Health Equity Assessment and Resource Team (HEART)
LTHD Health Equity Strengths and Needs Survey
Results Summary

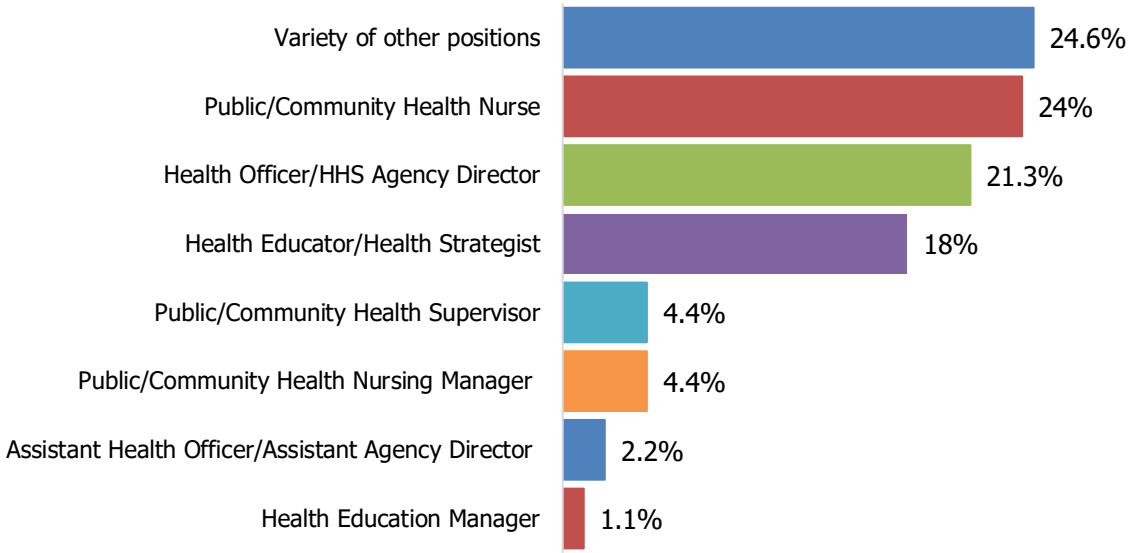
From April 20-May 11, 2022, local and tribal health departments (LTHDs) were invited to complete a survey to help the Office of Policy and Practice Alignment (OPPA) better understand the strengths and needs of local jurisdictions to advance health equity.

There were 183 unique responses, consisting of 113 fully and 70 partially completed surveys. Since the questions were designed to be optional, the number of responses for a given question is included with the results, whenever relevant.

Respondent demographics

Position

Most survey responses came from public health nurses or nursing managers; health officers, HHS agency directors or assistant officers/directors; or public health educators/strategists or health education managers.



Region

Responses came from all five regions:

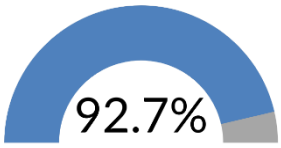
- About 25% each from the Western and Northeastern regions
- About 20% from the Southeastern region
- Around 15% each from the Northern and Southern regions

Most (61%) respondents serve rural jurisdictions, and 17.5% serve a primarily urban jurisdiction. The largest proportion of respondents (38.3%) serve jurisdictions with 20,001-50,000 people; while only six percent of respondents work in a jurisdiction serving more than 180,000 people.

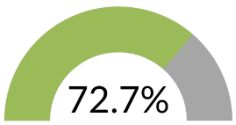
Health Equity and Social Determinants of Health (SDoH)

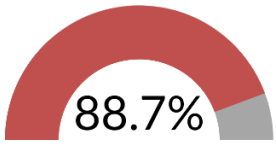
The vast majority of respondents view advancing health equity and addressing SDoH as being within their purview, however only half feel they have the necessary knowledge and skills to do so.

Role/responsibility

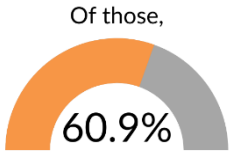


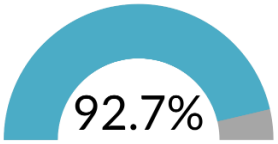
of 150 respondents indicated it is the role/responsibility of public health to improve health outcomes for groups experiencing the worst health outcomes.



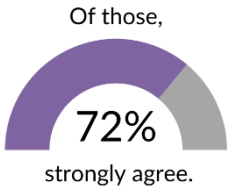


of 151 respondents indicated that it is the role/responsibility of LTHDs to work to improve social determinants of health.





of 150 respondents indicated that is the role/responsibility of LTHDs to work toward greater health equity.



Impact on programs and policies

69.5% of 151 respondents indicated that awareness of SDoH affects design & implementation of programs/policies. (**23.8%** strongly agreed)

67.1% of 149 respondents indicated that awareness of health equity and health disparities affects design & implementation of programs/policies. (**32.9%** strongly agreed)

Confidence

46.7% of 152 respondents indicated that they have the necessary knowledge and skills to incorporate SDoH into their work.

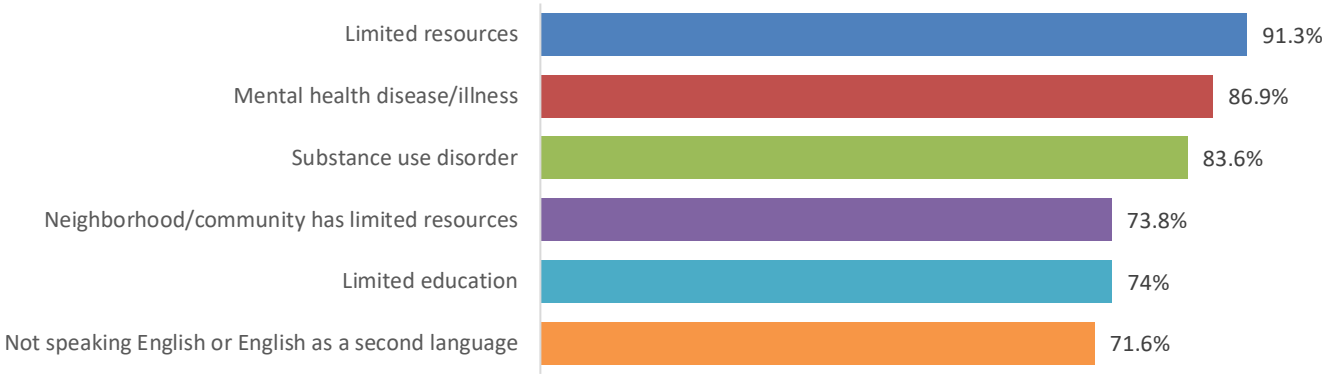
50.7% of 150 respondents indicated that they have the necessary knowledge and skills to incorporate health equity into their work.

45.6% of 112 respondents absolutely agree or agree that their LTHD has the knowledge, skills, and resources to evaluate public health policies and programs for health equity.

The low degree of confidence combined with a high degree of identifying equity as their role is a strong argument for providing ongoing learning communities and other opportunities for LTHD staff to learn and develop health equity skills.

Where, how, and for whom are inequities showing up?

LTHDs rely on relationships with community organizations and the CHA/CHIP process to identify which community members are experiencing inequities. Respondents identified that people in their jurisdictions experiencing the following have the greatest inequities in health outcomes:



An overwhelming majority of respondents identify that social, economic, and environmental factors impact health outcomes in their jurisdiction. The five factors seen as having the greatest impact are:

- Income (poverty, low wages, unemployment)
- Housing
- Transportation
- Food security
- Race/racism

Many LTHDs work with community partners to respond to these issues either through referrals or collaborations, while a small fraction engage in policy strategies.

Respondents overwhelmingly indicated they would like to learn more about the factors that influence health. The SDoH should be prioritized as topic areas for learning communities, along with information about developing and implementing policy changes.

Community input

A little more than half of 115 respondents said they absolutely agree or agree that their external partners include and/or represent the interests and needs of populations experiencing inequity in their jurisdiction.

LTHDs most commonly invite input from the following groups:

- Health care providers
- K-12 school districts
- Community coalitions
- Aging and disability resource centers
- Other government agencies

Online surveys are the most common method for gathering input from the community, followed by focus groups, comment forms, and one-to-one interviews. Organizations that represent or serve people who are marginalized most often provide input through steering committees or advisory groups. Participation

in focus groups, one-to-one interviews, and online surveys are also common strategies for gathering organizational input.

The majority of respondents indicated they would like to learn more about:

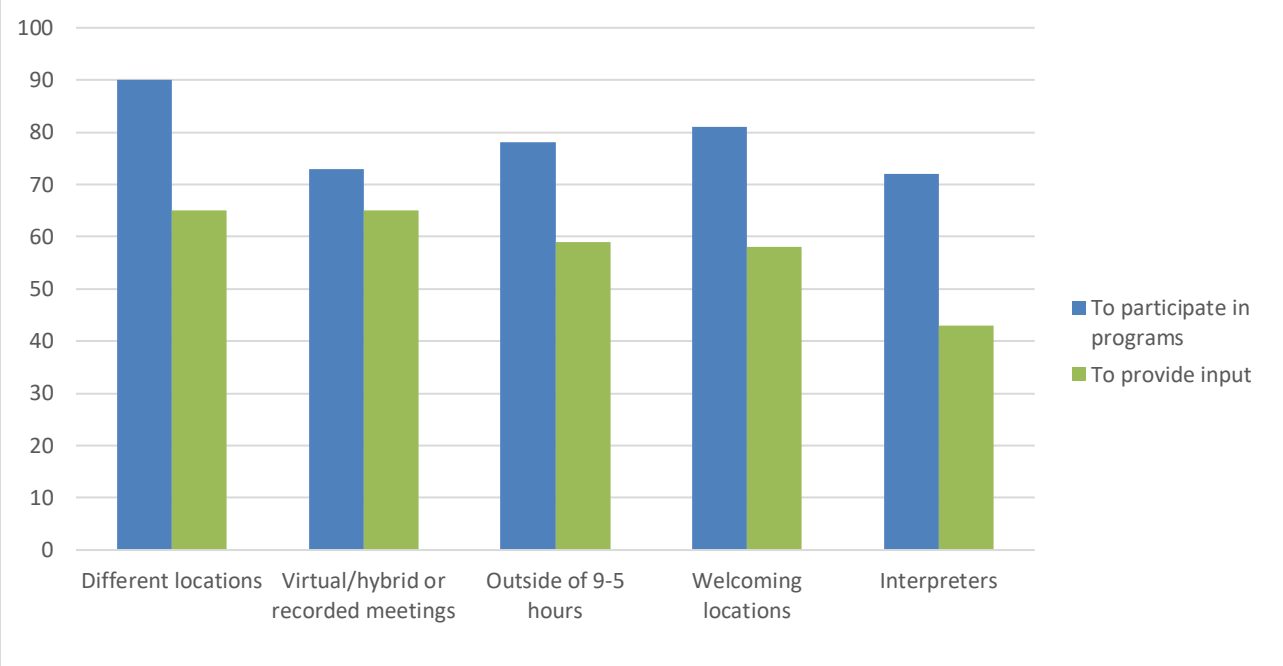
- Identifying potential new partnerships.
- Building relationships with organizations that work with marginalized members of their communities.
- Identifying, building, and sustaining relationships and partnerships to advance health equity.

Community input is deeply important, particularly from people who have limited access to influencing the systems and structures that impact our lives. It's equally important to be mindful of whose voices are heard and which experiences are represented. For example, using online surveys are useful for collecting and compiling information from the community, but can exclude the perspectives of people with limited internet access or literacy skills.

LTHDs use a variety of strategies to increase accessibility and community engagement. The following are commonly used to reduce barriers so people can participate in programming:

- Held at different locations for community convenience
- Held at locations where community members feel comfortable and welcomed
- Held outside of 9-5 work hours
- Virtual or hybrid options and/or meetings are recorded
- Interpreters are provided

These same strategies are used to decrease barriers and facilitate gathering diverse community input, but respondents indicated that they are all used to a lesser extent. The drop-off in use of interpreters for getting community input is particularly worth noting and of concern.



HEART learning communities will provide LTHDs with information on collaborating with community partners, and how to establish and work with partners who include and/or represent the interests of populations experiencing inequities.

Learning communities will also provide information on expanding where and how input is sought and collected to ensure that people in the most vulnerable positions are represented.

Evaluation and evidence

Respondents indicated interest in learning more about all nine evaluation methods listed in the survey:

- Results-based accountability (RBA)
- Community-based participatory research
- Environmental scan
- Program evaluation
- Gathering qualitative data
- Gathering quantitative data
- Quality improvement/Plan Do Study Act (PDSA)
- Customer satisfaction survey
- Logic model

The vast majority of respondents indicated that their LTHD currently monitors and assesses the impact of programs, policies, outreach, or initiatives on health equity. Quantitative data, program evaluation, and qualitative data are the three methods most commonly used.

Another opportunity for training and learning is reflected in the fact that about half of respondents identify that their LTHD uses evidence-based practices to improve health equity, and 41% use promising practices and practice-based evidence.

Preferred learning methods

Respondents indicated their preferred formats to learn about health equity are: