Statistical Brief

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Local Health Departments and Community Based Organizations: Results from the North Carolina 2003 Public Health Partnership Survey

by Harry Herrick

Introduction

In North Carolina, partnerships between Local Health Departments ('LHDs' or 'LHD') and Community Based Organizations ('CBOs' or 'CBO') are one of the keys to reducing health disparities among underserved populations. Gaps in services, such as medical care for the uninsured, can be addressed through these partnerships. In addition, by partnering with health departments, CBOs gain access to health department resources: building space for services, health department clients, and health department expertise. By partnering with CBOs, LHDs extend their reach into the community, are better able to address the needs of the state's minority populations, and also gain expertise from CBOs.

The catalyst for this survey arose, in large part, from the need for a comprehensive (statewide) assessment of the strengths and limitations of these partnerships. In early 2003, the State Health Director commissioned the State Center for Health Statistics to implement the N.C. Public Health Partnership (PHP) Survey and report on its findings.

The survey consisted of 13 questions which assessed the benefits and challenges of LHD/CBO partnerships, and barriers that affected the organization's ability to serve minority populations and provide after hours services. Two open-ended questions appeared at the end of the survey, allowing for written response on possible actions to improve these partnerships and improve services for minority/ethnic groups.

Methods

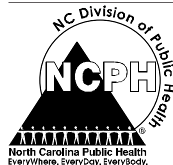
In March of 2003, survey packets were mailed to all LHD Directors and all CBOs funded by the Division. The packet contained an introductory letter signed by the State Health Director, the questionnaire, and a postage-paid envelope for returning the survey. Participants were given approximately six weeks to complete and return the survey. Those who did not respond within the time period were called at least twice and sometimes three times to encourage their participation. Full participation among LHDs was of particular interest to the State Health Director.

For the most part, the analysis of the survey was limited to categorical questions, requiring the respondent to choose from a list of predefined categories. In the following tables, we show only the top three categories chosen by LHDs and CBOs. Since both organizations were asked the same survey questions, their results are combined into a single table.

For Question 6, pertaining to the challenges of working collaboratively, the results were stratified by the perceived strength of the working relationship. LHDs and CBOs who gave their working relationship a score of 4 or higher on the five-point Working Relationship Scale (the **strong** group) were analyzed separately from those who rated their relationship with scores below 4 (the **moderate** group).

We begin with a brief description of the response rates for the NC 2003 PHP Survey sample.

NOTE: A full-length report of the NC 2003 PHP Survey results was produced for the Division and is available on the State Center's web site: www.schs.state.nc.us/SCHS/. In this Statistical Brief, we feature selected findings from that report.



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Results

Table 1 shows that the response rate among LHDs was about 73 percent, while the response rate for CBOs was about 35 percent. These differing response rates indicate that the study results of the LHD group are likely to be more representative of the LHD population than those of the CBO study group. Given the low response rate among CBOs, the results for this group need to be viewed with caution.

Table 1. Response Rates for NC 2003 PHP Sample

	Mailed Surveys	Completed Surveys (returned & useable)	Response Rate
LHDs	85	62	72.9%
CBOs	109	38	34.8%

In Table 2, the results show that both CBOs and LHDs selected mission compatibility as the top reason for initiating their partnerships. Having 'established a positive reputation in the community' was also one of the top three reasons for both groups. The ability to reach diverse populations and collaboration on community health assessments were also seen as important.

Table 2. Top *3* Most Important Reasons for Initiating Partnerships, in Order of Priority: LHDs & CBOs

		No.	%
LHDs:	1. Knew organization's mission was compatible with ours	41	66.1
	2. Knew organization could reach diverse population	30	48.4
	3. Has established a positive reputation in the community	28	45.2
CBOs:	1. Knew organization's mission was compatible with ours	20	74.1
	2. Has established a positive reputation in the community	9	33.3
	3. Collaborated on community health assessments	9	33.3

Note: Percentages add to more than 100% because respondents could check multiple answers.

When asked to rate the strength of their working relationship, LHDs gave a somewhat higher rating than CBOs: both the mean and mode (most frequently occurring value) were higher for LHDs (Table 3). Nonetheless, the majority of CBOs (over 70%) viewed their working relationship as strong, characterized by scores of 4 or 5 on the scale.

Table 3. Rating of Working Relationships, Based on the Working Relationship Scale: LHDs & CBOs

Needs improvement	1	2	3	4	5	Strong relationship
No. of LHDs	0	5	6	24	27	
Percentage of LHDs Mean – 4.2; Mode – 5		8.1%	9.7%	38.7%	43.5%	
No. of CBOs	2	3	6	15	12	
Percentage of CBOs Mean – 3.8; Mode – 4	5.2%	7.9%	15.8%	39.5%	31.6%	

For LHDs and CBOs with a **strong** working relationship (scores of 4 or 5 on the Working Relationship Scale), Table 4a reveals that the top 3 challenges of working together are the same for both organizations. Moreover, resource availability appears first on both lists.

Table 4a. Top *3* Challenges of Working Together, in Order of Priority: CBOs & LHDs with *Strong* Working Relationships

		No.	%
LHDs:	1. Resource availability	35	68.6
	2. Capacity of CBOs/HDs	25	49.0
	3. Organizational stability(staffing stability/turnover)	24	47.1
CBOs:	1. Resource availability	19	70.4
	2. Organizational stability (staffing stability/turnover)	11	40.7
	3. Capacity of CBOs/HDs	9	33.3

For LHDs and CBOs with a **moderate** working relationship (scores of 3 or lower on the Working Relationship Scale), 'Communications' was selected as the top challenge of working together (Table 4b).

Table 4b. Top *3* Challenges of Working Together, in Order of Priority: CBOs & LHDs with *Moderate* Working Relationships

		No.	%
LHDs:	1. Communications	6	54.5
	2. Capacity of CBO's/HD	5	45.5
	3. Resource availability	5	45.5
CBOs:	1. Communications	7	63.6
	2. Resource availability	5	45.5
	3. Coordination between agencies	5	45.5

Table 5 features the three most important benefits and advantages of working together. As was the case regarding the top 3 challenges of working together (Table 4a), the same three benefits (out of a possible 11 benefits) were top on the list for both organizations. The opportunity to extend resources received the most attention.

Table 5. Top *3* Benefits/Advantages of Working Together, in Order of Priority: LHDs & CBOs

		No.	%
LHDs:	1. Opportunity to extend resources	29	46.8
	2. Maximize resources – leverage	28	45.2
	3. Community unity focus on public health issues	24	38.7
CBOs:	1. Opportunity to extend resources	24	63.2
	2. Community unity focus on public health issues	23	60.5
	3. Maximize resources – leverage	17	44.7

When asked to identify the top three barriers that affect their ability to serve racial and ethnic minority populations, both CBOs and LHDs selected lack of client transportation and language differences between clients and providers as two of the top three barriers (Table 6). For LHDs, lack of insurance or ability to pay for services was also an important barrier, while for CBOs, inadequate number of staff was important.

Table 6. Top *3* Barriers to Providing Services for Racial/Ethnic Minorities, in Order of Priority: LHDs & CBOs

		No.	%
LHDs:	1. Language between clients and provider	36	58.1
	2. Lack of insurance or other means to pay for services	31	50.0
	3. Client's lack of transportation	31	50.0
CBOs:	1. Client's lack of transportation	20	52.6
	2. Inadequate number of staff	14	36.8
	3. Language between clients and provider	12	31.6

Lack of staff and lack of resources were two of the most important barriers to providing after hours services for both LHDs and CBOs (Table 7). In addition, the cost of services was an important barrier for LHDs; and for CBOs, 'Staff scheduling challenges' was an important barrier.

Table 7. Top *3* Barriers to Providing After Hours Services, in Order of Priority: LHDs & CBOs

		No.	%
LHDs:	1. Lack of staff	45	72.6
	2. Cost of services or operations	35	56.5
	3. Lack of resources	34	54.8
CBOs:	1. Lack of resources	21	55.3
	2. Lack of staff	20	52.6
	3. Staff scheduling challenges	17	44.7

Selected Open-ended Responses

From the two open-ended survey questions, the following (unedited) excerpts from CBOs and LHDs appear relevant to the topics posed by the categorical questions.

Reasons for initiating partnerships

"*As health care providers, our mission and goals should always be somewhat compatible to one another. We are both working hard towards improving the health of the entire community.*"

Working relationships

"*We have excellent relationships. Being small has mandated the need for all agencies to work together.*"

Challenges of working together

"*Coordinating goals and objectives to maximize health care delivery of service. Shared funding and resources …*"

"*… For local health department staff to think outside of bureaucracy and not expect community based organizations to be run or operate as they have to*."

Benefits of working together

"*Develop win-win situations*"

"*If LHD can provide resources such as transportation, and materials for classrooms, we will be better equipped to service our clients*."

Barriers affecting ability to serve minority populations

"*Language barriers.*"

"*Having more diverse population working in both the health department & community based organizations."*

"*Increased funding for translaters – communication is our greatest barrier – lack of interpreters."*

Key Findings

- Local Health Departments and Community Based Organizations share a common perception of their partnership. Both organizations tended to identify with the same challenges and benefits of their partnership.
  - The top challenge of working together was resource availability.
  - The top benefit of working together was the opportunity to extend resources.
- Language differences between clients/providers and lack of transportation were top on the list (for both CBOs & LHDs) of factors that affected their organization's ability to serve minority populations.
- For both CBOs and LHDs, lack of staff and lack of resources were seen as two of the most important barriers to providing after hours services.
  - The cost of services was second on the list of barriers for LHDs
  - The cost of services was not among the top 3 on the list for CBOs.

Study Limitations

The low response rate among CBOs limits the reliability of the study findings. Secondly, it was not known who completed the survey: the Health Director or some other staff person with possibly differing views of the partnership.

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