Report: Organizational Profile of PHDMC Partners

Meeting the Goals of the National Stakeholder Strategy for Achieving Health Equity

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This report illustrates descriptive data generated from a PHDMC-developed, on-line questionnaire, *National Partnership for Action (NPA) Organizational Checklist*. This is based on the *National Stakeholder Strategy for Achieving Health Equity* (full narrative outlining five goals available from http://minorityhealth.hhs.gov/npa/). The questionnaire was disseminated between March 4, 2013 and May 31, 2013 to 65 organizations that partner with Public Health- Dayton & Montgomery County. The Results and Discussion sections that follow are based upon data collected from 24 organizations (37% response rate) and are presented as a profile of organizations related to the five goals mentioned above (more description of each goal will be provided in the "Results" section).

Results

Demographics. This section highlights key characteristics of responding organizations, including role and organizational focus. The majority (n= 16, or 67%) of respondents are at the level of founder, director or executive director. The remaining roles include treasurer, project manager, or specialist.

The organizations indicated their focus and were able to select "all that apply" from 10 categories. Table 1 indicates the strongest presence of health-provider/ health related and community-based/minority-serving. However, only seven of 24 (29%) stated their focus as being the latter (a seemingly important distinction for this particular query).

Table 1
Organizational Focus

Focus (Presented in Order on Survey)	*Frequency*
Faith-Based	8% (n=2)
Community-Based/ Minority Serving	29% (n=7)*
Health-Provider/ Health-Related	42% (n=10)*
Business: Private/ For Profit	4% (n=1)
Business: Non/Not for Profit	25% (n=6)*
Clinic	21% (n=5)
Health Department	4% (n=1)
Hospital	0%
Government Agency/ Entity	4% (n=1)
School	4% (n=1)

*Note: Top three areas of focus

Six organizations provided comments to "Other". They include mental health, education, and public media.

Consumer/ client populations served by these organizations vary, although the majority (63%, n=15) checked "all that apply" to five categories: a) Asian- 25%; b) Black/African American- 33%; c) Caucasian/ White- 25%; d) Hispanic- 21%; e) Native American/ Alaskan- 13%. Three organizations that checked any or all categories also checked "all that apply". "Other" categories mentioned in open text were Appalachian, Somali, and African Nationals.

Within these ethnicity categories, organizations provided additional characteristics on their consumer/ client populations. The majority (75%) serve adults age 18 to 59 years. The majority (71%) also serve low-income individuals according to the federal criteria. A substantial portion (67%) serve children under 18 years old and seniors 60 years and older (63%). Many serve uninsured and unemployed individuals (both categories, 58% respectively). Limited/ non-English speaking (54%), disabled (50%), and insured/ underinsured (50%) are also prominently represented in these client groups. Some (46%) serve retired and fixed income individuals while 46% also assist non-U.S. citizens. "Other" categories mentioned included HIV and young adults (14-25 years old).

Organizations indicated several forms of programming (see Table 2 below). The top three areas are community outreach, health education, and advocacy/ public policy.

Table 2
Organizational Programs and Services

Focus (Presented in Order on Survey)	*Frequency*
Health Education	67% (n=16)*
Health Care/ Screenings	42% (n=10)
Public/ Private Education	17% (n=4)
Food/ Nutrition Assistance	21% (n=5)
Community Outreach	83% (n=20)*
Crisis Intervention	33% (n=8)
Interpretation/ Translation	33% (n=8)
Housing/ Shelter Assistance	17% (n=4)
Transportation Assistance	33% (n=8)
Advocacy/ Public Policy	46% (n=11)*
Signage in Multiple Languages	8% (n=2)
Elder Care	21% (n=5)

*Note: Top three areas of focus

The least frequent areas involve signage in multiple languages and public/private education. "Other" categories include mental health care, palliative and end of life care, violence intervention, school choice and higher education access, and air pollution control.

The Five Goals. The purpose of the NPA to End Health Disparities goal statements, available from http://minorityhealth.hhs.gov/npa/, is to provide a guiding framework from which organizations can assess their prioritization of recommended ways to enhance health equity. First, the NPA encourages organizations to improve public understanding of health disparities (Awareness- Goal 1). Next, the NPA sees capacity building for community solutions and investing in youth as important characteristics of community leadership (Leadership- Goal 2). Various organizational activities to improve healthcare access and improve the social determinants of health fall under Goal 3- Health System and Life Experience. Improving the diversity of the workforce and cultural competency where possible is related to Goal 4- Cultural and Linguistic Competency. Organizational activities that focus on data driven decision-making and evidence based research are annotated under Goal 5- Data, Evaluation, and Research. The items on the questionnaire (see following Tables 3-7) provide some operational definitions by which organizations can monitor their activities on the overarching goal statements.

Table 3 illustrates the averages (on a 0 to 4 scale) and standard deviations per eight items in Goal Area 1- Awareness (n=24). Of note, qualifiers and examples for some items listed in the on-line questionnaire are not listed in the tables. For each goal, respondents indicated whether their organizational functions in each area were 0- None, 1- Minimal, 2- Moderate, 3- Significant, or 4- Optimal.

Table 3
Goal 1 Results

Goal #1- *Increase awareness of the significance of health disparities, their impact on population health, and the actions necessary to improve health outcomes for underserved populations, including racial and ethnic groups.*	Average (S.D.)	None to Minimal Frequency
1. Include health disparities on the organization's board agenda.	2.25 (1.15)	25%
2. Provide administration leaders, health professionals, and staff information or an orientation about health disparities.	2.46 (1.02)	17%
3. Develop and support partnerships that drive action.	2.92 (.88)	8%
4. Utilize traditional media such as print or flyers.	2.04 (.96)	33%
5. Utilize electronic and social media.	2.30 (1.11)	21%
6. Tailor messaging and communication mechanisms for specific audiences across the lifespan.	2.26 (1.18)	21%
7. Tailor messages that are culturally sensitive and culturally appropriate.	2.71 (.96)	13%
8. Tailor messages to present varied views of the consequences of health disparities in a way that fosters understanding, action, cooperation, and collaboration.	2.71 (1.04)	17%

Although most organizations show between moderate and significant activity generally for this goal, some of the 24 organizations are notably low, noting either "None" or "Minimal". For instance, 25% of organizations indicate 0 or 1 on including health disparities as a topic on their agenda. The omnibus average for Goal #1 is 2.46 (between moderate and significant), which includes all responding organizations. They appear most adept at developing and supporting partnerships (m=2.92, s.d. = .88).

Table 4 illustrates the averages (on a 0 to 4 scale) and standard deviations per the three items in Goal Area 2- Leadership (n=24). As shown, the highest rated item is around capacity building with groups such as coalitions and organizations to provide effective health services.

Table 4
Goal 2 Results

Goal #2- *Strengthen and broaden leadership for addressing health disparities.*	Average (S.D.)	None to Minimal Frequency
1. Engage in capacity building. Work to increase ability and empower other organizations or groups to provide effective health services at all levels of decision making to promote community solutions.	2.67 (1.13)	17%
2. Solicit community input on funding priorities.	2.17 (1.13)	29%
3. Invest in, engage youth in planning and/or implementation of initiatives.	2.25 (1.19)	29%

Although most organizations show between moderate and significant activity for this goal, some of the 24 organizations are on the low side, noting either "None" or "Minimal". For instance, 29% (n=7) of organizations indicated 0 or 1 on soliciting community input on funding priorities and engaging youth. The omnibus average for Goal #2 is 2.36 (between moderate and significant).

Table 5 (below) illustrates the averages (on a 0 to 4 scale) and standard deviations in Goal Area 3. As shown, the highest rated item is working to ensure access to quality health care for all. The least-rated activity appears to be around working to increase high school graduation rates.

Table 5
Goal 3 Results

Goal #3- *Improve health and healthcare outcomes for racial, ethnic, and underserved populations.*	Average (S.D.)	None to Minimal Frequency
1. Work to ensure access to quality health care for all.	3.04 (1.16)	13%
2. Ensure the provision of services to children, including at-risk and those in foster care.	2.42 (1.47)	29%
3. Enable provision of services and programs for older adults to foster healthy aging.	2.63 (1.31)	21%
4. Engage in enhancement and improvement of health service experiences.	2.71 (1.20)	21%
5. Work to increase high school graduation rates.	2.04 (1.55)	42%
6. Promote the connection between educational attainment and long-term health benefits.	2.12 (1.26)	29%
7. Support and implement policy (ies) that improve social economic conditions necessary for improved health outcomes.	2.83 (1.01)	13%

As in other tables, several items in Goal 3 show high standard deviations (>1.0). This indicates that several of them did not "agree" in arriving at the average. For example, 14 indicated they worked to increase high school graduation rates at a moderate to optimal level, while 10 indicated this at a low to minimal level (42%). Although most organizations showed between moderate and significant activity for this goal, some (between 13% and 42%) of the 24 organizations were notably low, noting either "None" or "Minimal". The omnibus average for Goal #3 is 2.54 (between moderate and significant).

Table 6 illustrates the averages (on a 0 to 4 scale) and standard deviations per items in Goal Area 4- Cultural and Linguistic Competency (n=24). As shown, the highest rated item is about

Table 6
Goal 4 Results

Goal #4- *Improve cultural and linguistic competency and the diversity of the health-related workforce.*	Average (S.D.)	None to Minimal Frequency
1. Promote availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities (workforce development).	1.96 (1.16)	38%
2. Increase diversity and inclusion through recruitment, retention, training, and inclusion of racially, ethnically, and culturally diverse individuals through leadership action (hiring, board representation).	2.83 (.76)	4%
3. Encourage interpreters, translators, and bilingual staff who provide services in languages other than English, to follow codes of ethics and standards of practice for interpreting and translation.	2.26 (1.60)	33%
4. Encourage financing and reimbursement of health interpreting services.	1.96 (1.49)	42%

increasing ethnic and racial diversity in hiring and board recruiting. However, workforce training on cultural competency and encouraging reimbursement of health interpreting services are rated lowest. The omnibus average for Goal # 4 is 2.25 (between moderate and significant).

Table 7 illustrates the averages (on a 0 to 4 scale) and standard deviations per items in Goal Area 5- Data, Evaluation, and Research (n=24). The highest rated item is collecting demographic or health data. The lowest rates areas are around improving research coordination and community-based participatory research. The omnibus average for Goal #5 is 2.28 (between moderate and significant).

Table 7
Goal 5 Results

Goal #5- *Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes.*	Average (S.D.)	None to Minimal Frequency
1. Collect demographic or health data.	2.67 (1.37)	21%
2. Ensure availability of data for all racial, ethnic, and underserved populations.	2.29 (1.43)	33%
3. Make opportunities for and/or participate in community-based research and action.	2.25 (1.19)	21%
4. Make opportunities for and/or participate in community-originated intervention strategies.	2.25 (1.23)	29%
5. Invest in community-based participatory research and evaluation of community-originated intervention strategies, in order to build capacity at the local level.	2.13 (1.36)	38%
6. Support and improve coordination of research that enhances understanding about methodology.	2.04 (1.30)	38%
7. Participate in academic collaborations (i.e., clinical rotations, mentoring, etc.)	2.38 (1.44)	29%
8. Utilize, expand, and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making utilization of evidence-based research/models.	2.25 (1.23)	25%

Discussion Points

- Although several respondents are from the health provider/ health-related and community/ minority serving sectors, they are not the majority. The database for collecting these data could be reviewed for better matches to the NPA Profile. Organizations serving minorities in the community seem particularly important to this query.

- Overall and across goals, respondents show Moderate and Significant activity levels, but not Optimal. In some cases, this may reflect an organizational desire for more resources and/or capacity building on specific items (working to increase high school graduation rates, soliciting community input on funding priorities) within the goals to boost activity.

- The organizations were consistently Moderate to Significant across goals; however, there are stronger areas than others as noted by the omnibus means. The strongest area, per means comparisons, appears to be in Goal #3- *Improve health and healthcare outcomes for racial, ethnic, and underserved populations.* However, this strong area begs some follow up as to why such a low proportion of organizations noted "community-based/ minority serving" for their client populations.

- The lowest omnibus means are in Goal # 4- *Improve cultural competency and workforce diversity* and Goal #5- *Improve diffusion of research and evaluation outcomes*. Some follow up could be employed to determine if organizational programming opportunities exist for improving the rate of minorities in the health professions. Organizations without evaluators or academic partnerships that foster community-based participatory research may not prioritize it. Given that the organizations report strength in developing and supporting partnerships (Goal #1), they would likely have the social infrastructure in place to seek funding around community-based participatory research and evaluation of grassroots interventions.

- The stronger items shown in Goals 1 and 2 both have to do with fostering partnerships (such as formal collaborations or coalitions) to improve community conditions. It seems that organizations then could use their partnership infrastructure for working on weaker goal areas such as improving workforce diversity and employing community-based participatory research practices.

- Despite a fairly high rate of youth as clients (67% of organizations reporting this), the youth engagement items of Goals 2 and 3 have a fair amount of "None to Minimal" responses (29% and 42%, respectively). Some PHDMC follow-up in the form of phone calls or interviews on the reasons behind these lower priority areas (with the organizations reporting youth as constituents x "None to Minimal" responses), could lead to desired consultation and resource referral opportunities.