

REGIONAL HEALTH EQUITY ASSESSMENT FOR COOS, CURRY,
AND DOUGLAS COUNTIES

Executive Summary

The Public Health Modernization Program for the region consisting of Coos, Curry, and Douglas Counties conducted two surveys based on the Bay Area Regional Health Inequities Initiative. The surveys are an attempt to describe and analyze the programmatic aspects related to public health departments' capability and capacity to work on issues and address environmental, social, and economic conditions that impact health. The target of one survey is the staff of the local health departments. The target of the second survey is the community partners that work with public health on the issues. The environmental, social and economic conditions that impact health will be referred to in the text as the Social Determinants of Health (SDH).

The surveys began in early September starting with the staff survey and concluded in 4 weeks. The partners survey began in mid-October and concluded in 3 weeks. Survey Monkey was used each time. The staff surveys were managed by using individual accounts; staff could enter and leave the survey and return to it without losing any data. The partners survey was managed by a sending a single link to the partner which the partner could share with their respondents. It needed to be completed in one sitting; the respondent could not leave and return without beginning over.

Overall, the return rates were quite good for the health department staff: 88% for Coos, 82% for Curry, and 100% for Douglas. Because of the management practice we could identify who had started and finished the surveys among LHD staff. The partners survey was less successful. We sent the survey to 49 agencies. We received 42 responses, and of those only 22 were completed surveys. We can only tell the type of agency that responded, not the specific agency.

The Staff Survey surveyed Coos (Coos Health and Wellness—CHW), Curry (Curry Community Health—CCH), and Douglas (Douglas Public Health Network—DPHN). A total of 40 staff responded: CHW (22); CCH (9), and DPHN (9). The partners survey was less successful. We sent the survey to 49 agencies. We received 42 responses, and of those only 22 were completed surveys. We can only tell the type of agency that responded, not the specific agency.

Staff Survey Results

There were 49 questions in the staff survey. Questions 1 through 10 were introductory questions that asked about the person's job and experience in public health. They also asked about what they thought are the most disproportionately and unjustly distributed health issues, and how much their health department addressed health inequities. Questions 11 through 21 asked about LHD plans and policies concerning health inequities. Questions 22 through 27 asked about collaboration within the health department; questions 28 through 30 asked about collaboration with external partners; questions 31 through 38 asked about collaboration with community groups; and questions 39 through 49 asked about support and training staff received to address SDH. All questions related to health inequities and SDH.

Questions 1-10 summary: Staff have a wide range of years of experience and various responsibilities. CHW is a larger, varied health department. All departments have a majority of staff who work directly with community residents and who are likely to understand the issues of the community. Those issues at the highest need of addressing are substance abuse, obesity/nutrition, behavioral health/mental health, lack of providers/access to care, low income, and homeless/housing. The social determinants of health that need addressing are housing, poverty, education and employment. About half the staff think that health departments are not doing enough to address health equity issues, although about a half think they are "about right" in their levels of effort.

Questions 11-21 summary: Planning a policy questions were answered with a very mixed opinion. This could be because some staff have very limited responsibilities and don't do or know about a much broader range of responsibilities. Many staff think their health departments have mission, vision, and value statements that address health equity. However, about an equal number say "No" or they do not know. The same goes for plans and policies that address SDH. Most staff think that the health departments and staff are committed to working on these, even if there may be a lack of written commitment, policies, strategies, and plans. In creating plans and strategies, staff were asked about the role of outside partners and community leaders play in strategizing and directing the work to address health inequities. Most staff do not know what those roles are, or which groups are involved. Staff feel that many of the programs are designed to address the issues and feel that they play a part in program planning efforts. Asked about their work in relation to the Ten Essential Services of Public Health, a bit more than half of the answers agreed or strongly agreed that the work was tied to one of the 10 services. There were many "Not applicable" answers. For instance, "Link to provider care" was the most commonly answered "Agree" or "Strongly Agree". This was heavily weighted by CHW because it has clinics and clinical workers. The same is not true of DPHN, which has no clinics. Its CD program, however, does make referrals for tests and treatment.

Question 22-27 summary: Not all staff feel that they have a chance to collaborate inside their health departments on issues of SDH. Most staff feel that they can give input on program decisions, but some do not know if it is effective. The same is said about department decisions. Most staff will know why a decision that affects their program was made, but less likely to always know why a decision that affected the whole department was made. Staff are split whether they agree or are neutral when asked if they are encouraged to be creative in approaches to challenges or in learning from each other or other sources about SDH.

Question 28-30 summary: It was not believed that there was a lot of collaboration with external public agencies. Where it does occur seems to be with agencies that serve youth, children, and in community safety. There are not many who believe that there is a lot of collaboration with community-based organizations. Some think it is happening but are not certain with whom it is occurring. Staff understand that external partners represent the issues and needs of residents, and that there are trusting relationships between the health department and the agency

Question 31-38 summary: The health department staff feel that they work well with community members and that they understand the community and its issues. The staff have some problems with resolving conflicts, bringing resources to the community, or being the voice of the community when bringing community issues to the health department. As mentioned before, CWH is larger and has more staff working with community groups. All community groups listed have at least one LHD staff person who works with them. A larger percentage of CCH and DPHN staff work with community groups than does CWH. There are indications of strong networks, relationships, and strategies to work with community groups on issues that impact health. Fewer than half of the staff in all three departments believe that they do enough to build capacity of community leaders to address SDH.

Question 39-49 summary: Most staff have had training on SDH. There are great variations among the LHDs' percentages of staff who received some type of training for planning, policy development and advocacy work aimed at the SDH. As a region, we have some work to do helping our staff develop these skills. Training seems concentrated only on conferences, trainings and workshops. There is little encouragement to use opportunities for professional development in the area of SHD. More encouragement, policies, and training assistance would help staff engage, plan, and execute program strategies within their agency and with other public and external partners. Staff feel comfortable with discussing classism and racism and other topics of cultural competency. They do not know much about management practices when it comes to seeking, hiring, or keeping a diverse workforce. Few think that culturally appropriate methods are assessed, or that culturally appropriate program delivery is planned or implemented. Overall, our region itself is not very diverse and that is reflected in the demographic makeup of staff. That is not to say we should not identify and work towards better delivery of needed public health services to the minority populations in our counties. The root of health inequities is in institutionalized racism.

Partner Survey Results

There were 18 questions in the Collaborating Partner Survey. Unlike the Staff Survey, this survey was not divided into topical sub-sections.

Questions 1-6 were introductory questions that asked about the respondent, the organization or group they work for, and their work with the local health department in the community. They also asked about what they thought are the top 5 unevenly and unfairly distributed health issues in the community and what the leading environmental, social, and economic conditions (SDH) that impact these issues are. Questions 7-9 addressed the organization/group's work with their local health department (LHD) with regards to SDH. Question 10 asked about the LHD's role in and commitment to addressing SDH as well as the commitment of individual LHD staff member and their understanding of and familiarity with the community. Question 11 asked about community meetings held by the LHD. Question 12 asked about the LHD's relationship and communication with the community. Questions 13-15 asked about community and external partner involvement in program planning and delivery. Question 16 asked about LHD involvement with and support for community groups and the work they are doing as well as the appropriateness of materials distributed and data shared with the community.

Each LHD collaborates with different organizations; however, the primary work of partner organizations for all three counties was advocacy/policy based. No collaboration is done by any LHD with private business or research focused groups. Many of the partner organizations have worked with their LHD for at least 5 years. CCH and DPHN also have a large portion of partners with whom they have worked with less than 5 years. However, as they are both relatively new LHDs, this is not unexpected or problematic. For all three LHDs, the relationship with partners is one of cooperation with/assisting the LHD. Most DPHN partners also work with the LHD on networking/info sharing. Collaboration is a two-way street. Ensuring that the LHD is truly collaborating with partner organizations and not just including them in LHD activities should be a top priority.

The most frequently listed unevenly and unfairly distributed health issues in the region are mental/behavioral health, chronic illness, substance abuse, access to care, and obesity/nutrition. The main SDH related to these issues were poverty, housing/homelessness, transportation, access to care, and lack of mental health services. Many of the SDH listed were interconnected, so addressing one will likely impact the others.

Most participants indicated that their organization/group's work with their LHD addresses SDH in some way, which was good. However, region wide improvements should be made with regards to educating community members and external partners on what SDH are and the importance of always including them in the work being done.

Survey results indicate that LHD need to focus on working with a diverse group of partners in order to address the issue impacting SDH. While there are limitations to how much an LHD can feasibly do, increasing the numbers and types of collaborative partners should still be a top priority for the region.

Another top priority for the region should be communication. Especially with regards to programming, LHDs should be more transparent. Additionally, regarding programming, LHDs should strive to include partner organizations in the entire program planning process. Currently, regional LHDs are doing an okay job including partners in the beginning of the process, but that's it. Additionally, community needs, and input should be a significant factor in program planning. Utilizing community partners and leaders to provide this feedback is very important and under-utilized in the region.

A final priority area, based on these survey results, is supporting community leaders and building the capacity of community members to advocate for themselves. Again, collaboration is a two-way street. As a whole, the region does a decent job of including partners in LHD business. However, the LHDs should also be integral parts of their community networks and supporting community partners in the work that they are doing as well.