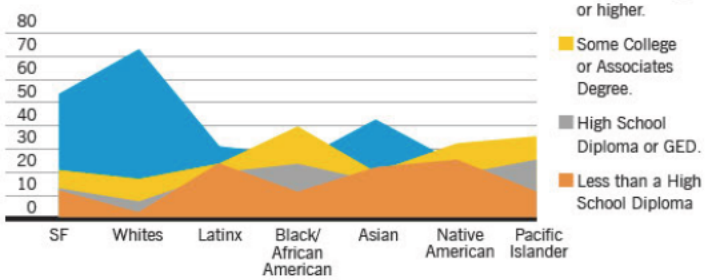
Black/African American youth make up over **57%** of bookings at juvenile hall even though they make up only 6% of the population.[9]

Together Black/African American and Latinx youth comprise **86%** of all juvenile bookings. Samoan youth are also over-represented and make up **3%** of the bookings, but only account for less than 1% of the youth population.

Unduplicated Account of Juvenile Hall Bookings — Criminal Offenses by Ethnicity, 2017



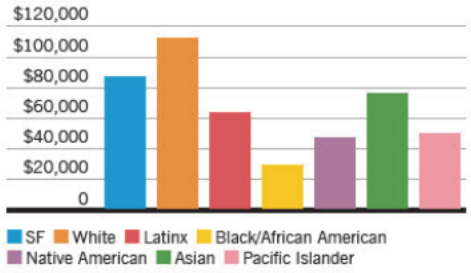
Educational Attainment 2012–2016[3]



The starkest inequities are seen between Black/African American residents and all other groups, and occur across the lifespan.

Median Household Income

The median income in San Francisco varies greatly by race/ethnicity. Typically, Whites earn 4x more than Black/African Americans in San Francisco.[3]



Homelessness

Black/African Americans are over-represented among the homeless in San Francisco.

35%
of the homeless persons are Black/ African American

22%
are Latinx compared to

5% and **15%**,
respectively,
of the city overall. [3,10]

Heart Disease

Heart Disease impacts Black/African Americans at younger ages. Rates of heart disease related hospitalizations among Black/African Americans in their 40s and 50s **are comparable to those seen in other races/ ethnicities over 75 years of age.**[7]

	2005-2007			2015-2017		
	All	♀	♂	All	♀	♂
All	80.8	84.0	77.6	83.1	86.1	80.3
Asian	85.1	87.5	82.4	87.0	89.6	83.9
B/AA	68.5	73.7	64.2	72.1	76.5	68.3
Latinx	82.7	85.8	79.4	85.1	87.9	82.5
PI	73.4	77.0		76.0	76.8	75.5
White	79.7	83.1	76.9	81.7	84.2	79.6

Major Findings
Health Needs

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services

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Healthy People 2020 defines access to health care as "the timely use of personal health services to achieve the best possible health outcomes."[1]

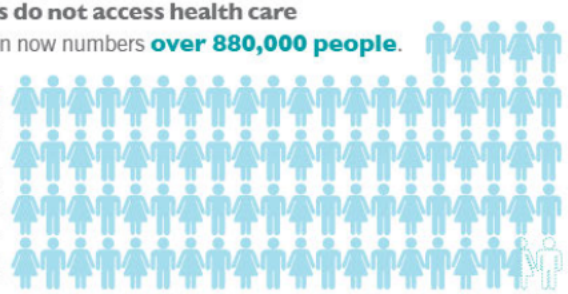
Access is influenced by availability of providers, location, affordability, hours, and cultural and linguistic appropriateness of health care services. Accessible health care can prevent disease and disability, detect and treat illnesses, maintain quality of life, and extend life expectancy.[2]

From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations and can save public and private dollars.

While access to health care in San Francisco is better than many other places, significant disparities exist by race, age, and income.

Many San Franciscans do not access health care

San Francisco's population now numbers **over 880,000 people**.



Fewer Uninsured

Over 10,000 fewer San Franciscans were uninsured in 2017 compared to 2015. However, 2% of San Franciscans, 16,000, still lack insurance or health care access via Healthy San Francisco or Healthy Kids.[3-4]

8% do not have a usual place to go for medical care.[5]

24% of adults have not had a routine check-up in the past year.[5]

51% have not had a flu shot in the past year.[5]

54% of women ages 18–44 have not received counseling or information about birth control from a doctor or medical provider in the past year.[5]

15% of women with public safety net insurance do not receive timely prenatal care.[6]

27% of adults have not seen a dentist in the past year.[5]

82% of Denti-Cal eligible infants aged 2 years or less do not access dental care.[7]

Young adults are at risk. Young adults 18 to 34 years of age and people of color are less likely to be covered by insurance.[4]

Language barriers and cultural competency of services are serious barriers to receiving quality care.

Increased cultural competence requires structural and systemic improvements, and can be linked to improvements in healthcare access, participation, and patient satisfaction.[10-11]

From the community we heard...

"Cultural competency doesn't happen with just a class or a one-day training."

"Healthcare professionals need to be from the community and actually know the culture of the community."

"Community-based organizations serve a critical role in small, datasparce cohorts, by informing public health efforts and bringing resources to multicultural communities."

Different Levels of Prenatal Care

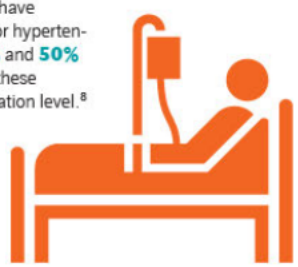
- In 2013-15, **≥99%** of mothers with private insurance received prenatal care in the first trimester.[6]
- Only **86%** of those with Medi-Cal received early prenatal care.[6]

Residents covered by public safety net insurance do not receive preventative care at the same rate as those with private insurance.

Preventable Hospitalizations and Emergency Room Visits

While preventable hospitalizations for most causes have decreased over time, preventable hospitalizations for hypertension and diabetes have respectively increased **45%** and **50%** between 2011 and 2016 — potentially indicating these conditions are not being well managed at the population level.[8]

Preventable hospitalizations and ER visits are significantly higher among Black/African Americans and Pacific Islanders compared to all other ethnicities in San Francisco.[9]



Major Findings
Health Needs

Food Insecurity, Healthy Eating, and Active Living

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Good nutrition means getting the right amount of nutrients from healthy foods and drinks. Good nutrition is essential from infancy to old age.

The USDA's MyPlate.org recommends that fruits and vegetables make up at least half of our plate, or approximately five servings a day.[1]

Leading medical and health associations recommend drinking water instead of sugary drinks.[2] The institute of Medicine recommends 13 cups of liquids per for men and 9 cups for women who live in temperate climates.[3]

A healthy diet promotes health and reduces chronic disease risk. It is critical for growth, development, physical and cognitive function, reproduction, mental health, immunity, stamina, and long-term good health.[4]

Many in San Francisco are food insecure

50% of low income residents surveyed in SF report food insecurity.[6]

20–30% of Black/African American and Latinx pregnant women are food insecure.[5]

50% of SFUSD students qualify for free or reduced-price meals.[9]

Over **100,000** food insecure adults and seniors are eligible to receive meals, groceries or eating vouchers.

Services to ameliorate food insecurity are not meeting need

70% Percentage of eligible students not participating in the Summer Lunch Program.

-7% Decrease in the number of food vendors authorized to acccept food stamps.[14]

1,969 The number of meals denied Seniors and persons with disabilities at congregate meal sites.[6]

21 days/187 days The number of days seniors/persons with disabilities must wait to start getting home delivered meals.[6]

616 The number of persons waiting for enrollment at a food pantry.[33]

The USDA has designated the Oceanview, Merced, Ingleside, Bayview Hunters Point, Visitation Valley and Treasure Island neighborhoods as areas of low food access.[10]

Many in San Francisco do not eat and drink healthily

2 out of 3 pregnant women in the WIC Eat SF program and **2 out of 3 youth** do not eat 5 or more servings of fruits or vegetables daily.[5]

Some San Franciscans do not drink enough water

614 people were hospitalized for "potentially preventable" dehydration in 2016.[7]

Many do drink sugary drinks. **Two thirds** of high school students and **one third** of young adults regularly consume soda.[8]

Facilities necessary to eat and drink healthily are not available for all

Barriers to drinking enough water include limited access to bathroom facilities to go to the bathroom.[31-32] **San Francisco operates 28 public restrooms that are open all day, which amounts to 3.3 restrooms per 100,000 residents.[13]**

The Mission, Bayview Hunters Point and Treasure Island districts **each have only one public access drinking water fountain.[12]**

Not all have a kitchen to cook in. Over 21,000 occupied housing units in San Francisco do not have complete kitchen facilities.

Major Findings
Health Needs

Food Insecurity, Healthy Eating, and Active Living

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Regular exercise extends lives.

The World Health Organization (WHO) recommends that children and adolescents, age 5 to 17 years, should do at least one hour of moderate-to-vigorous physical activity daily, while adults, age 18 years and above, should do at least 150 minutes of moderate-intensity physical activity, 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate and vigorous activity throughout the week.[15]

Just 2.5 hours of moderate intensity aerobic physical activity each week is associated with a gain of approximately three years of life.[16]

Walking is a simple, affordable way for people to get around. A walkable city provides a free and easy way for people to incorporate physical activity into their daily lives as they walk to work, to school, to the market, to transit or other nearby services, or just for fun.[17]

Many San Franciscans don't spend the recommended amount of time doing physical activity

1 out of 2
(56%) adults does not walk at least 150 min per week for transportation or leisure.[18]

1 out of 2
(47%) children ages 3–5 years in child care centers are not physically active for 90 min per school day.[19]

2 out of 3
(67%) middle schoolers do not spend 60 min per day each day of the week doing physical activity.[20]

4 out of 5
(83%) high schoolers do not spend 60 min per day each day of the week doing physical activity.[20]

Each day,
4.5 million
transportation trips are made in San Francisco.

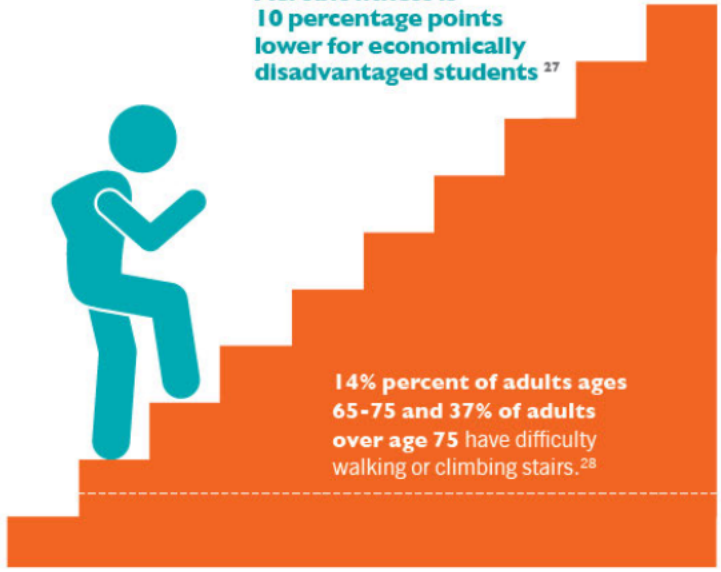
Of these, only about **37%** are walking trips or public transit trips which include walking.[21]

Many San Franciscans don't meet activity standards

In San Francisco about **30%** of 5th and 7th graders and **40%** of high school students do not meet the Fitnessgram standard for aerobic capacity, which is ability to run one mile or pass a PACER test.

60 percent of Black/African American and Latinx 9th graders, do not meet the fitness standards, compared to 30% of White and Asian students. [27]

Aerobic fitness is 10 percentage points lower for economically disadvantaged students [27]



14% percent of adults ages 65-75 and 37% of adults over age 75 have difficulty walking or climbing stairs.[28]

Major Findings
Health Needs

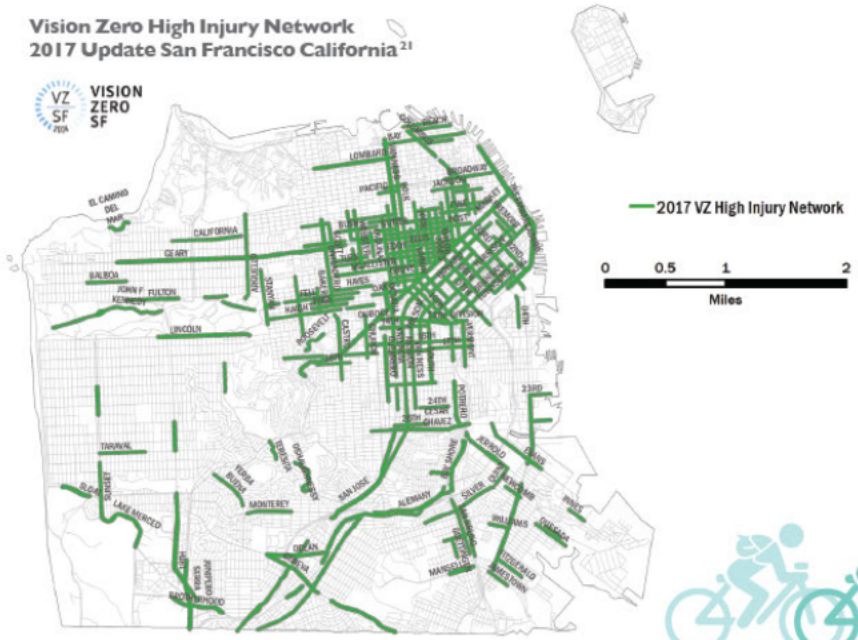
Food Insecurity, Healthy Eating, and Active Living

Safety, and a lack of resources and other supports are barriers to physical activity in San Francisco

Every day, on average 2 people walking are hit by cars

Cars violating a pedestrian's right-of-way is the top risk factor for injuries to people walking. **In 2018, there were 15 pedestrian deaths and 3 cyclist deaths.**[22-23]

Vision Zero High Injury Network
2017 Update San Francisco California[21]



There are gaps in neighborhood resources for physical activity

Sidewalk networks support walkers to varying degrees. Downtown and in Chinatown, the blocks are short and provide many pedestrian connections. In other neighborhoods, pedestrians have to walk further to make less direct connections.[34]

35% of San Francisco playgrounds do not score an A or B for infrastructure quality, cleanliness and upkeep.[26]

There are gaps in school and workplace supports for physical activity

2 out of 3 (67%) child care centers do not use physical activity curriculum.[29]

All of our students, regardless of which neighborhood they live in or which school they attend, should be able to safely walk or bike to school. We are adding crossing guards across the City and I am pushing the SFMTA to expedite Vision Zero projects because we do not have time to waste. We need safer, more livable streets now."
— MAYOR LONDON BREED [23]

Although each April, more than 10,000 people participate in Walk to Work Day, including San Francisco's Mayor and Supervisors, **over 200,000 workers drive to work on a daily basis**.[30]

SF has 0.18 miles of bike lane for every 1 mile of streets.[24]

Major Findings
Health Needs

Housing Security and an End to Homelessness

sfhip

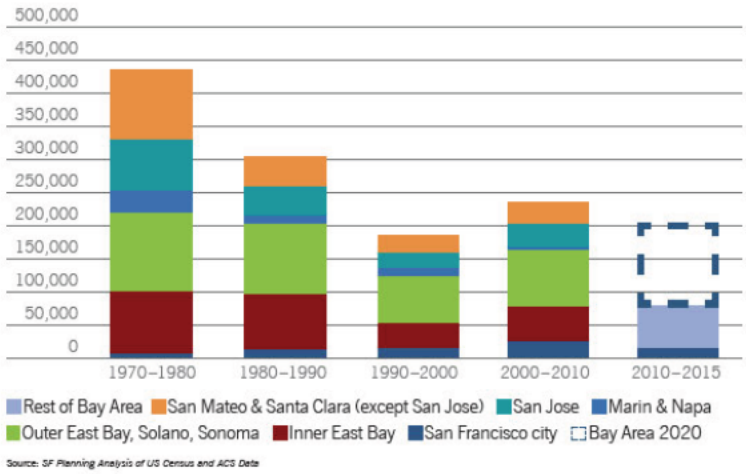
Shelter is a basic human need

Housing is foundational to meeting people's most basic needs. Quality housing provides a place to prepare and store food, access to water and sanitation facilities, protection from the elements, and a safe place to rest. Stable/ permanent housing can also provide individuals with a sense of security. Unfortunately, California, and especially the Bay Area, suffers from an acute housing shortage which has been driving housing costs to unaffordable levels, leading an increasing number of residents to become homeless.[1]

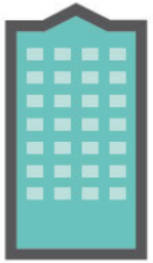
Housing production has declined in the Bay Area

Between 2011 and 2015, the Bay Area added 501,000 new jobs — but only 65,000 new homes.[2]

Housing Production Decline in the Bay Area, 1970–2015



Source: SF Planning Analysis of US Census and ACS Data



San Francisco usually exceeds requirements for development of above moderate-income housing (120% AMI), but builds less than a third of the units allocated for moderate and low-income residents.[3]

Homelessness

In 2017, about 7,500 homeless persons were counted in San Francisco.[7] Despite making up only 6 percent of the general population, **35% of the homeless persons counted were Black/African American**.

Among the many challenges homeless persons face, including those in temporary housing, are: [8-9]

- Safely storing medications
- Eating healthfully
- Finding a job
- Maintaining relationships
- Going to the doctor

Overcrowding

An estimated 24,000 people in San Francisco live in crowded conditions.[4]

Living in overcrowded conditions can increase risk for infectious disease.[5]

Major Findings
Health Needs

Housing Security and an End to Homelessness

sfhip

Housing Affordability

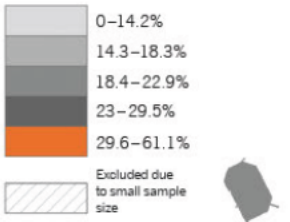
Between 2010 and 2018, the median market rate rent for a 2–bedroom unit **increased 48%** to $4,725.[10]

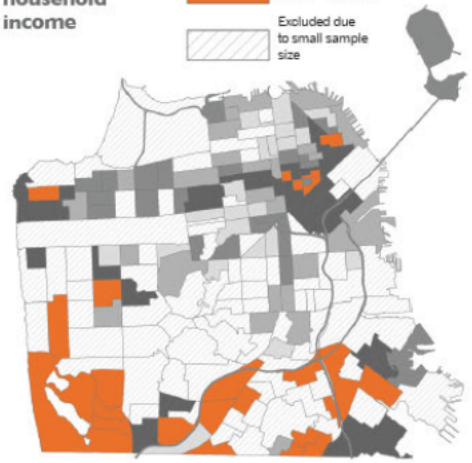
4 full-time minimum wage jobs to afford a "fair market rate" ($3,121) 2–bedroom unit [11]

6 full-time minimum wage jobs to afford a "median market rate" ($4,725) 2–bedroom unit [10]

The median percent of income paid to gross rent in San Francisco was **30%** in 2017.
17% of renter households spend **50%** or more of their income on rent.[4]

Percent of renter households whose rent is 50% or more of their household income





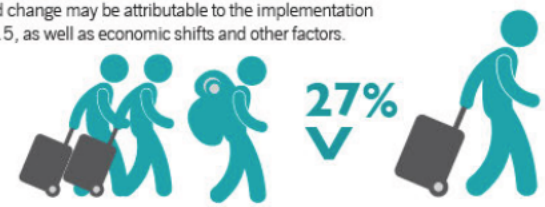
Nearly one-third of Chinatown residents live in overcrowded conditions.[12]

Evictions

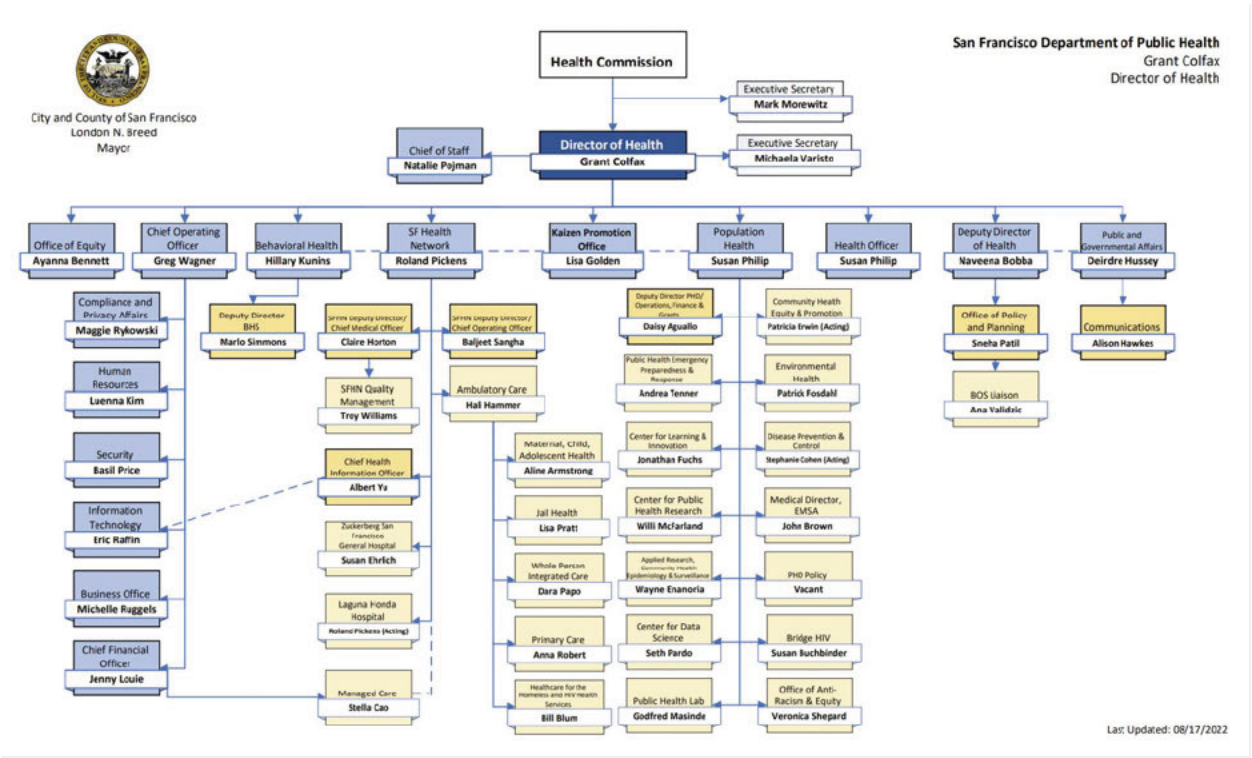
There had been a steady increase in the number of all-cause eviction notices between 2011–2016; however, **in 2017 there was a 27% decrease in the number of eviction notices filed**.[6] This rapid change may be attributable to the implementation of Eviction Protection 2.0 in November 2015, as well as economic shifts and other factors.

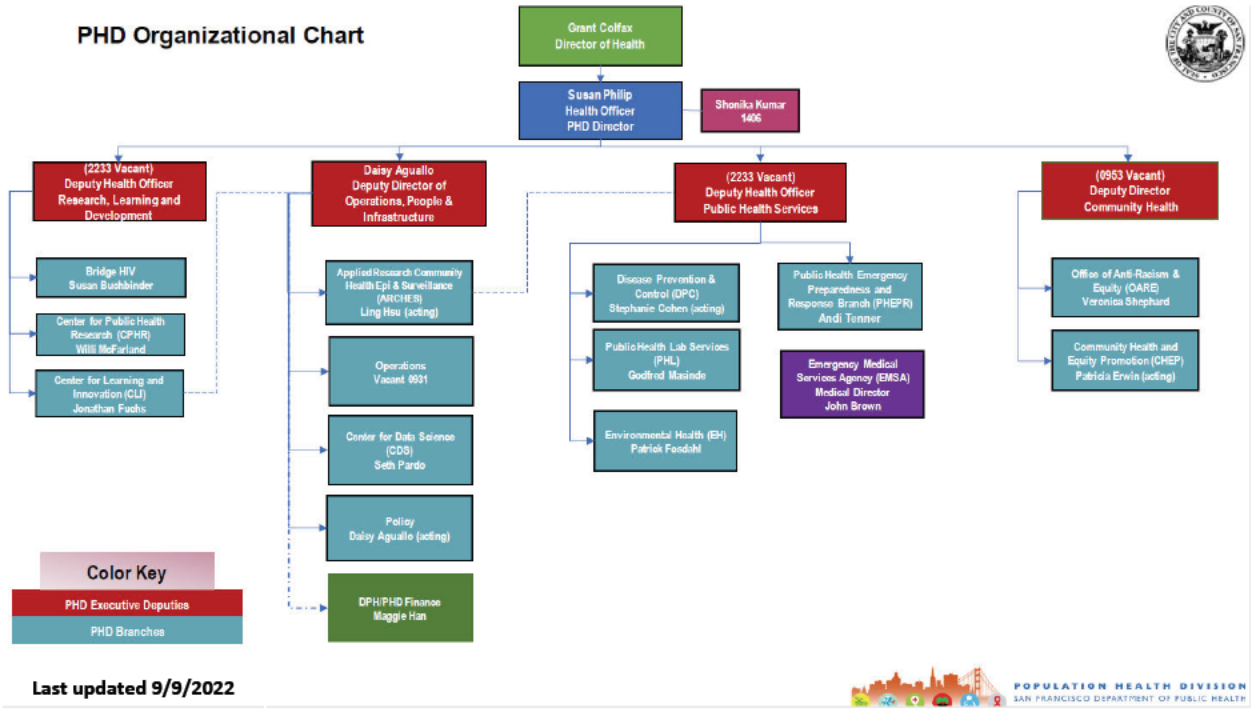
Moving can result in: [5]

- Loss of employment
- Difficult school transitions
- Increased transportation costs
- Loss of health protective social networks



Appendix C. The Organizational Chart for SFDPH and PHD





Appendix D. 10 Essential Public Health Services

10 Essential Public Health Services

PHAB's public health department accreditation domains are aligned to the 10 Essential Public Health Services (EPHS) framework. Equity is at the center of the 10 Essential Public Health Services to actively promote policies, systems, and overall community conditions that enable optimal health for all. Public health department accreditation standards address a range of core public health programs and activities including, for example, environmental public health, health education, health promotion, community health, chronic disease prevention and control, infectious disease, injury prevention, maternal and child health, public health emergency preparedness, access to clinical services, public health laboratory services, vital records and health statistics, management/administration, and governance. Thus, public health department accreditation gives reasonable assurance of the range of public health services that a health department should provide.

Appendix E. Racial Justice Competency Model (RJCM) for Public Health Professionals

The RJCM contains 3 domains (Assessment, Policy Development, and Assurance) and 51 total statements (17 Introductory, 17 Intermediate, and 17 Leading).

Domain	Introductory	Intermediate	Leading
Assessment	Examine social issues and messages for racial biases and their impact on oneself and others' thinking, emotions, and behaviors	Evaluate the effects of policy issues and actions on BIPOC and other marginalized groups, both within and outside the organization	Manage emerging issues using systematic problem-solving and adaptive skills
	Recognize the intersecting and interdependent systemic discrimination some face because of race, gender, sexuality, gender identity, ability, and other critical forms of identity	Identify existing relationships affecting community health and resilience (e.g., relationships among health departments, hospitals, community health centers, primary care providers, schools, community-based organizations, environmental agencies and organizations, businesses, financial institutions, housing authorities, and other types of organizations)	Interpret the interrelationships of factors affecting the health of a community (e.g., social determinants of health, inequity, income, education, environment, demographic trends, and legislation)
	Describe historical and current conditions that contribute to disparities in health outcomes between populations	Examine historical and current conditions that actively contribute to disparities in health outcomes between populations today	Create mechanisms for addressing historical and current conditions that contribute to disparities in health outcomes between populations
Assessment	Identify assets and resources for improving health in a community (e.g., community coalitions, community-based organizations, etc...)	Create opportunities for individuals and organizations within a community, including non-traditional or unconventional partners, to collaborate to improve health	Support opportunities for individuals and organizations within the community to maintain assets and resources for improving health
	Reflect on one's own identity, power, privilege, and oppression, and how these factors influence experiences, biases, and choices	Analyze internal and external facilitators and barriers that may affect implementation of population health policies, programs, and services	Assemble data to inform policies, programs, and services when addressing barriers or social determinants of health and health inequities
	Describe how conditions of power shape social determinants of health and health inequities	Examine how various individual conditions (WHO intermediary determinants), and population-level systems and policies (WHO structural determinants) drive health inequities	Suggestion: Evaluate how various individual conditions (WHO intermediary determinants), and population-level systems and policies (WHO structural determinants) drive health inequities

Racial Justice Working Group (https://rjcmph.org/)

Domain	Introductory	Intermediate	Leading
Policy Development	Describe the concept and value of diversity as it applies to individuals and populations (e.g., language, culture, socioeconomic status, education, race, gender, age, ethnicity, sexual orientation, profession, religious affiliation, mental and physical abilities, etc...)	Implement effective channels and strategies to engage diverse public and professional audiences in dialogue about complex health information	Illustrate strategies and policies to engage diverse audiences, particularly in decision-making processes, incorporating feedback from those involved and/or affected by policy changes
	Recognize how privilege and power dynamics appear for oneself within the organization	Identify how privilege and power dynamics influence policies, programs, and services within the organization and community	Organize conversations with community, governing bodies, and elected officials regarding policies, programs, and services that address inequities and strength the community
	Examine policies, programs, and services that affect the diversity of individuals and populations under discussion	Collaborate with the community to identify systemic and structural barriers that perpetuate health inequities (e.g., discriminatory policies, lack of affordable housing or public transportation, and food deserts)	Implement strategies with the community to reduce systemic and structural barriers that perpetuate health inequities (e.g., discriminatory policies, lack of affordable housing or public transportation, and food deserts)
	Advocate for policies or decisions that improv the physical, environmental, social, and economic conditions in the community	Develop plans and policies that include specific and meaningful goals and action items that improve the conditions in the community	Demonstrate equitable use of power among staff through planning, programming, policy development, implementation, evaluation, and improvement
Policy Development	Describe racial justice and health equity concepts (e.g. race, four levels of racism, health inequities, root causes of inequities, social determinants of health, oppression, privilege, implicit bias, racial justice) and the relationships among them	Examine the historical role of racism in medicine, public health, intersectional oppression, and racial justice strategies	Identify opportunities for organizational, regional, state and federal policy changes to address inequities

Domain	Introductory	Intermediate	Leading
Assurance	Share resources, approaches, and tools on structural racism, racial justice, and health equity work	Advocate for health equity, social and environmental justice (e.g., sharing power, educating public and policymakers, and influencing funding)	Critique structural and systemic racism embedded within public systems, policies, and practices to advance health equity
	Define the roles of public health in addressing and dismantling racism and systemic discrimination	Identify strategies for assessing equity, diversity, and inclusion of BIPOC and other marginalized groups in the public health workforce including at the leadership level	Create strategies to sustain a diverse and inclusive public health workforce (e.g., recruitment, retention, and promotion practices; creating inclusive, safe work environments; respecting diverse perspectives; sustaining a culture that values collaboration, peer learning, flexibility, and equal opportunity)
	Demonstrate equitable use of power among staff through planning, programming, policy development, implementation, evaluation, and improvement	Identify opportunities within and external to the organization to engage diverse stakeholders in advancing health equity and racial justice	Collaborate with various stakeholders, government agencies, and organizations to develop shared ownership and accountability for addressing health equity on an ongoing basis
	Develop a common language of racial justice and health equity terms for use within your organization	Practice in ongoing learning about racial justice and health equity (e.g., attending community sessions, engaging in dialogue with colleagues, independent research, community events, etc...)	Design opportunities that build collective knowledge between racial justice, health equity, and public health
Assurance	Identify effective mechanisms to highlight equity issues within the organization	Demonstrate confidence in challenging inequities and the status quo to create paradigm shifts in organizational policy and practice	Evaluate the organization's capacity to act on the root causes of health inequities, systemic racism, and racial disparities
	Foster empathy and social skills to advance health equity and racial justice in work and interpersonal dynamics	Monitor a high-level of self-awareness, empathy, and social skills in work and interpersonal dynamics	Implement health equity and racial justice principles through teaching and/or mentoring peers on self-awareness and reflection, empathy, and interpersonal dynamics

Appendix F. Mandatory Trainings

The table below lists trainings that are required for PHD staff, including frequency, and comments to guide where to find such trainings. The mandatory trainings are organized by the City and County of San Francisco Department of Human Resources (Citywide DHR), The SFDPH Office of Health Equity, the SFDPH Human Resources, (SFDPH HR) and the Population Health Division (PHD).

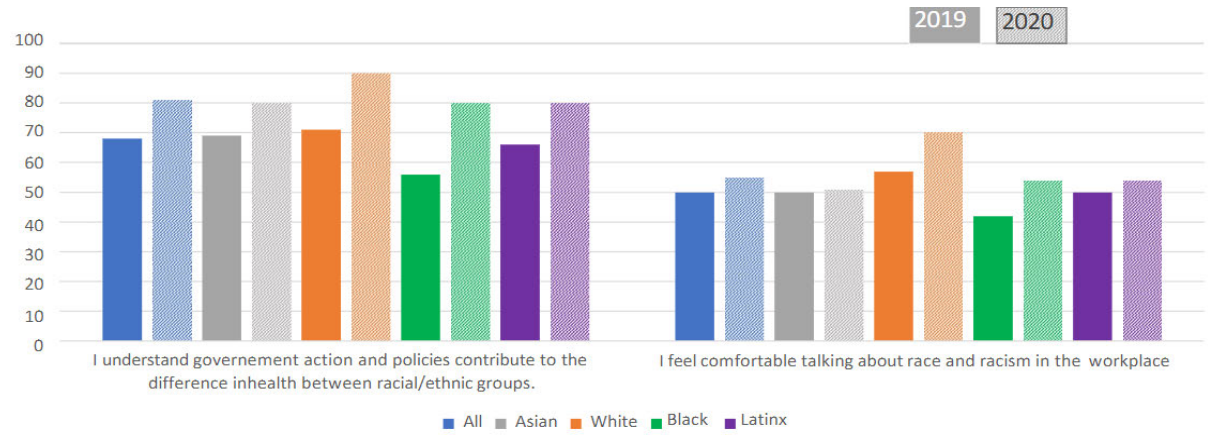
Required Trainings for ALL PHD Staff		
Frequency	**Titles of trainings**	**Comments and Resources**
Onboarding (take within 30 days of hire date)	Citywide DHR New Employee Orientation	Complete once. To access trainings: 1. Open SF Employee Gateway: login steps in Welcome Letter 2. Open **DPH** Human Resources New Hire Orientation module 3. These individual trainings will automatically launch Additional resources for trainings:
	Citywide Sanctuary City	
	Citywide Whistleblower Protection Awareness	
	Citywide Office Ergonomic Awareness	
	Citywide Telecommuting for Employee	
	SFDPH New Employee Orientation	
	SFDPH HR Overview	
	SFDPH Disaster Service Worker Training IS 100	
	SFDPH Disaster Service Worker Training IS 700	
	SFDPH Compliance and Privacy	
	SFDPH HR Occupational Safety and Health	
	SFDPH Security	
	SFDPH Cybersecurity	
	SFDPH Cybersecurity for Working Remotely	
	SFDPH HR Cultural Humility	
	SFDPH Introduction to Health Equity	
	SFDPH Cal/OSHA Requires COVID-19 Basic Health and Safety	
	DPH Transforming stress-trauma	
	DPH LEAN	
	DPH Zero Waste	
	Trauma Informed Systems	

	SFDPH Practicing Cultural Humility in Collecting Information about Sexual Orientation and Gender Identify (SOGI)	Once, then as needed after
	SFDPH Intro to Implicit Bias	Once, then every **2 years**
	PHD New Employee Orientation	Once
	Health Equity training hours	Minimum **4 hours** of training required per year. List of approved equity trainings
Every 2 years	DPH Personal Preparedness	
	PHD Sexual Harassment Prevention	All must complete, except supervisors (see below)
Annual	SFDPH Statement of Incompatible Activities Training	SF Learning (DPH30013)
	Citywide Cybersecurity	Complete annually
Additional Required Trainings for Managers and Supervisors ONLY		
Frequency	**Titles of trainings**	**Comments and Resources**
Onboarding (take within 30 days of hire date, unless specified)	Citywide 24-Plus Supervisory Training	Complete within 6 months of supervisory assignment. Please contact kevin.oshiro@sfdph.org to enroll in the mandatory 24 Plus Manager training
	Citywide Harassment Prevention Training	Complete within 6 months of supervisory position; **then every 2 years**
	Citywide Managing a Telecommuting Employee	Complete once
	SFDPH Effective Communication with Diverse Teams	Access training at SFDPH - Human Resources Events | Eventbrite
Annual	SFDPH Fairness in Hiring Interviews for Panel members	Annual and/or before participating in a hiring interview. Email cherry.tactacy@sfdph.org to enroll.
	SFDPH Whistleblower Protections-Sup duties	Complete once
	SFDPH Planning and Appraising Employees Performance	Complete annually and submit to DPH HR
Additional trainings as needed		
Onboarding	Heluna Health Orientation	HH HR will send invite to contractors to meet on start date

Appendix G. Racial Equity Action Plan (REAP). The San Francisco Racial Equity Action Plan 2021 – 2023 outlines six Focus Areas for the plan to increase diversity and retention of the workforce. The table below lists the areas of the REAP and their alignment with the PHAB Accreditation standards.

Link to DPH REAP: SFDPH REAP_2021 update.cleaned.pdf

REAP Areas	REAP Area Description	REAP Level	Accreditation Area
OHE-1	Hiring & Recruitment	DPH-Wide Areas	Domain 8
OHE-2	Retention & Promotion		Domain 8
OHE-3	Discipline & Separation		Domain 8
OHE-4	Diverse & Equitable Leadership		Domain 8
OHE-5	Mobility & Professional Development		Domain 8
OHE-6	Organizational Culture of Inclusion & Belonging		Domain 8
OHE-7	Boards and Commissions		Domain 10
PHD-8	Community	PHD Areas	Domain 4
PHD-9	Finance & Resource Allocation		Domain 10

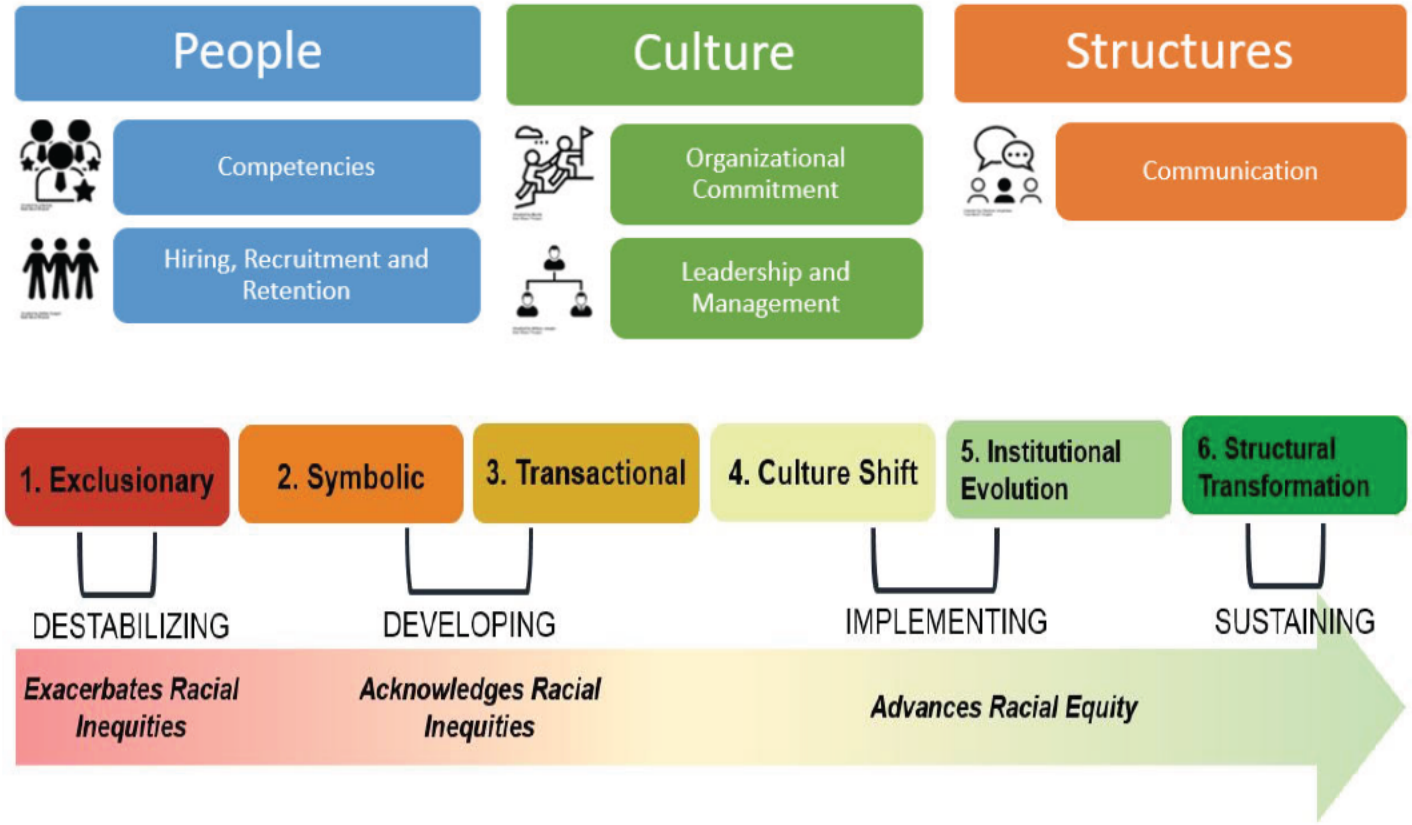


About 70% of DPH staff, overall, agreed that government actions contribute to health disparities, a description of structural racism. Only 51% of SFDPH employees answered favorably to the statement, "I'm comfortable talking about race and racism in the workplace" with wider variation; only 42% of Black/African American employees agreed with this statement. This number is even lower (38%) when looking at PHD respondents (Appendix H).

Appendix H. Equity Assessments: Below, we share the results of 1) the **Government Alliance for Racial Equity (GARE)**, completed in 2018, 2) the 2019 **Press Ganey Staff Engagement survey**, with select results stratified by race/ethnicity, and 3) the **Racial Equity Self-Assessment**, conducted in 2021.

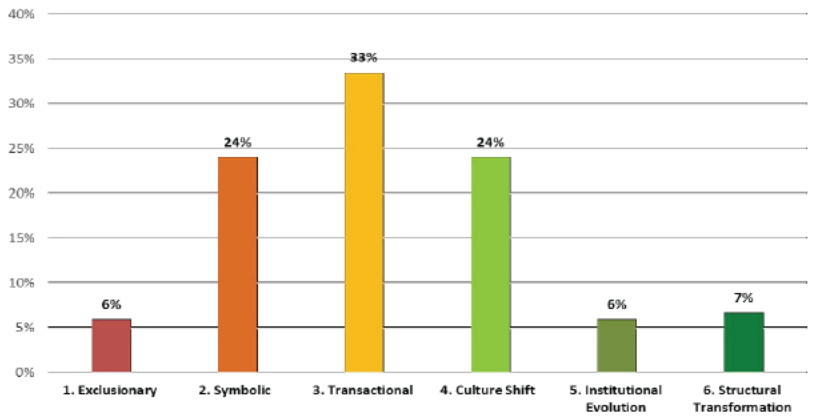
1) Governmental Alliance for Racial Equity (GARE) Assessment, May 11 – June 8, 2018

For each dimension under People, Culture, and Structures, PHD staff were asked to "choose the option that most closely reflects your experience at PHD". PHD staff rated 5 organizational characteristics on a scale of 1 to 6, ranging from Exclusionary in nature to those that advance Structural Transformation. The distribution of those responses across the 5 domains are displayed below.

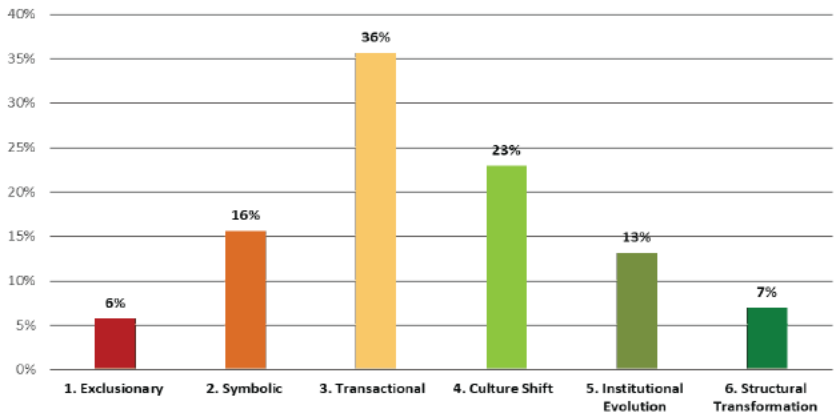


People

Competencies (n=254)

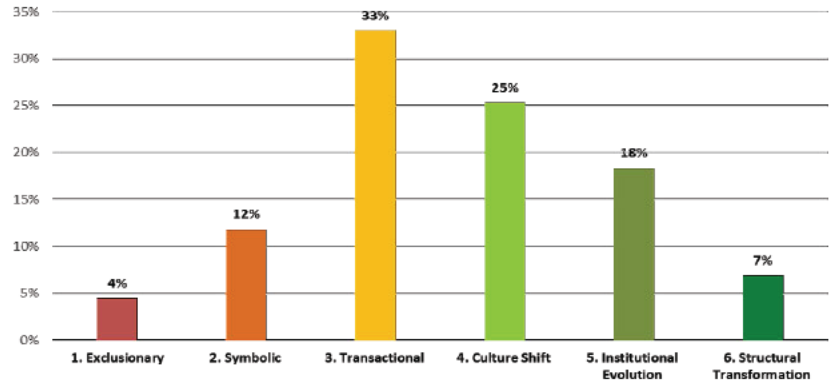


Hiring, Recruitment, and Retention (n=244)

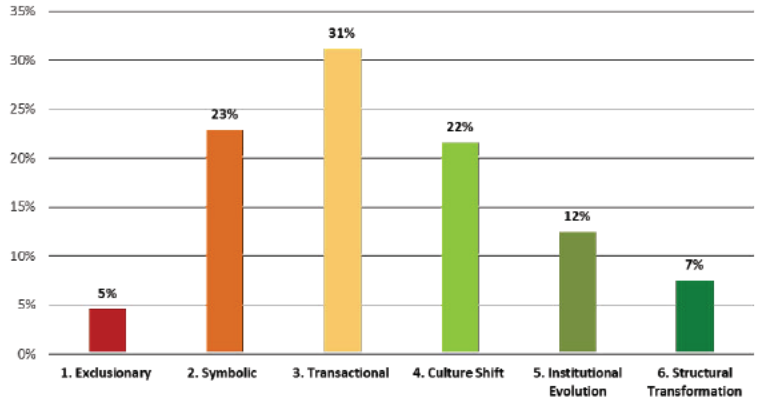


Culture

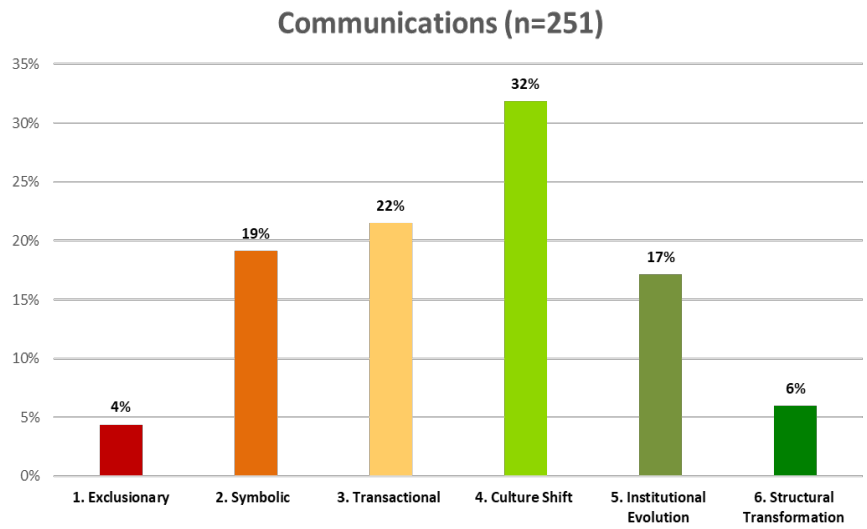
Organizational Commitment (n=245)



Leadership and Management (n=241)



Structures

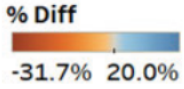


As seen above, the largest number of staff rated the first 4 domains as “transactional” whereas under Communications, the largest number of staff indicated that PHD was undergoing a culture shift. Using data from this survey, PHD prioritized improving our organizational commitment to advancing racial equity. PHD created the Office of Anti-Racism and Equity (OARE) as a key outcome of the assessment to promote organizational change across the division and to enhance ways in which the Division engages communities experiencing health inequities across San Francisco.

2) Press-Ganey SFDPH Staff Engagement Survey, 2019

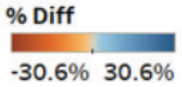
SFDPH utilized both divisional and department-wide Employee Engagement Surveys to learn the needs and thoughts of employees. The Press-Ganey department-level Employee Engagement survey was conducted in the spring of 2019 and PHD had an 82% response rate. The survey asked 58 questions on topics including leadership, communication, benefits, diversity, respect, staffing levels, and career advancement opportunities. The results demonstrate the differences by race, specifically for Black/African American employees regarding communication, staff morale, trust, and psychological safety in the workplace. The SFDPH's top two areas of focus are communication and racial equity.

% Favorable on Communications Question by Race at PHD



Question	PHD	Asian	Black	Latinx	White
There is a climate of trust within my work unit.	60% n=392	70% n=143	41% n=51	51% n=55	60% n=132

% Favorable on Racial Equity Questions by Race at PHD



Question	PHD	Asian	Black	Latinx	White
I feel comfortable talking about race and racism in the workplace	50% n=382	44% n=137	38% n=50	60% n=52	56% n=132
My department is taking active steps to improve racial equity.	58% n=368	55% n=126	41% n=49	60% n=52	65% n=130
Managers in my department treat staff from all racial/ethnic groups with respect.	75% n=389	76% n=142	59% n=51	76% n=55	78% n=130
Staff in my department treat community members from all racial/ethnic groups with respect.	76% n=385	78% n=139	53% n=51	76% n=55	80% n=129

The percent Population Health Division (PHD Employees that Responded Favorably (4-agree or 5-strongly agree) to questions on the 2019 SFDPH Employee Survey.

Overall measures of staff engagement, key drivers of engagement, and the lowest and highest performing items compared to health care organizations across the county are provided below.

PHD Engagement

Engagement Item	2019 Population Health	% Unfav
19. I am proud to tell people I work for this organization.	4.01	6%
20. I would stay with this organization if offered a similar position elsewhere.	3.45	17%
25. I would like to be working at this organization three years from now.	3.68	13%
30. I would recommend this organization as a good place to work.	3.65	13%
31. Overall, I am a satisfied employee.	3.68	14%
48. I would recommend this organization to family and friends who need care.	3.71	13%
Engagement	**3.70**	**13%**

SFDPH Key Drivers of Engagement

KEY DRIVERS of Engagement (in order of influence)	Domain	2019 SFDPH	% Unfav
28. I feel like I belong in this organization.	EMP	3.81	9%
12. I like the work I do.	EMP	4.27	3%
47. This organization provides high-quality care and service.	ORG	3.89	6%
29. I have confidence in senior management's leadership.	ORG	3.28	24%

Lowest Performing Items vs Natl HC Average

KD = Key Driver

Item	Domain	2019 Population Health	% Unfav
6. Different levels of this organization communicate effectively with each other.	ORG	2.84	39%
22. This organization provides career development opportunities.	ORG	3.22	26%
14. This organization makes employees in my work unit want to go above and beyond.	EMP	3.13	29%
44. Communication between work units is effective in this organization.	ORG	3.18	28%
29. I have confidence in senior management's leadership. KD	ORG	3.35	22%

Highest Performing Item compared to National Health Care Average

Item	Domain	2019 Population Health	% Unfav
13. My pay is fair compared to other healthcare employers in this area.	ORG	3.41	23%

3) Racial Equity Self-Assessment, 2021

Each division within DPH conducts an annual self-assessment to gauge progress and identify areas for improvement.

The GARE framework highlights **three main stages in the advancement of racial equity in an organization**: Normalizing, Organizing, and Operationalizing. The assessment tool reviews shared departmental objectives for each of the GARE Areas on a scale of 1 to 5 (1-Planning, 2-Begun, 3-Working, 4-Achieved, 5-Sustained):

- Normalizing (16 objectives) stage aims to make equity a visible and prioritized part of normal work.
- Organizing (9 objectives) stage refers to the Department's equity infrastructure including leadership, staffing, data, and resources.
- Operational (16 objectives) stage targets policy, practice, and process change.

PHD/OARE used the GARE framework to conduct a self-assessment of progress in 2021. OARE core staff scored each question on behalf of PHD. The table below demonstrates that OARE staff and equity leads and champions perceived that PHD was between beginning work and actively working on normalizing, organizing, and operationalizing activities.

PHD/OARE Self-Assessment of GARE Area	Average Score out of 5 *(1- Planning, 2-Begun, 3- Working, 4- Achieved, 5- Sustained)*
Normalizing (Priority setting, shared language, training)	2.1 (Begun-Working)
Organizing (Role, Resources, Data, Communications)	2.4 (Begun-Working)
Operationalize (Implementation, Policy, Practices, Process)	2.1 (Begun-Working)

Appendix I. People Development A3

Title: Developing Our People: Strategic A3
Last Updated: April 21, 2019 **Version: 5**

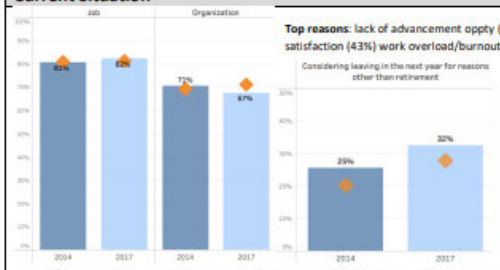
Team Lead: Jonathan Fuchs

Team Members: Jessica Brown, Karen Pierce, Sara Lin, James Duren, Stephanie Cushing, Isela Ford, Tracey Packer, Tomas Aragon

Background

Our workforce is our most vital asset as we protect and promote the health of all San Franciscans. As an accredited department, we must 1) encourage the development of a **sufficient number of qualified staff** at all levels (non-supervisory, supervisors and managers, and executives) to deliver the 10 essential services, and 2) ensure a skilled workforce by assessing **core competencies** in public health, offering **individual training and professional development**, and fostering a **supportive work environment.** These workforce development (WD) goals need to be accomplished in a highly constrained and largely grant-funded and civil service labor environment where city employees work alongside contractors, many of whom have limited access to professional development resources. Some pockets of WD excellence exist in PHD, but there are few efforts to coordinate WD activities or training budgets across siloed branches and there is only 1 FTE at CLI dedicated to PHD-wide training/WD. Also, PHD relies on HR for hiring—rigid rules and cumbersome processes contribute to organizational dissatisfaction and burden managers who are already stretched. While overall job satisfaction is good and employees are connected to mission, communication challenges contribute to team dysfunction. Limited staff engagement threatens employee retention and PHD's achievement of its aims.

Current Situation*



Satisfaction and retention compared to national averages (orange diamonds)

Top reasons: lack of advancement oppty (60%), job satisfaction (43%) work overload/burnout (36%)

Overall, **70%** of PHD staff agree/strongly agree with: *"I recommend my organization as a good place to work"*

Top skill gaps and training opportunities

Only **50%** of staff have had their training needs assessed in past year

49% agree that *"employees have sufficient training to fully utilize technology needed for work"*

Identified gaps: Systems/strategic thinking, change management, budget/financial management, QI

Supportive Environment

Only **46%** agree that *"Creativity and innovation are rewarded"*

Only **50%** agree that *"Communication between senior leadership and employees is good in my organization"*

*Informed by data from the PHWINS 2014 and 2017 surveys and listening sessions with staff

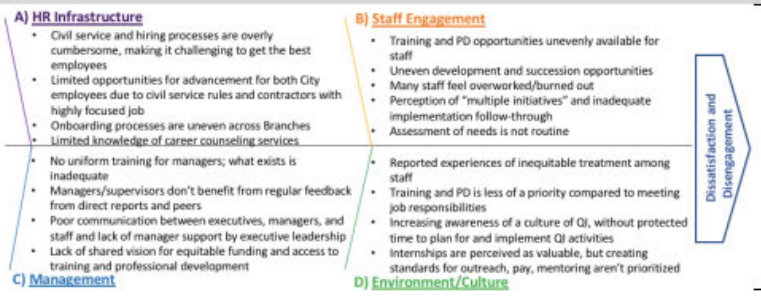
Problem Statement

Insufficient investment in our people and the environment that respects and values them limits organizational satisfaction and threatens our ability to retain a highly qualified public health workforce.

Goals and Targets

1. 70% of PHD staff "recommend org. as a good place to work" on Press Ganey survey conducted in Feb '19 (baseline measure)
2. 75% of staff w/ PPARs completed report that training needs/PD objectives assessed (assessed by 12/30/19)
3. Describe staff retention rates, stratified by Branch and civil service/contract, for reasons other than retirement/grant funded program completion (data development agenda with HR/Heluna Health)

Analysis



Countermeasures

Cause/Barrier Addressed	Countermeasure/Idea	Description and Expected Results ("If-Then")	Impact (H/M/L)	Effor (H/M
Poor retention and limited succession planning (A, B)	1. Expand access to career coaching; relieve advancement barriers (in partnership with HR) 2. Address burnout/workload 3. Review HR data (e.g., exit surveys, classifications at risk through retirement) and manager input	*If* we address underlying issues that limit advancement in PHD, build resilience to burnout, and know where we are at risk for losing key positions *then* we can increase engagement over time, limit staff turnover, and pursue strategic succession planning	H H M	H M M
Lack of & inequitable training/PD to address core competencies (B, C)	1. Manager 360 eval. data to support targeted training/PD plan 2. PPAR training assessment objectives defined 3. Strategic investment in front-line training (e.g., tech), ensuring equity 4. Online training (e.g., SOGI)	*If* we focus on staff (frontline as well as managers/supervisors) with unmet needs and inequitable access to training/PD, *then* we will observe improved engagement and skills among prioritized staff	M H H M	L L M L
Suboptimal supportive work environment (D)	1. Partner with racial equity A3 team to facilitate discussions within each PHD branch 2. Support communications skill building (e.g., Crucial Conversations)	*If* we increase staff self-efficacy to have crucial conversations, including those around racism, and increase cultural humility, *then* we will observe a more respectful, supportive work environment	H	H
Limited and inconsistent plans to recruit future public health workforce (D)	1. Develop PHD-wide internship standards (e.g., recruitment, pay, mentoring) and a comprehensive outreach strategy to academic and community partners	*If* we strategically partner with academic/community institutions and create quality experiences for trainees, *then* we will attract talented and diverse candidates to apply for PHD jobs	H	M

Implementation Plan

Countermeasure/Action	Description and Expected Result	Owner	Date
Convene a recruitment/ retention task force w/ a focus on staff of color	Review HR data and engage staff on barriers to effective recruitment and advancement, access to career coaching, and work overload/burnout	PHD Lead: Jessica Brown and LEO team	Convene LEO team Mar 2019
Plan and launch a cross-PHD Training and Professional Development QI effort	Generate tactical T/PD A3 that will review data on training gaps from PHWINS/listening sessions, conduct an equity analysis (manager input on who has/hasn't received training with a focus on contract staff), work with HR on Sharepoint one-stop-shop for training opps, and create PHD T/PD resource plan to support priority trainings for all staff	PHD Leads: Jonathan Fuchs, Jessica Brown/ Betsy Gran (HR)	Strategy developed by June 2019 using data from Staff Engagement event (4/19)
Use 360s to grow leadership competencies	Review 360 pilot conducted with Directors; modify for managers. Offer coaching and share aggregate results with all staff on key growth areas for leadership.	PHD Lead: J.Fuchs/ Beata Chapman (HR)	Complete 360s managers by Ju 2019
Develop a cross-PHD Internship Workgroup	Generate a tactical A3 that addresses strategies to recruit and support interns at PHD; work with DPH Pathways group	PHD Lead: Jessica Brown	Develop plan b July 2019

Follow-up

- Share training priorities derived from staff at 4/19 PHD Staff Engagement event with Directors/Managers
- Rollout Press Ganey Survey results to PHD after Exec team review/planning (target May 2019)
- Schedule Beata Chapman visits to Branches to discuss 360 process

Appendix J. Action Plans to strengthen high priority areas in Capacity, Capabilities, and Equity: Objectives, including lead organizations charged with implementation, performance measures, status and timeline.

Capacity				
Goal H2.1: Fill existing vacancies, hire new positions, and retain and sustain diverse talent.				
Indicator: Number/percent position vacancies in PHD (Data source, DPH HR, PHD Operations)				
Objectives	**Lead Organization**	**Performance Measures**	**Status**	**Timeline/ Comments**
H2.1a. Assemble a **PHD Operations taskforce** to hire and fill over 120 FTE by June 30, 2023.	SFDPH HR and PHD OPS hiring task force	Number and type of staff hired overall and by job type, classification, and race/ethnicity Time to fill job vacancies	In progress	Initiate Hiring Task force 11/2022
H2.2b. Enhance the **New Employee Orientation (NEO)** for new Population Health division staff in Q1 of 2023.	OPS CLI SFDPH HR	Number/percent of hired staff that complete the NEO within 30 days of start date Number/percent of staff completing the NEO who understand the 10 essential services (data source: knowledge check from online module)	In progress	Pilot to launch Q1 2023
H2.3c. Train managers and frontline staff on use of **annual Performance Plan and Appraisal (PPAR).**	CLI SFDPH HR	Number/percent of completed PPARs annually through PHD Number of annual trainings dedicated to support managers/staff with PPAR completion	Ongoing	Integrate training into managers CoP 6/2023 Integrate into staff workshop series by 5/2023
H2.4d. Develop **succession plans for each PHD branch**.	CLI PHD leadership SFDPH HR OARE	Number of succession plans drafted for each branch Number of senior management positions staffed by BIPOC leaders	In progress	Draft plans for all branches by 12/2023; update annually Workforce mobility trainings (eventbrite)
H2.5e. Conduct a **mixed methods workforce gap analysis**, integrating stakeholder interviews, and HR data to guide future workforce development investments, management and forecasting.	CLI SFDPH HR Public Health Institute (PHI)	PHI plan drafted and submitted to PHD	Not started	Gap analysis and plan completed by 5/2024 (funded by Project INVEST)

Capability				
Goal H2.2: Invest in fortifying PHD internal and external communications.				
Indicator: Percent of staff that believe leadership and frontline employees communicate well (Data source: PHWINS).				
Objectives	**Lead Organization**	**Performance Measure(s)**	**Status**	**Timeline/ Comments**
H.2.2.a. Host **monthly virtual PHD Town Halls**.	PHD OPS	Number of town halls hosted per year Proportion of PHD staff attending	Ongoing	Launched 7/6/2021
H.2.2.b. Distribute a **biweekly PHD newsletter** to provide staff with division events and updates.	PHD OPS	Number of PHD Newsletters published per year Percent of staff that "click through" open the PHD newsletter monthly	Ongoing	Email format launched 2014; Emma platform launched 10/2/2020
H.2.2.c. Launch and sustain a **community of practice (CoP) for managers and supervisors** to strengthen leadership skills, including communications.	CLI	Number of managers/supervisors attending CoP Number of trainings delivered on lean daily management system, including huddles	Ongoing	Initiated managers CoP 8/2022
H.2.2.d. Launch and maintain a **"one-stop-shop" Sharepoint site** dedicated to PHD staff training and professional development.	CLI	Number of site visitors per month Proportion of PHD staff using the site that would recommend it to colleagues (data source: website survey)	In progress	Launch site by March 2023
H.2.2.e. Provide multilingual PHD **staff training in working with the media** and communication science.	Public Information Office (PIO) CLI	Number of trainings offered Number and proportion of multilingual staff who feel confident in working with multilingual media (data source: training evaluation)	Not started	PHD communications specialist to be hired by 12/2023 through Project INVEST

Equity				
Goal H.2.3: Advance equity and anti-racism in PHD.				
Indicator: Percent of Black staff who "feel comfortable talking about race and racism in the workplace" (Data Source: Staff engagement survey)				
Objectives	Lead Organization	Performance Measure(s)	Status	Timeline/ Comments
H.2.3.a. Promote the **Black African American Health Initiative (BAAHI) learning series** for PHD staff.	DPH Office of Health Equity OARE CLI	Number/percent of PHD staff who self-report they attended BAAHI learning series sessions to complete the annual required equity training hours	Ongoing	Learning sessions launched in 2018
H.2.3.b. Host monthly **equity-focused workshops and healing sessions** for PHD staff.	OARE/ CLI	Number of attendees at monthly workshops/sessions Percent of staff who would recommend the program to colleagues	In progress	Launching 2/2023
H.2.3.c. **Promote Employee Affinity Groups (EAGs)** and provide technical assistance to PHD staff interested in starting/joining one.	DPH Office of Health Equity OARE CLI	Number of staff receiving technical assistance to participate in EAGs Number/% of EAGs meeting self-determined goals	Ongoing	Policies and tools released by the Office of Health Equity on 10/2022
H.2.3.d. **Host workshops on communications across cultures** for diverse PHD teams.	DHR/ CLI	Number of trainings delivered Number of participating staff that recommended training colleagues	In progress	Launch by 7/2023