A Report on the North Carolina 2003 Public Health Partnership Survey of Local Health Departments and Community Based Organizations

North Carolina
Department of Health and Human Services
Division of Public Health
State Center for Health Statistics

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Foreword

The Division of Public Health is very pleased to present the findings of the 2003 North Carolina Public Health Partnership Survey sent to every local health department and community based organization (CBO), and which was funded by the Division. I would like to take this opportunity to thank you for your participation in this effort. We know that strong community based partnerships will help us achieve our collective goal of a healthier North Carolina for all people and the elimination of disparities in health status.

The Executive Summary of this survey highlights key findings regarding the relationships between local health departments and community based organizations, including concerns that we all have in common and issues that we can continue to work together to improve. Not surprisingly, both CBOs and local health departments listed collaboration on specific health initiatives as the major reason they work together. Both CBOs and local health departments listed resource availability as a top challenge.

North Carolina's public health system is strong and responsive. We have met and overcome many challenges, foreseen and unforeseen, time and time again. However, we are also concerned that the needs of our communities are increasing during a time when resources are not increasing fast enough to meet those needs. For example, the survey clearly points out that both CBOs and local health departments listed language differences between clients/providers and lack of transportation as top factors affecting their ability to serve minority populations. These challenges are not new and they are serious barriers that impede our mission. However, ongoing and unacceptable health disparities in our state require that we continue to work together at the local and state level to develop short- and long-term solutions.

Thank you again for participating in the survey. We encourage you to read and study these findings and discuss them with your staff and, more importantly, with each other as public health partners. The results of this survey point out the value of active communication and collaboration within communities. The best resources public health has in the fight to eliminate health disparities are the partnerships between local health departments and community based organizations.

Thank you for your hard work and commitment everywhere, every day on behalf of everybody we serve.

Leah Devlin, DDS, MPH
State Health Director
Director, N.C. Division of Public Health

Executive Summary

The following are key findings from the 2003 N.C. Public Health Partnership (PHP) Survey regarding the relationship between Local Health Departments and Community Based Organizations:

- Both LHDs and CBOs selected mission compatibility as the most important reason for initiating partnerships.
- On a scale of 1 to 5, LHDs tended to give a higher rating to the strength of their relationship than CBOs did.
- Collaborating on health initiatives was first on the list of ways in which both organizations have worked together.
- The opportunity to extend resources was selected by both as the most important benefit of their partnership.
- For CBOs and LHDs with strong relationships, the top challenge of working together was resource availability.
- For CBOs and LHDs that had moderately strong relationships ("needs some improvement"), the top challenge was communication.
- Outreach through clients and student intern opportunities were the primary ways in which both organizations recruited professional staff from minority groups.
- Language differences between clients/providers and lack of transportation were tops 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 a factor (top 3 on the list) among CBOs.

Purpose of the Survey

The 2003 North Carolina Public Health Partnership (PHP) Survey was designed to assist state and local-level policy makers with a better understanding of the strengths, benefits, barriers, and challenges of the working relationships between Local Health Departments ('LHDs' or 'LHD') and Community Based Organizations ('CBOs' or 'CBO'). The survey was intended to yield insight into factors which might promote or attenuate the development of these ongoing working relationships. The survey was also designed to capture the degree of racial/ethnic diversity among health department and CBO staff, and identify barriers to services being offered to minority groups after business hours.

Survey Background

CBO & Local Health Department Partnerships

Working together, CBOs and LHDs help broaden and enhance the availability of public health services in North Carolina, especially for the underserved. 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 and are better able to address the needs of the state's minority populations.

Implementation of the Survey

The N.C. PHP Survey was commissioned by the State Health Director and implemented by the State Center for Health Statistics in the spring of 2003. The State Center is located within the North Carolina Division of Public Health, whose broad activities are overseen by the State Health Director. In addition to other major responsibilities, the State Center assists the Division with survey and data analysis needs.

The State Center's role in implementing the survey included: 1) compiling the population list (i.e., names, addresses, telephone numbers) of all county health directors and the list of all directors of CBOs that are funded by the Division; 2) overseeing the design of the survey; 3) mailing the survey; 4) entering the survey data in electronic format; 5) analyzing the data; and 6) preparing a brief report of findings.

The survey was designed exclusively as a mail survey. Because of the possible sensitivity of some of the survey questions, and because of the State Center's ties with the State Health Director, it was deemed that a telephone survey (or telephone follow-up survey of mail non-responders) might compromise the validity of responses, particularly those from open-ended questions, such as "What actions can help to establish and improve relationships between Local Health Departments and Community Based Organizations?"

Methods

Data Collection

In early March 2003, survey packets were mailed to all eligible CBO executives and LHD directors. The packet contained an introductory letter (see Appendix J for LHD letter) specifying the importance of the project, and date for returning the survey, which was signed by the State Health Director. The questionnaire and a postage-paid envelope for returning the survey were included in the packet. 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. Inadequate response rates during the initial data collection period forced an extension of data collection that continued through June. Throughout this process, the State Health Director was keenly interested in obtaining the highest possible response rate from county health directors. On at least one occasion, additional copies of the survey were handed out during a statewide meeting of county health directors, which was attended by the State Health Director.

Analysis

This is a descriptive report of the NC 2003 PHP Survey results. The results for this study pertain only to the closed-ended questions found in the CBO and LHD surveys. These questions contain a forced-choice format that do not allow for written responses. Of the 13 total questions in the CBO and LHD surveys, questions 2, 3, 4, 5, 6, 7, 8, 9, and 11 were analyzed for this report (see LHD and CBO surveys in Appendix H & I).

The format of the data tables follows the format of the survey questions. Each table uses the exact wording of the survey question and all categories pertaining to the question. Since CBOs and LHDs were asked the same closed-ended questions, the results from their responses were shown a single table for each of the closed-ended questions.

In the tables, we show the number and percentage of LHDs and CBOs responding to each of the categories associated with the survey question. Question categories were sorted in descending frequency; this means that the category that was most often selected appears first, followed by the second most-often selected category, and so on.

For survey question Q3, we show the arithmetic mean and modal value of the 5 point Working Relationship Scale, pertaining to LHDs' and CBOs' perceived strength of their working relationships. The arithmetic mean is the average of all scores from 1 to 5; the modal value is the most frequently occurring score.

For item Q6, pertaining to the challenges of working collaboratively, the results are shown first for the entire distribution of categories (Table 6); and the results are shown a second time (Tables 6a and 6b) for the top three challenges, 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 Working Relationship Scale (Q3) were assigned to the STRONG group; those with a score below 4 were assigned to the MODERATE group. The results of Q6 were then re-analyzed for each of these two subgroups.

For item Q9, separate tables were constructed for LHDs and CBOs. The LHD table (Table 9a) used weighted data. To adjust (or account) for different staff sizes of North Carolina health departments, the percentages of FTE staff by race/ethnicity and occupational levels that were reported by LHDs were weighted using the number of LHD employees obtained from the State Center's 1999 Facilities Management Survey of LHDs. We did not have current information on the staff sizes of CBOs to allow weighting of the CBO data.

The appendices begin on page 27 and end on page 107. All open-ended responses from the questionnaires may be found in these appendices. Some of these responses are also featured in the results when relevant to the topics of the close-ended questions.

We begin with a brief description of the response rates of the North Carolina 2003 PHP Survey sample.

Results

Table 1 shows that the response rate for LHDs was about 73 percent, more than twice as high the response rate for CBOs. We may assume from these differing response rates 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, with fewer than 35 percent of these organizations participating in the study. Because of the low response rate among CBOs, the results for this group ***need to be viewed with caution*.**

Table 1. Response Rates for N.C. 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 CBOs and LHDs most often selected the compatibility of their organizational missions as the most important reason for initiating their partnerships; about two-thirds of LHDs and about three-quarters of CBOs selected this category. Among the second or third most important reasons for initiating partnerships, both groups also selected having 'established a positive reputation in the community' as an important factor. In this case, however, the number of LHDs or CBOs who selected this factor dropped sharply from their first-choice numbers. This suggests there was less consensus among LHDs and CBOs on the second or third most important reasons for initiating partnerships.

Among the top three reasons that differed between LHDs and CBOs, LHDs saw the importance of knowing the CBO could reach a diverse population, while CBOs saw the importance of having worked on community health issues with LHDs (Table 2).

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

Local Health Departments			
Q2.	What were the 3 most important reasons that you initiated your partnership with a Community Based Organization? (check three)	**No. of LHDs**	**% of 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
	Work in a Healthy Carolinians partnership	27	43.5
	Collaborated on community health assessments	16	25.8
	Knew the organization's Director or one of its Board members personally	10	16.1
	My staff spoke highly of the organization's community work	9	14.5
	Other	8	12.9
	Had an initial meeting with staff from the LHD/left with a favorable impression	7	11.3

Community Based Organizations			
Q2.	What were the 3 most important reasons that you initiated your partnership with the Local Health Department? (check three)	**No. of CBOs**	**% of 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
	Had an initial meeting with staff from the LHD/left with a favorable impression	8	29.6
	Knew organization could reach diverse population	8	29.6
	Knew the organization's Director or one of its Board members personally	7	25.9
	Other	7	25.9
	Work in a Healthy Carolinians partnership	6	22.2
	My staff spoke highly of the organization's community work	3	11.1

Selected Comments Depicting Reasons for Initiating Partnerships

LHD:

"KNOWING YOUR COMMUNITY PARTNERS AND ACTIVELY SEEKING OPPORTUNITIES TO COLLABORATE ON ACTIVITIES AND PROJECTS THAT IMPACT ON COMMUNITY HEALTH IMPROVEMENT."

"COMMON INTEREST, PROBLEM OR NEED IN COMMUNITY"

CBO:

"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."

As shown in Table 3, it appears that LHDs have a somewhat more favorable view of their working relationships with CBOs than vice versa. Both the mean and modal values for the Working Relationship Scale were higher for LHDs compared to CBOs. Moreover, 43.5 percent of LHDs gave their relationship a rating of 5 – the highest possible score – compared to 31.6 percent of CBOs. Nonetheless, the results of Table 3 *also* indicate that the great majority of CBOs (over 70%) and LHDs (over 80%) view their working relationship as strong, characterized by scores of 4 or 5 on the scale.

As noted previously, data from item Q3 were used to define the stratification variable for Question 6. Those with scores below 4 comprised the MODERATE working relationship group; the remainder were assigned to the STRONG group, while 17.8 percent of LHD respondents (n=11) and 28.9 percent of CBO respondents (n=11) fell into the MODERATE working relationship group.

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

Local Health Departments							
Q3.	Overall, how would you rate your ongoing working relationship with community based organizations in your county?						
	Needs Improvement	1	2	3	4	5	Strong Relationship
	No. of LHDs	0	5	6	24	27	
	Percentage of LHDs		8.1%	9.7%	38.7%	43.5%	
	Mean – 4.2						
	Mode – 5						

Community Based Organizations							
Q3.	Overall, how would you rate your ongoing working relationship with local health departments in your county?						
	Needs Improvement	1	2	3	4	5	Strong Relationship
	No. of CBOs	2	3	6	15	12	
	Percentage of CBOs	5.2%	7.9%	15.8%	39.5%	31.6%	
	Mean – 3.8						
	Mode – 4						

Selected Comments Describing Working Relationships

LHD:

"WE HAVE EXCELLENT RELATIONSHIPS. BEING SMALL HAS MANDATED THE NEED FOR ALL AGENCIES TO WORK TOGETHER. I DON'T HAVE ANY SUGGESTIONS FOR IMPROVEMENT UNLESS IT WOULD BE MORE STAFF TO DO MORE OUTREACH TOGETHER."

"RELATIONSHIPS ARE OK – BUT ALL ARE BUSY. TO ACCOMPLISH GOALS, NEED ADEQUATE FUNDING COMMUNITY BASED & PERSONAL INITIATIVES."

CBO:

"WE HAVE A WONDERFUL WORKING RELATIONSHIP WITH OUR LHD."

"WE ALREADY ENJOY A VERY STRONG COLLABORATIVE RELATIONSHIP WITH OUR LOCAL HEALTH DEPARTMENT."

With regard to ways CBOs and LHDs have worked together (Table 4), the top three categories most often selected among LHDs were: 1) collaboration on health initiatives, 2) assisting with planning and implementing projects, and 3) attending and participating in event planning. The top three on the list for CBOs were similar: 1) collaboration on health initiatives, 2) carrying out community education programs, and 3) attending and participating in event planning. Other joint activities that were chosen with some degree of frequency included coordinating free space for meetings, having health fairs, and providing technical assistance.

Those activities that were least often selected by CBOs and LHDs included assisting with staff trainings and orientations, and inviting members to attend Local Board of Health meetings.

Selected Comments on Ways LHDs & CBOs Have Worked Together

LHD:

"THE HEALTH EDUCATION SECTION PROVIDES COMMUNITY OUTREACH & EDUCATION & PROGRAM PLANNING IMPLEMENTATION & EVALUATION."

CBO:

"OUR PROGRAM PROVIDES MORE FOLLOW-UP ALONG WITH HOME VISITS AS NEEDED. THERE ARE SUPPLIES THAT WE PROVIDE THAT MAY NOT BE AVAILABLE AT THE CLINIC SUCH AS CLOTHING, PAMPERS, HEALTH & BEAUTY AIDS, ETC. WE HELP EACH OTHER WITH FILLING GAPS WE BOTH MAY HAVE."

"WE ARE PARTNERING WITH THEM ON A TEEN OUTREACH PROGRAM."

Table 4. Ways LHDs & CBOs Have Worked Collaboratively, in Order of Priority

Local Health Departments			
Q4.	Check ways your LHD has worked with CBO. (Check all that apply.)	**No. of LHDs**	**% of LHDs**
	Collaborate with CBOs on health initiatives	56	90.3
	Staff assist with planning and implementing projects	52	83.9
	Attend and participate in event planning	52	83.9
	Carry out joint community education programs	50	80.6
	Carry out health screening/counseling with CBO	49	79.0
	Have health fairs with CBO	46	74.2
	Staff provide technical assistance	43	69.4
	Donate supplies for community activities	41	66.1
	Coordinate providing free space for the CBO to hold meetings/conduct outreach	36	58.1
	Underwrite the cost of printing materials	30	48.4
	Assist CBO with staff training and orientations	22	35.5
	Invite CBO to attend Local Board of Health meetings	19	30.6
	Other	13	21.0

Community Based Organizations			
Q4.	Check ways your CBO has worked with the LHD. (Check all that apply.)	**No. of CBOs**	**% of CBOs**
	Collaborate with CBOs on health initiatives	28	73.7
	Carry out joint community education programs	27	71.1
	Attend and participate in event planning	26	68.4
	Have health fairs with CBO	25	65.8
	Staff assist with planning and implementing projects	21	55.3
	Staff provide technical assistance	17	44.7
	Coordinate providing free space for the CBO to hold meetings or conduct outreach	15	39.5
	Donate supplies for community activities	14	36.8
	Carry out health screening/counseling with CBO	14	36.8
	Assist CBO with staff training and orientations	12	31.6
	Invite CBO to attend Local Board of Health meetings	10	26.3
	Other	8	21.1
	Underwrite the cost of printing materials	4	10.5

Table 5 shows that both CBOs and LHDs selected the same most important benefit in working together: the opportunity to extend resources. Furthermore, when the top three benefits are named, the list is the same for both groups. CBOs and LHDs also placed the same relative priority on other benefits as well, including building health care capacity, lending credibility to public health activities, and community advocacy.

The public/private bridge and community ownership were least likely to be perceived as benefits.

Selected Comments Related to Benefits/Advantages of Working Together

LHD:

"DEVELOP WIN-WIN SITUATIONS"

"IF CBOS & LHDS KNOW ABOUT EACH OTHER'S GOALS, PURPOSES, PROJECTS, THEN [THEY ARE] MORE LIKELY TO CONTACT EACH OTHER TO COORDINATE OR COLLABORATE ON A COMMON GOAL OR PROJECT"

CBO:

"USE CBOS EXPERIENCE WITH DIVERSE POPULATIONS – THEY ARE OFTEN EXPERTS IN THIS AREA."

"IF LHD CAN PROVIDE RESOURCES SUCH AS TRANSPORTATION AND MATERIALS FOR CLASS-ROOMS, WE WILL BE BETTER EQUIPPED TO SERVICE OUR CLIENTS."

Table 5. Most Important Benefits/Advantages of Working Together, in Order of Priority: LHDs & CBOs

Local Health Departments			
Q5.	What are the three most important benefits/advantage of working with a Community Based Organization? (Check three)	**No. of LHDs**	**% of 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
	Build health care capacity	21	33.9
	Generate support for public health issues	20	32.3
	Credibility to public health activities/focus – shared credibility	20	32.3
	Community advocacy	13	21.0
	Local control	11	17.7
	Community ownership	9	14.5
	Public/private bridge	3	4.8
	Other	1	1.6

Community Based Organizations			
Q5.	What are the 3 most important benefits/advantage of working with the Local Health Department? (Check three)	**No. of CBOs**	**% of 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
	Build health care capacity	12	31.6
	Credibility to public health activities/focus – shared credibility	10	26.3
	Local control	7	18.4
	Community advocacy	6	15.8
	Generate support for public health issues	3	7.9
	Public/private bridge	3	7.9
	Other	3	7.9
	Community ownership	1	2.6

Similarly, Table 6 shows unanimous agreement among CBOs and LHDs with regard to the top challenge of working together: resource availability. There was further agreement among CBO and LHD respondents on the challenges of the organization's capacity, the organization's stability, and communications. Least among the challenges for LHDs was loss of control and least among the challenges for CBOs was accountability.

Table 6. Top Challenges of Working Together, in Order of Priority: LHDs & CBOs

	Local Health Departments		
Q6.	What are the 3 top challenges of working with your county's Community Based Organizations? (Check three)	**No. of LHDs**	**% of LHDs**
	1. Opportunity to extend resources	29	46.8
	1. Resource availability	40	64.5
	2. Capacity of CBOs/LHDs	28	45.2
	3. Organizational stability (staffing stability/turnover)	28	45.2
	Communications	25	40.3
	Coordination between agencies	22	35.5
	Accountability	18	29.0
	Other	7	11.3
	Loss of control	6	9.7
	Community Based Organizations		
Q6.	What are the 3 top challenges of working with your county's Local Health Department? (Check three)	**No. of CBOs**	**% of CBOs**
	1. Resource availability	24	63.2
	2. Communications	14	36.8
	3. Capacity of CBOs/LHDs	14	36.8
	Organizational stability (staffing stability/turnover)	14	36.8
	Coordination between agencies	13	34.2
	Other	8	21.1
	Loss of control	6	15.8
	Accountability	1	2.6

Selected Comments Related to Challenges of Working Together

LHD:

“ORGANIZATIONAL STABILITY (CBO) AND STABLE STAFF – MEANINGFUL COLLABORATIONS & WILLING TO ACTUALLY SHARE RESOURCES AND INFORMATION AND OVERCOME TURF.”

“COORDINATING GOALS AND OBJECTIVES TO MAXIMIZE HEALTH CARE DELIVERY OF SERVICE – SHARED FUNDING AND RESOURCES …”

“RESTRAINTS TIED TO FUNDING”

CBO:

“WILLINGNESS – COMMUNICATION – OPPORTUNITIES – WE DO NOT COLLABORATE WITH SOME HEALTH DEPARTMENTS VERY WELL”

“… 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.”

“ … THAT LOCAL HEALTH DIRECTORS TREAT CBOS WITH RESPECT AND AS PEERS.”

Table 6a shows the top three challenges for CBOs and LHDs that have **strong** working relationships, as defined by scores of 4 or 5 on the Working Relationship Scale. The type and ordering of the top three challenges for these LHDs (n=51) remains the same as that of all LHDs, as shown in Table 6. For CBOs with strong working relationships (n=27), the challenge of communication drops out as one of the top three challenges, which was present among all CBOs (Table 6). Furthermore, the types of challenges for strong-relationship CBOs and LHDs are the same: resource availability and organizational capacity and stability.

Table 6a. Top 3 Challenges of Working Together, in Order of Priority: CBOs & LHDs with STRONG Working Relationships

	Local Health Departments		
Q6.	What are the 3 top challenges of working with your county's Community Based Organizations?	**No. of LHDs**	**% of LHDs**
	1. Resource availability	35	68.6
	2. Capacity of CBOs/LHDs	25	49.0
	3. Organizational stability (staffing stability/turnover)	24	47.1
	Community Based Organizations		
Q6.	What are the 3 top challenges of working with your county's Local Health Department?	**No. of CBOs**	**% of CBOs**
	1. Resource availability	19	70.4
	2. Organizational stability (staffing stability/turnover)	11	40.7
	3. Capacity of CBOs/LHDs	9	33.3

Table 6b shows the top three challenges for CBOs and LHDs that have **moderate** working relationships, characterized by scores of less than 4 on the Working Relationship Scale. Among LHDs (n=11) and CBOs (n=11) with moderate working relationships, the issue of communication becomes the number-one challenge. For moderate-relationship LHDs, the remaining two challenges are the same as those of LHDs with strong relationships. For moderate-relationship CBOs, coordination between agencies emerges as one of the top three challenges.

Table 6b. Top 3 Challenges of Working Together, in Order of Priority: CBOs & LHDs with MODERATE Working Relationships

Local Health Departments			
Q6.	What are the 3 top challenges of working with your county's Community Based Organizations?	**No. of LHDs**	**% of LHDs**
	1. Communications	6	54.5
	2. Capacity of CBOs/LHDs	5	45.5
	3. Resource availability	5	45.5
Community Based Organizations			
Q6.	What are the 3 top challenges of working with your county's Local Health Department?	**No. of CBOs**	**% of CBOs**
	1. Communications	7	63.6
	2. Resource availability	5	45.5
	3. Coordination between agencies	5	45.5

Table 7 displays the prioritized list of efforts being employed by LHDs and CBOs to recruit minority professional staff. Top on the list for LHDs is the category of 'other.' From some of the write-in responses of Q7, respondents noted: advertising in local newspapers, websites, the Employment Security Commission, bulletin boards in county offices and public libraries, and job fairs at local universities (see Appendix C). Next on the list for LHDs are the provisions of student internship opportunities and outreach through CBOs. Advertising in minority-owned newspapers ranked fifth on the list for LHDs.

For CBOS, the three top efforts to recruit minority staff included outreach through CBOs, out-reach through clients, and student internships. Advertisement in minority-owned newspapers ranked fourth on the list.

For both CBOs and LHDs, TV advertisements were the least likely to be used.

Table 7. Efforts to Recruit Management, Professional, and Clinical Staff from Minority Groups, by Order of Priority: LHDs & CBOs

	Local Health Departments		
Q7.	What efforts are done in your local health department to recruit management, professional, and clinical staff from minority groups? (Check all that apply)	**No. of LHDs**	**% of LHDs**
	Other	31	50.0
	Student Intern opportunities	30	48.4
	Outreach through grassroots Community Based Organization	24	38.7
	Outreach through clients served	24	38.7
	Advertise in minority-owned newspapers	14	22.6
	Advertise in career offices of Historical Black Colleges and Universities	11	17.7
	Advertise in career offices of Community Colleges	11	17.7
	Advertise in radio stations targeting significant numbers of minority populations	6	9.7
	Advertise in TV stations serving minority populations	5	8.1

	Community Based Organizations		
Q7.	What efforts are done in your community based organization to recruit management, professional, and clinical staff from minority groups? (Check all that apply)	**No. of LHDs**	**% of LHDs**
	Outreach through grassroots Community Based Organization	23	60.5
	Outreach through clients served	22	57.9
	Student Intern opportunities	19	50.0
	Advertise in minority-owned newspapers	14	36.8
	Advertise in career offices of Community Colleges	8	21.1
	Advertise in radio stations targeting significant numbers of minority populations	7	18.4
	Other	7	18.4
	Advertise in career offices of Historical Black Colleges and Universities	6	15.8
	Advertise in TV stations serving minority populations	2	5.3

For CBOs and LHDs, clients' lack of transportation and language barriers between clients and providers were both seen as two of the top three barriers that affect their organization's ability to serve racial and ethnic minority populations (Table 8). For LHDs, lack of insurance or means to pay for services was listed as the second most important barrier; half of all LHDs selected this factor. For CBOs, inadequate number of staff was listed as the second most important barrier.

Low on the list of barriers for both CBOs and LHDs was low literacy and waiting time. Lack of minority staff was lowest on the list of barriers for CBOs and sixth on the list for LHDs.

Table 8. Barriers that Affect Organization's Ability to Serve Minority Populations, in Order of Priority: LHDs & CBOs

	Local Health Departments		
Q8.	What are the top three barriers that affect your organization's ability to serve racial and ethnic minority populations? (Check three)	**No. of LHDs**	**% of 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
	Lack of information and/awareness about service availability	20	32.3
	Inadequate number of staff	16	25.8
	Client's cultural beliefs	13	21.0
	Lack of minority staff	9	14.5
	Low literacy	8	12.9
	Waiting time	5	8.1
	Facilities open too few hours or inconvenient hours	5	8.1
	Client's attitudes	3	4.8
	Community Based Organizations		
Q8.	What are the top three barriers that affect your organization's ability to serve racial and ethnic minority populations? (Check three)	**No. of CBOs**	**% of 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 information and/awareness about service availability	12	31.6
	Lack of insurance or other means to pay for services	9	23.7
	Client's attitudes	7	18.4
	Facilities open too few hours or inconvenient hours	5	13.2
	Client's cultural beliefs	5	13.2
	Low literacy	4	10.5
	Waiting time	2	5.3
	Lack of minority staff	1	2.6

Selected Comments on Barriers Affecting Ability to Serve Minority Populations

LHD:

"$FUNDING$."

"INCREASED FUNDING FOR TRANSLATORS – COMMUNICATION IS OUR GREATEST BARRIER – LACK OF INTERPRETERS."

"RECRUITING MINORITIES BECAUSE OF OUR NON-COMPETITIVE LOW PAY SCALE."

"OVER 1/2 OF SERVICE POPULATION IS HISPANIC WITH NO REIMBURSEMENT – IF FUNDED COULD EXPAND STAFF & HOURS. HAVE NURSING SCHOOLS/DENTAL HYGIENE HAVE MORE MINORITY GRADUATES – RETURN TO RURAL AREAS."

"MORE MATERIALS IN SPANISH, ADVERTISING/OUTREACH TO DIVERSE POPULATION – BI-LINGUAL SPEAKING STAFF IN EACH DEPT, ESPECIALLY AT FRONT DESK"

CBO:

"LANGUAGE BARRIERS"

"INCREASE FUNDS FOR TRANSLATION/INTERPERTATION CLASSES FOR PROVIDERS IN LANGUAGE OTHER THAN ENGLISH. NON-TRADITIONAL HOURS OF OPERATION. TRAIN HEALTH DEPT ON DIVERSITY/SENSITIVITY & FLEXIBILITY."

"HAVING MORE DIVERSE POPULATION WORKING IN BOTH THE HEALTH DEPARTMENTS & COMMUNITY BASED ORGANIZATIONS."

"IT IS VERY DIFFICULT IN MANY CASES TO SERVE INDIVIDUALS OF VARIOUS DIVERSE POPULATIONS. ISSUES SUCH AS CULTURAL COMPETENCE AND MULTICULTURALISM ARE TOP FACTORS THAT NEED TO BE ADDRESSED. WE AS LHDS & CBOS CAN COLLABORATE ON A MULTI-ETHNIC APPROACH LEVEL AND ENCOURAGE ONE ANOTHER TO PARTICIPATE IN DEVELOPING MINORITY SUPPORT MECHANISMS."

Table 9a (below) features the reported LHD data for the percentage of FTE staff by race/ethnicity and job classification. The percentages in Table 9a are the weighted average or mean percentages obtained from the LHDs in the study. Collectively, it appears that high-level or managerial positions in LHDs are predominantly filled by whites (84.3%). African Americans occupy a little more than 10 percent of these jobs, while their numbers in the general population represent about 20 percent of North Carolina's adult population. For administrative support positions and service positions in LHDs, the distribution of African American employees more closely reflects their numbers in the population. Hispanics appear in less than one percent of all LHD positions, while their numbers now represent about five percent of the state's population.

Table 9a. Average Percentage of FTE Staff (Weighted) by Race and Occupation Level In North Carolina: Local Health Departments, 2003 PHP Survey

	Local Health Departments						
Q9.	Please fill in the percentages of FTE staff belonging to a particular race or ethnicity within each occupational level.						
	Type of Staff	**White %**	**Black %**	**Asian %`**	**Am. Indian %**	**Hispanic %**	**Other %**
	Management/Supervisory FTEs	84.3	12.4	1.3	0.3	0.3	1.3
	Admin. Support/Clerical FTEs	70.5	24.1	0.1	1.3	0.5	3.4
	Service delivery/all other service providers FTEs	75.5	18.6	0.2	1.6	0.4	3.7

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Table 9b (below) features unweighted average percentages of FTE staff by race/ethnicity and job classification reported by the CBOs. The percentages in Table 9b are the average or mean percentages obtained from the 38 CBOs in the study. Unlike LHDs, whites and African Americans occupy about an equal percentage of all CBO managerial and administrative support jobs. No CBOs, however, reported having any Hispanics in these types of jobs. Among service-level positions, African Americans occupy a noticeably higher percentage of these jobs than whites. Also, American Indians were somewhat more likely to be represented among CBOs than among LHDS.

These results for CBO staffing need to be tempered by the fact that the number of CBO FTEs are likely to be considerably smaller than the number for LHDs, and small numbers can greatly influence the mean.

Table 9b. Average Percentage of FTE Staff (Unweighted) by Race and Occupation Level in North Carolina: Community Based Organizations, 2003 PHP Survey.

Community Based Organizations							
Q9.	Please fill in the percentages of FTE staff belonging to a particular race or ethnicity within each occupational level.						
	Type of Staff	**White %**	**Black %**	**Asian %`**	**Am. Indian %**	**Hispanic %**	**Other %**
	Management/Supervisory FTEs	47.7	45.2	0.0	3.0	0.0	4.1
	Admin. Support/Clerical FTEs	44.1	46.9	0.0	3.7	0.0	5.3
	Service delivery/all other service providers FTEs	33.5	49.9	0.4	3.9	0.4	12.1

Table 10. Major Barriers to Providing After-Hours Services, in Order of Priority: LHDs and CBOs

	Local Health Departments		
Q11.	What are the top three factors that are a major barrier to providing after-hours services? (Check three)	**No. of LHDs**	**% of LHDs**
	1. Lack of Staff	45	72.6
	2. Cost of services or operations	35	56.5
	3. Lack of Resources	34	54.8
	Staff scheduling challenges	33	53.2
	Lack of clients	20	32.3
	Other	5	8.1
	Safety of providers	4	6.5

	Community Based Organizations		
Q11.	What are the top three factors that are a major barrier to providing after-hours services? (Check three)	**No. of CBOs**	**% of CBOs**
	1. Lack of Resources	21	55.3
	2. Lack of Staff	20	52.6
	3. Staff scheduling challenges	17	44.7
	Cost of services or operations	14	36.8
	Safety of providers	10	26.3
	Other	10	26.3
	Lack of clients	4	10.5

Lack of staff and lack of resources were seen as two of the most important barriers to providing after-hours services (Table 10). For LHDs, the cost of these services was included in the list of the three most important barriers; for CBOs, staff scheduling challenges was included in the list.

Lack of clients was the least important barrier for CBOs, but was, to some extent, a problem with LHDs (32.3%). The safety of providers was lowest on list of barriers for LHDs, but was, to some degree, a problem for CBOs (26.3%).

Selected Comments Related to Barriers Affecting Provision of After Hours Services

LHD:

"1. CBOS NEED TO RECOGNIZE THAT HEALTH DEPTS ARE NATURAL PARTNERS – NOT THE ENEMY. 2. CBOS NEED TO UNDERSTAND THAT "AFTER HOURS" AVAILABILITY OF SERVICE IS NOT A GUARANTEE CLIENTS WILL COME IN AT ALTERNATE HOURS."

CBO:

"MORE BILINGUAL CLINICAL STAFF ARE DESPERATELY NEEDED – AFTER HOURS CARE IS ALSO A MAJOR NEED – NEITHER OF WHICH ARE BEING SUFFICIENTLY ADDRESSED CURRENTLY."

Conclusion

The most prominent and consistent finding from this study of Local Health Departments and Community Based Organizations is that both share a common perception of their partnership. When given a list of reasons for initiating their partnership, a list of benefits derived from their partnership, a list of challenges for the partnership, and a list of barriers that affect their ability to serve minority populations, both organizations – independently of one another – tended to select the same most important reasons or factors on the list; they share a common understanding of their relationship, their mission, and the challenges they face.

Secondly, in light of their mutual perception of benefits and challenges, both share a similar view of the strength of their relationships. When asked to rate the strength of their relationship, the majority of LHDs and CBOs rated their working relationship closer to "strong" than "needs improvement." Among the minority of LHDS (17.8%) and minority of CBOs (28.9%) who rated their working relationship closer to "needs improvement," the issue of communication was chosen by both as the number-one challenge. Certainly, communication is the cornerstone of any effective organizational partnership – any effective relationship.

Thirdly, where their perceptions tended to differ, we found that LHDs have a somewhat more positive view of their working relationship than CBOs, which may indicate that LHDs see less need for improvement in the relationship. We also found that LHDs may be more concerned about the cost of rendering services.

Finally, we note the limitations of this study. Most importantly, we do not know if the Local Health Director or CBO Director actually completed the survey; this task may have been relegated to a lower-level employee who may have had different views of the partnership than the Director. Also, the small number of CBOs in the study limits the reliability of these findings. In addition, there's a great deal of qualitative information in this study that was not brought into our analysis. This information (in the Appendices) may support or weaken some of our conclusions, which were based on the categorical and numeric data.

Appendices

2003 Public Health Partnership Survey

Appendix A. Participating Local Health Departments and Community Based Organizations

Local Health Departments

Alamance
Alexander
Anson
Avery
Beaufort
Bladen
Brunswick
Buncombe
Cabarrus
Caldwell
Carteret
Catawba
Chatham
Cherokee
Cleveland
Craven
Dare
Davidson
Davie
Duplin
Durham
Edgecombe
Franklin
Gaston
Granville-Vance
Guilford
Henderson
Hoke
Iredell
Jackson
Johnston
Jones
Lee
Lenoir
Lincoln
Macon
Madison
Mecklenburg
Montgomery
Nash
New Hanover
Northampton
Pamlico
Pender
Person
Pitt
Randolph
Richmond
Robeson
Rockingham
Rowan
Sampson
Scotland
Stanly
Surry
Swain
Wayne
Wilkes
Wilson
Yadkin
Name Missing (2)

Community Based Organizations

ALFA
Anson County Partnership for Children
Caldwell Council on Adolescent Health
Caswell County Partnership for Children
Catholic Social Services
Chatham Social Health Council
Coalition to Improve the Quality of Life*
Coastal Carolina HIV Care Consortium
Eastern NC HIV/AIDS Consortium (ENCHAC)
Exchange Club Family Center in Alamance
Faith Assembly Christian Center
Family First
Gaston Family Health Services
Guilford County Coalition on Infant Mortality*
Healthy Mothers/Healthy Babies Coalition of Wake County*
Hertford County QUOLA*
Inner Healing Ministry
Living Water Family Resource*
Lumbee Regional Development Assoc., Inc.*
Migrant Benevolent Assoc.*
Mother WIT, Inc.*
Mt. Zion Community Development*
New Jerusalem Missionary Baptist Church Ministry of Health
NIA Community Action Center*
Opportunities Industrialization Center of Wilson, Inc.*
Peers Family Development Center
Piedmont HIV Health Care Consortium
Present Day Cares, Inc.*
Sickle Cell Disease Assoc. of the Piedmont*
SOZO Ministries, Inc./Rocky Mount, NC*
Step One
Today's Woman Health & Wellness Ctr.*
Triad Health Project
United Way of Carolina/Regional Consortia
Western NC Community Health Services
YWCA

* indicates minority CBO.

APPENDIX B. LHD Partnerships with CBOs

Q1.	Please list the names of up to 10 Community Based Organizations with an ongoing working partnership with your local health department.

Health Departments

ALAMANCE

Name of the Community Based Organization	Areas of Partnership or Focus
ALAMANCE REGIONAL MEDICAL CENTER	CHILD ASTHMA COALITION, PROJECT ACCESS
CROSSROADS SEXUAL ASSAULT CENTER	HEALTHY RELATIONSHIPS (services for teens)
FAMILY ABUSE CENTER	VIOLENCE, CHILD ABUSE PREVENTION
ALAMANCE REGIONAL MEDICAL CENTER	CHILD ASTHMA COALITION, PROJECT ACCESS
EXCHANGE CLUB FAMILY CENTER OF ALAMANCE	CHILD ABUSE PREVENTION
OUTREACH & PREVENTION SERVICES	DRUG ABUSE PREVENTION
HEALTHY ALAMANCE (HEALTHY CAROLINIANS)	COMMUNITY COLLABORATION
SALVATION ARMY BOYS & GIRLS CLUB	TEEN PREGNANCY PREVENTION
CHILDCARE RESOURCE & REFFERAL	TRAINING FOR DAYCARE PROVIDERS
TIMES NEWS	ONGOING PUBLIC HEALTH MEDIA

ALEXANDER

Name of the Community Based Organization	Areas of Partnership or Focus
SMART START (ALEXANDER PARTNERSHIP FOR CHILDREN)	
ALEXANDER CO DOMESTIC VIOLENCE	ANY FAMILY & D VIOLENCE
ALEXANDER CO BAPTIST ASSOC	FAITH GROUP-WELLNESS ISSUES
CHRISTIAN CRISIS CENTER	SHORT TERM CRISIS INTERVENTIONS

ANSON

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTHY ANSONIANS	TEEN PREG., CHRONIC DISEASE, ASTHMA, INJURY PREV.
ASTHMA COALITION	ASTHMA
BRIDGE OVER TROUBLED WATER	CHILD WELL BEING
BURNSVILLE CENTER	CHILD WELL BEING
CRISIS MINISTRY	SOCIAL/POVERTY

AVERY

Name of the Community Based Organization	Areas of Partnership or Focus
VOLUNTEER AVERY CO	COMMUNITY NEEDS
AVERY PARTNERSHIP FOR CHILDREN	CHILDREN B-5
THE HUNGER COALITION	HUNGER & RX NEEDS
BANNER ELK KIWANIS	CHILDREN
AMERICAN CANCER SOCIETY	CANCER
ACADA	DOMESTIC VIOLENCE
PROJECT AVERY LIST	READING
LIONS CLUB	VISION
WAYNE DENSCH	HEALTH CARE
UNITED WAY	HEALTH

BEAUFORT

Name of the Community Based Organization	Areas of Partnership or Focus
METROPOLITAN HLTH SRVS.	HIV/STD PREVENTION

BLADEN

Name of the Community Based Organization	Areas of Partnership or Focus
BLADEN HEALTHWATCH	PREVENTIVE & CHRONIC HEALTH ISSUES
BLADEN FAMILY SUPPORT INITIATIVE	FAMILY SUPPORT ALL AGES
BLADEN UNITED WAY	
BLADEN CRISIS ASSISTANCE, INC .	FOOD CLOSET
NUMEROUS CHURCHES	PREVENTIVE & CHRONIC HEALTH ISSUES

BRUNSWICK

Name of the Community Based Organization	Areas of Partnership or Focus
MINORITY WOMEN'S ASSOC.	MINORITY INFANT MORTALITY
BIG/LITTLE MACEDONIA CHURCH	HEALTHY CAROLINIANS & MORTALITY
COMMUNITIES IN SCHOOLS	HEALTH CHECK/CHOICE
PARTNERSHIP FOR CHILDREN	INFANT MORTALITY
MARCH OF DIMES	SERVE UNSERVED PEOPLE

BUNCOMBE

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTH PARTNERS HEALTH CAR	ACCESS TO MEDICAL & DENTAL CARE HEALTH DISPATCH, CANCER, COMM
WNCCHS	PRIMARY CARE AIDS
WNCAP	AIDS
MISSION ST JOSEPHS HOSPITAL	SCHOOL NURSING ELECTRONIC MEDICAL
PROJECT NAF	AFRICAN AMERICAN INFANT MORTALITY

CABARRUS

Name of the Community Based Organization	Areas of Partnership or Focus
COMMUNITY FREE CLINIC	CHRONIC DISEASE MANAGEMENT
CABARRUS COMMUNITY CARE PLAN	ACCESS AND TREATMENT
HEALTHY CABARRUS	COLLABORATION ON HEALTH ISSUES
DENTAL TASK FORCE	DENTAL ACCESS ISSUES
NORTHEAST MEDICAL CENTER	COMMUNITY ACCESS ISSUES
IMMUNIZATIONS FOR EVERYONE INITIATIVE	IMPROVE IMMUNIZATION RATES
SCHOOL HEALTH	FT SCHOOL NURSE IN EVERY SCHOOL
TRAIL PROGRAM	ABSTINENCE EDUCATION
CABARRUS SERVICE CITIZENS COUNCIL	CHRONIC DISEASE MGT.
PEER EDUCATION PROJECT	TEEN HEALTH

CALDWELL

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTHY CALDWELLIANS	HEALTH ISSUES
CALDWELL/COUNCIL ON ADOLESCENT HEALTH	ADOLESCENT HEALTH/FAMILY PLANNING
HELPING HANDS CLINIC	MEDICAL CARE/PHARMACEUTICALS
SMART START/COMMUNITIES IN SCHOOLS	HEALTH/DEV. SKILLS
LENOIR HOUSING AUTHORITY	HEALTH/WELLNESS/EDUCATION

CARTERET

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTHY CAROLINIANS	CHRONIC DISEASE, ACCESS TO CARE, NUTRITION, PHYSICAL INACTIVITY
CHURCH GROUPS	ENVIRONMENTAL POLICY CHANGE
ASTHMA COALITION	ASTHMA, SCHOOL AGE CHILDREN
CHAMBER OF COMMERCE	ENVIRONMENTAL CHANGE
SENIOR CENTER	IMMUNIZATIONS
PRENATAL PLANNING COMMITTEE	FOLIC ACID, SMOKING CESSATION, SIDS
SMART START-CARTERET CO. PARTNERSHIP FOR CHILDREN	O-5 YR OLD ISSUES
DIABETES SUPPORT GROUP	DIABETES
COOPERATIVE EXTENSION	NUTRITION (COLOR ME HEATING)
CARTERET COUNTY HOSPITALITY GROUP	NUTRITION FOOD SAFETY

CATAWBA

Name of the Community Based Organization	Areas of Partnership or Focus
COOPERATIVE CHRISTIAN MINORITY	PRIMARY CARE-ADULTS/DENTAL CARE-ADULTS
CATAWBA COUNTY HISPANIC MINISTRY	SPANISH INTERPRETER FOR PREGNANT WOMEN

CHATHAM

Name of the Community Based Organization	Areas of Partnership or Focus
CHATHAM ANIMAL RESCUE & EDUC	ANIMAL CONTROL
PARTNERSHIP FOR CHILDREN	WCH 0-5
CHATHAM HOPSITAL	DIABETES, BCCCP
HISPANIC HARSON	IMMIGRANT HEALTH
CHATHAM SOCIAL HEALTH ASSOC.	HIV/AIDS & STDS
ACTIVE CHATHAM	PHYSICAL ACTIVITY
COALITION FOR FAMILY PEACE	FAMILY VIOLENCE
UNC HEALTH CARE-CHATHAM PRIMARY CARE	MATERNITY, FP, PRIMARY CARE
FAMILY RESOURCE LENGTH	IMMIGRANT HEALTH, PARENTING
UNITED WAY	COMMUNITY ASSESSMENT

CHEROKEE

Name of the Community Based Organization	Areas of Partnership or Focus
NANTAHALA AIDS CONSORTIUM	HIV
REACH	BATTERED & ABUSED WOMEN

CLEVELAND

Name of the Community Based Organization	Areas of Partnership or Focus
GREATER CLEVELAND CO BAPTIST ASSOC.	HIV-AIDS, COMMUNITY HEALTH
ALLIANCE FOR HEALTH/HEALTHY CAROLINIANS COALITION	COMMUNITY HEALTH
SAFE KIDS COALITION	CHILDREN INJURY PREVENTION
UNITED WAY OF CLEVELAND COUNTY	HEALTH AND HUMAN SERVICES
EBENEZER MINISTERIAL ASSOCIATION	COMMUNITY HEALTH (AFRICAN-AMERICAN)
COMMUNITIES IN SCHOOLS	HEALTH EDUCATION, HE-PROM.
ABUSE PREVENTION COUNCIL	WOMEN'S HEALTH, CHILDREN
PARTNERSHIP FOR CHILDREN (SMART START)	CHILDREN 0-5 HEALTH, DENTAL
COMMUNITY ETHICS TASK FORCE (CRMC)	COMMUNITY HEALTH ETHICS ISSUES
CAROLINA'S COMMUNITY HEALTH INSTITUTE	COMMUNITY HEALTH

CRAVEN

Name of the Community Based Organization	Areas of Partnership or Focus
COASTAL COMMUNITY ACTION	DENTAL CARE FOR HEAD START
MERCI CLINIC	CARE OF UNINSURED
PARTNERSHIP FOR CHILDREN	HEALTH CARE 0-5
CRAVEN REGIONAL MEDICAL CENTER FOUNDATION	HEALTH CARE-SMOKING CESSATION
UNITED SENIOR SERVICES	HEALTH PROMOTION
COUNCIL ON WOMEN	SEXUAL ABUSE, DOMESTIC VIOLENCE
CONCERNED CITIZENS	HEALTH PROMOTION

DARE

Name of the Community Based Organization	Areas of Partnership or Focus
CHILDREN & YOUTH PARTNERSHIP FOR DARE COUNTY	PARENT EDUCATION
HOTLINE INC	EDUCATION; HIV CASE MANAGEMENT
GEM CREATION CENTER	PROBLEMS W/AGING TASK FORCE

DAVIDSON

Name of the Community Based Organization	Areas of Partnership or Focus
FAMILY SERVICES	FAMILIES
ACT COALITION	FATHERS
DAVIDSON MEDICAL MINISTRIES	MEDICAL NEEDY
COOPERATIVE MINISTRIES	SOCIAL NEEDS
CRISES MINISTRY	HOMELESS

DAVIE

Name of the Community Based Organization	Areas of Partnership or Focus
DAVIE COUNTY PARTNERSHIP FOR CHILDREN	CHILD HEALTH, IMMUNIZATONS, DAYCARE
HEALTHY CAROLINIANS OF DAVIE COUNTY	NUMEROUS COMMUNITY HEALTH ISSUES
A STONEHOUSE FOR JESUS	FREE CLINIC OF ADULTS
MARCH OF DIMES	PRENATAL TRANSPORTATION
HEAD START	CHILD HEALTH AND DAYCARE
WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER	PRENATAL & PROSTATE CA ACTIVITIES
NOVENT HEALTH	BREAST & CERVICAL CA ACTIVITIES
CANCER SERVICES INC.	CA PREVENTIS & SCREENING ACTIVITIES
DC PRETRIAL RELEASE AND DAY REPORTING	PARENTING, HEALTH EDUCATION

DUPLIN

Name of the Community Based Organization	Areas of Partnership or Focus
DUPLIN COUNTY SCHOOLS	DENTAL, TEEN PREGNANCY PREVENTION
DUPLIN GENERAL HOSPITAL	HEALTH EDUCATION, DIABETES, ASTHMA
SARAH'S REFUGE	DOMESTIC VIOLENCE

DURHAM

Name of the Community Based Organization	Areas of Partnership or Focus
EL CENTRO HISPANO	HIV/STDS
HEALTHY FAMILIES-DURHAM	SUPPORT SERVICES FOR PARENTS
CO-ORDINATING COUNCIL FOR SENIOR CITIZENS	AGING-NUTRITION, HEALTH SUPPORT
SENIOR PHARM ASSIST	MEDICATION SUPPORT FOR ELDERLY
DURHAM CAN	LEAD POISONING
CENTER FOR CHILD & FAMILY HEALTH	TRAUMA EVAL. & TREATMENT-CHILDREN
DURHAM AFFORDABLE HOUSING COALITION	LEAD POISONING

EDGECOMBE

Name of the Community Based Organization	Areas of Partnership or Focus
OIC, INC.	HIV STD OUTREACH
COMMUNITY ENRICHMENT ORIG., INC	ADOLESCENT PREG. PREVENTION
HOSPICE FOUNDATION, INC	HOSPICE VOLUNTEERS/FUNDING HOME HEALTH

FRANKLIN

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTHY CAROLINIANS	OVERALL OF HEALTH
SUSAN G KOMEN	BREAST CANCER AWARENESS
ASTHMA	ASTHMA
TEAM UP FOR HEALTHY EATING & SUCCESSFUL LEARNING	NUTRITION/PHYSICAL ACTIVITY
LOCAL FITNESS COUNCIL	PHYSICAL ACTIVITY
PARKS/RECREATION	PHYSICAL ACTIVITY

GASTON

Name of the Community Based Organization	Areas of Partnership or Focus
AIDS COUNCIL OF GASTON CTY	AIDS PREVENTION
GASTON FAMILY HEALTH SERVICES	PREVENTIVE HEALTH SVS.
GASTON NUTRITION & FITNESS COUNCIL	NUTRITION
GASTON CTY DIABETES COALITION	DIABETES
CANCER SERVICES	SMOKING-YOUTH, CANCER
ALLIANCE FOR CHILDREN & YOUTH	CHILD HEALTH ISSUES
GASTON TOGETHER	PREVENTIVE HEALTH SVS
YMCA	FITNESS
GASTON-LINCOLN PARTNERSHIP FOR CHILDREN	CHILD HEALTH ISSUES
QUALITY NATURAL RESOURCES COMMISSION	ENVIRONMENTAL ISSUES

GRANVILLE-VANCE DISTRICT

Name of the Community Based Organization	Areas of Partnership or Focus
MARIA PARHAM HOSP.	(NONE LISTED)
GRANVILLE MEDICAL CENTER	
UNITED WAY	
HIV/AIDS PREVENTION COALITION	
RED CROSS	
COUNTY SCHOOLS	
LOCAL EMERGENCY PLANNING	
COOPERATIVE EXTENSION AGENCY	
AMERICAN CANCER SOCIETY	
SENIOR CENTERS - RURAL HEALTH - 10/03	

GUILFORD

Name of the Community Based Organization	Areas of Partnership or Focus
SICKLE CELL DISEASE ASSN OF THE PIEDMONT	HIV COUNSELING & TESTING
TRIAD HEALTH PARTNERSHIP	STD COUNSELING & TESTING
HEALTH SERVE MEDICAL CTR	ADULT PRIMARY CARE
GUILFORD CHILD HEALTH	PRIMARY MEDICAL CARE

HENDERSON

Name of the Community Based Organization	Areas of Partnership or Focus
BLUE RIDGE COMMUNITY HEALTH SERVICES	CSC, MCC, MOW, WIC
VOLUNTEER MEDICAL RESOURCE CENTER	BD MEMBERSHIP, MEDICATION, FLU
WESTERN CAROLINA COMMUNITY ACTION	TRANSPORTATION, HEAD START
PARDELL HOSPITAL	OZ, MCC, MOW, CSC, LAB
PARK RIDGE HOSPITAL	OZ, WIC, MCC, MOW, CSC, LACTATION, LAB
CHILDREN AND FAMILY RESOURCE CENTER	STAFF OUTPOSTED, BD MEMBER, REFERRALS
HENDERSON CTY PARTNERSHIP FOR CHILDREN	DENTAL, CHILD HEALTH CARE CONSULTANTS
HENDERSON CTY PARTNERSHIP FOR HEALTH	BD.MEMBER, CVH PROJECT, KBR GRANT
TREND (MENTAL HEALTH)	ADHD CLINIC, REFERRAL
LATINO ADVOCACY COALITION	BD.MEMBER, REFERRAL, NEWSLETTER

HOKE

Name of the Community Based Organization	Areas of Partnership or Focus
SMART START	CHILD HEALTH

IREDELL

Name of the Community Based Organization	Areas of Partnership or Focus
BROAD STREET UNITED METHODIST CHURCH	EMERGENCY MONEY & FOOD
TEEN HEALTH	FAMILY PLANNING & STDS
PREGANANCY RESOURCE CENTER OF STATESVILLE	FAMILY PLANNING
FOOTHILLS SICKLE CELL ANEMIA FOUNDATION	COUNSELING FINANCE & EDUCATION
SCAN	CHILD ABUSE PREVENTION & PARENTING
CHRISTIAN MISSION OF MOORESVILLE	EMERGENCY MONEY & FOOD
WESTERN AVENUE BAPTIST CHURCH	EMERGENCY MONEY & FOOD
FIFTH STREET MINISTRIES	SHELTER OPEN FOOR CLINIC
SOUP KITCHEN OF MOORESVILLE	FOOD NUTRITION
RED CROSS OF GREATER CAROLINAS	DISASTER CLINIC ASSISTANCE

JACKSON

Name of the Community Based Organization	Areas of Partnership or Focus
COMMUNITY HEALTH LINK	HEALTH PROGRAMS COMM ASSESSMENT
SMART START	NURSING & DENTAL PROJECTS

JOHNSTON

Name of the Community Based Organization	Areas of Partnership or Focus
HARBOR	DOMESTIC VIOLENCE
DAY-BY-DAY	PARENTING SKILLS HIV PREVENTION
DAPPA	HIV DRUGS AND ALCOHOL
JOHNSTON MEMORIAL HOSPITAL	VARIETY OF COMMUNITY EDUCATION
JOHNSTON COUNTY INDUSTRIES	DISABLED SPECIAL NEEDS
LOCAL CHURCH ORGANIZATIONS	YOUTH ADULTS SENIORS HEALTH EDUCATION
HOMEMAKER CLUBS	NUTRITION HEALTH PREVENTION & WELLNESS
ARTHRITIS RESEARCH FOUNDATION	HEALTH EDUCATION & PREVENTION
UNITED WAY	COMMUNITY BASED PUBLIC HEALTH INTERVENTION WITH ALL AGENCIES
ROTARY	EDUCATION & TEACHING OF COMMUNITY HEALTH ISSUES

JONES

Name of the Community Based Organization	Areas of Partnership or Focus
JONES PARTNERSHIP FOR CHILDREN	CHILD HEALTH AGE 0-5
JONES HEALTHY CAROLINAS	CHILDHOOD OBESITY/SCHOOL HEALTH
JONES CO JCPC	CHILD ADOLESCENT HEALTH
HEALTH WORKS	CHILD HEALTH

LEE

Name of the Community Based Organization	Areas of Partnership or Focus
COALITION TO IMPROVE QUALITY OF LIFE	TEEN PREGNANCY
(LEE CAN) LEE COMMUNITY ACTION NETWORK	SAFE & HEALTHY ISSUES
BRICK CAPITAL	HOUSING
HAVEN	DOMESTIC VIOLENCE
BOYS SCOUTS CLUB	YOUTH ENHANCEMENT
HISPANIC TASK FORCE	INFORMATION ASSISTANCE
JOHNSTON LEE COMMUNITY ACTION	FINANCIAL ASSISTANCE
LEE COUNTY INDUSTRIES	SERVICES TO PERSONS W/ DISABILITIES
UNITED WAY	SUPPORT COMMUNITY PROGRAMS
HELPING HAND CLINIC	HEALTH SERVICES

LENOIR

Name of the Community Based Organization	Areas of Partnership or Focus
YOUNG WOMEN'S OUTREACH CENTER	FAMILY PLANNING/PRENATAL
KINSTON COMMUNITY HEALTH CENTER	PRENATAL

LINCOLN

Name of the Community Based Organization	Areas of Partnership or Focus
LINCOLN DENTAL HEALTH SERVICES, INC.	CHILD DENTAL
HELPING HANDS HEALTH CLINIC, INC.	PRIMARY CARE FOR UNINSURED

MACON

Name of the Community Based Organization	Areas of Partnership or Focus
ANGEL MEDICAL CENTER	CAP-DA HEALTHY CAROLINIANS
HIGHLANDS CASHIERS HOSPITAL	HEALTHY CAROLINAS HC
MACON COUNTY DEPARTMENT OF SOCIAL SERVICES	HC MEDICATION ASSISTANCE PROGRAM
FIRST BAPTIST CHURCH OF FRANKLIN	MEDICATION ASSISTANCE PROGRAM
MACON PROGRAM FOR PROGRESS	HC
MACON COUNTY EMERGENCY MEDICAL SERVICES	BIOTERRORISM & DISASTER PREPAREDNESS
MACON COUNTY HUMANE SOCIETY	ANIMAL SHELTER & BIOTERORISM
MACON COUNTY SHERIFF'S DEPT	BIOTERRORISM & JAIL HEALTH
MACON FUNERAL HOME	BIOTERRORISM & JAIL HEALTH
MACON COUNTY SCHOOLS	SCHOOL NURSING & HEALTH FAIRS

MADISON

Name of the Community Based Organization	Areas of Partnership or Focus
MADISON COMMUNITY HEALTH CONSORTIUM	COMMUNITY HEALTH ASSESMENT ASTHMA TASK FORCE SENIOR HEALTH FAIR
HOT SPRINGS HEALTH PROGRAM	MATERNAL & CHILD HEALTH
BLUE RIDGE MENTAL HEALTH	CHILD HEALTH
DEVELOPMENTAL EVALUATION CENTER	CHILD HEALTH
MOUNTAIN AREA HEALTH ED CENTER	MATERNITY & FAMILY PLANNING
BUNCOMBE COUNTY HEALTH CENTER	LAB
SMART START	CHILD HEALTH
PROJECT ASSIST	TOBACCO PROGRAM IN SCHOOLS
MISSION ST JOSEPHS HEALTH SYSTEM PROGRAM	BREAST & CERVICAL CANCER CONTROL
LOCAL INTERAGENCY COORDINATING COUNCIL	SPECIAL CHILDREN'S NEEDS

MECKLENBURG

Name of the Community Based Organization	Areas of Partnership or Focus
FRIENDSHIP BAPTIST CHURCH	HOMELESS & SYPHILIS ELIMINATION
PRESENT DAY CARES	SUBSTANCE ABUSE/HIV/AIDS
MOTHERS OF MURDERED OFFSPRINGS, INC.	VIOLENCE
THE CRUSADE	SUBSTANCE ABUSE/HOMICIDES
METROLINA COMPREHENSIVE HEALTHCARE CTR.	HEALTH SCREENINGS/PATIENT ASST. FUND
CHARLOTTE MEDICAL SOCIETY	DIABETES CHOLESTEROL, BMI TEST
MED ASSIST	PRESCRIPTION ASSISTANCE FOR ELDERLY
MCCROREY FAMILY YMCA	ANNUAL COMMUNITY WALK/FITNESS
PROGRAM ESPERANZA OF CATHOLIC SOCIAL SVCS.	HEALTH INFO TO IMMIGRANTS
HEALTHY FAMILIES/HEALTHY COMMUNITIES & MANY MORE	DIABETES/CARDIOVASULAR

MONTGOMERY

Name of the Community Based Organization	Areas of Partnership or Focus
MONTGOMERY COMMUNITY RESOURCE TEAM	HEALTHY CAROLINAS, COMMUNITY ASSESSMENTT
ADOLESCENT PREGNANCY PREVENTION TASK FORCE (PART OF MCRT)	ADOLESCENT PROGRAM PREVENTION
MONTGOMERY COUNTY PARTNERSHIP FOR CHILDREN	EARLY CHILDHOOD HEALTH
AMERICAN RED CROSS	SHELTERS IN EMERGENCIES
MONTGOMERY COMMUNITY FOUNDATION	SMALL GRANTS FOR HEALTH RELATED NEEDS
SAFE KIDS COALITION	CAR SEATS, SAFETY CAMP

NASH

Name of the Community Based Organization	Areas of Partnership or Focus
OIC	AIDS/HIV
NEED	HOUSING/HEADSTART

NEW HANOVER

Name of the Community Based Organization	Areas of Partnership or Focus
WILMINGTON HEALTH ACCESS FOR TEENS	ADOLESCENT HEALTH
COASTAL HORIZONS CTR	SUBSTANCE ABUSE
PARENTS AS TEACHERS	CHILDHOOD INJURY PREVENTION
AMERICAN CANCER SOCIETY-LOCAL	SKIN CANCER TOBACCO PREVENTION
SAVE - SURVIVORS & VICTIMS EMPOWERMENT	TOBACCO PREVENTION
HOLA - HELPING OUR LATIN AMERICANS	ACCESS TO HEALTH CARE
ST MARY'S CHURCH - TILESTON CLINIC	ACCESS TO HEALTH CARE
FULL POTENTIAL PROGRAM - NHHN	INJURY PREVENTION
TRAUMA SERVICES - NHHN	INJURY PREVENTION
MARCH OF DIMES - LOCAL	INFANT MORTALITY

NORTHAMPTON

Name of the Community Based Organization	Areas of Partnership or Focus
SMART START-NORTHAMPTON PARTNERSHIP	CHILDREN 0-5
ALTERNATIVE HEALTH SYSTEMS, INC	HIV CASE MANAGE. & EARLY INTERVENTION SERV.
METROPOLITAN COUNSELING, INC.	HIV CASE MANAGEMENT
GENERAL BAPTIST STATE CONVENTION	PRENATAL CLIENTS
ROANOKE CHAPEL	ADOLESCENTS, PREGNANCY PREV, ABSTINENCE
CADA-FAMILY PRESERVATIONS, FAMILY RESOURCE CTR HEADSTART	AT RISK CHILDREN & FAMILIES

PAMLICO

Name of the Community Based Organization	Areas of Partnership or Focus
CAPITAL AREA YMCA	CHILD HEALTH, PHYSICAL FITNESS WATER SOCIETY
TOWN OF BAYBORO	WALKING TRAIL, PHYSICAL FITNESS
PAMLICO COUNTY SCHOOLS	FITNESS TRAIL, SCHOOL HEALTH
METROPOLITAN HEALTH	HIV TESTING
HIV TASK FORCE	COMMUNITY EDUCATION
INTERFAITH COUNSEL GARDENS OF PAMLICO	AREA CITIZEN NEEDS
PITT MEMORIAL HOSPITAL & ECU	SCHOOL HEALTH
HABITAT FOR HUMANITY	HOUSING
HOPE INDIGENT CARE	INDIGENT CARE
PAMLICO COUNTY CHARTER SCHOOL	FITNESS TRAIL SCHOOL HEALTH

PENDER

Name of the Community Based Organization	Areas of Partnership or Focus
SMART START/PARTNERSHIP FOR CHILDREN	DENTAL/CHILD HEALTH
HEAD START	DENTAL/CHILD HEALTH
HEALTHY CAROLINA	GENERAL HEALTH/HLTH PROM.
ADOLESCENT PARENTING PROGRAM	MATERINITY/CHILD HEALTH
EAST COAST HEAD START	DENTAL/CHILD HEALTH
PUBLIC HEALTH FOUNDATION	GENERAL HEALTH

PERSON

Name of the Community Based Organization	Areas of Partnership or Focus
PERSON COUNTY PARTNERSHIP FOR CHILDREN	CHILDREN
PERSON FAMILY MEDICAL CENTER	PRIMARY CARE
HEALTHY PERSONIANS	COMMUNITY HEALTH

PITT

Name of the Community Based Organization	Areas of Partnership or Focus
PICASO	HIV/AIDS
HEALTH ASSIST	PRIMARY CARE
RED CROSS	HIV EDUC/EMERGENCY PREPAREDNESS
AMERICAN HEART ASSOC	CARDIOVASCULAR HEALTH
SAFE COMMUNITIES COALITION OF PITT	INJURY PREVENTION
PITT PARTNERS FOR HEALTH	COMMUNITY HEALTH
BLACK MINISTERS ALLIANCE	DIABETES
MARCH OF DIMES	INFANT MORTALITY
BREAST FEEDING ADVISORY COUNCIL	BREAST FEEDING
PITT MEMORIAL HOSPITAL FOUNDATION	COMMUNITY HEALTH

RANDOLPH

Name of the Community Based Organization	Areas of Partnership or Focus
RANDOLPH HOSPITAL	HEALTH PROMOTION, COMM DISEASE
RANDOLPH HEALTH IMPROVEMENT PARTNERSHIP	HEALTHY CAROLINIANS
EMERGENCY MEDICAL SERVICES	BIOTERRORISM DISASTER
CITY & COUNTY SCHOOL SYSTEMS	SCHOOL HEALTH
SHERIFF'S OFFICE	ANIMAL CONTROL COMM DISEASE
COOPERATIVE EXT	ENVIRONMENTAL NUTRITION ISSUES
FIRMNESS COUNCIL	HEALTH PROMOTION
MENTAL HEALTH	ECI SUBSTANCE ABUSE
DSS	CHILD WELFARE
RANDOLPH HOSPITAL	NEWBORN HEALTH DAYCARE HEALTH

RICHMOND

Name of the Community Based Organization	Areas of Partnership or Focus
RICHMOND COUNTY PARTNERSHIP FOR CHILDREN	PRESCHOOL CHILDREN
RICHMOND CO HEALTHY CAROLINIANS PARTNERSHIP	ALL AGES, TEENS PREG. OBESITY, ASTHMA
RICHMOND CO SCHOOLS	OBESITY, ASTHMA

ROBESON

Name of the Community Based Organization	Areas of Partnership or Focus
NATIVE AMERICAN INTERFAITH MINISTRIES	SYPHILIS, HIV
PALMER PREVENTION	SYPHILIS, HIV
BART	HIV/AIDS
COMMUNITIES IN SCHOOLS	CH SVCS
RC CENTER FOR CHILD & FAMILY HEALTH	CH
RC PARTNERSHIP FOR CHILDREN	CH
RC PARTNERSHIP FOR COMMUNITY HLTH	PHYS ACT/SYPHILIS/PHYSICAL ACT.
HUMANE SOCIETY	ANIMAL CONTROL
ASHTON COALITION	ASTHMA/SMOKING
SAFE KIDS	CH

ROCKINGHAM

Name of the Community Based Organization	Areas of Partnership or Focus
ROCKINGHAM CO STUDENT HEALTH CENTERS	PHYSICAL ACTIVITY, NUTRITION, TOBACCO PREVENTION & CESSATION
ROCKINGHAM CO HEALTHY CAROLINIANS	ORAL HEALTH MATERNAL & CHILD HEALTH PHYSICAL ACTIVITY & NUTR
ROCKINGHAM CO ADOLESCENT PREGNANCY PREVENTION COALITION	PREGNANCY PREVENTION
AMERICAN RED CROSS	DISASTER RELIEF
UNITED WAY	HEALTHY CAROLINIANS
YMCA	HEALTHY KIDS-NUTRITION & PHYSICAL ACTIVITIES

ROWAN

Name of the Community Based Organization	Areas of Partnership or Focus
HEALTHY ROWAN!	INFANT MORTALITY SUBSTANCE ABUSE CHILDHOOD OBESITY/OVERWEIGHT
HEALTH LINK	INFANT MORTALITY MATERNAL & CHILD HEALTH
ROWAN PARTNERSHIP FOR COMMUNITY HEALTH	CHILDHOOD OBESITY/OVERWEIGHT - GREENWAYS/PARKS & REC
ALLIES FOR SUBSTANCE ABUSE PREVENTION	YOUTH SUBSTANCE ABUSE PREVENTION
HISPANIC COALITION OF SALISBURY ROWAN	HISPANIC QUALITY OF LIFE ISSUES
ADOLESCENT AND FAMILY ENRICHMENT COUNCIL	MATERNAL & CHILD HEALTH, FAMILY SUPPORT INVOLVEMENT
ROWAN PARTNERSHIP FOR CHILDREN	SAME AS ABOVE AND HEALTH SERVICES FOR CHILDREN O-5 YRS & ORA
FAMILY CRISIS COUNCIL	SUPPORT FOR WOMEN & CHILDREN OF DOMESTIC VIOLENCE
CHILDHOOD ASTHMA COALITION	ASTHMA CHILDHOOD
ROWAN COUNTY UNITED WAY	SAME AS HEALTHY ROWAN!

SAMPSON

Name of the Community Based Organization	Areas of Partnership or Focus
TRI COUNTY HEALTH CENTER	CVD - HIV/AIDS - PHYSICAL ACTIVITY
GOSHEN MEDICAL	MATERNAL HEALTH

SCOTLAND

Name of the Community Based Organization	Areas of Partnership or Focus
DOMESTIC VIOLENCE & RAPE CRISIS CENTER	DOMESTIC VIOLENCE, RAPE
CHURCH & COMMUNITY SERVICES	FOOD ASSISTANCE, CLOTHING
NORTHVIEW HARVEST MINISTRIES	FOOD & CLOTHING ASSISTANCE
ADOLESCENT WELLNESS COUNCIL	TEEN WELLNESS
CAROLINAS RACE TO EDUCATE	ASTHMA
	HOMELESS

STANLY

Name of the Community Based Organization	Areas of Partnership or Focus
PARTNERS IN HEALTH	HEALTHY CAROLINIANS-HEART HEALTH, SUBSTANCE ABUSE
INTERAGENCY COUNCIL	CHILDHOOD/ADULT OBESITY
STANLY COUNTY AIDS TASK FORCE	HIV/AIDS

SURRY

Name of the Community Based Organization	Areas of Partnership or Focus
SURRY SCAN (STOP CHILD ABUSE)	CHILD HEALTH/FAMILY CARE COORDINATION
SURRY FRIENDS OF YOUTH	FAMILY CARE AND SUPPORT
SURRY MEDICAL MINORITIES	MEDICALLY UNDERSERVED
YOKE FELLOW	UNDERSERVED-MEDICAL CARE & FAMILY CARE
FOOTHILLS FOOD PANTRY	FAMILY CARE COORDINATION

SWAIN

Name of the Community Based Organization	Areas of Partnership or Focus
SWAIN CO PARTNERSHIP FOR HEALTH	FITNESS, SMOKING CESSATION, TEEN PREGNANCY
RELAY FOR LIFE	CANCER
FAMILY RESOURCE CENTER	CHILD HEALTH

WAYNE

Name of the Community Based Organization	Areas of Partnership or Focus
WAYNE INITIATIVE SCHOOL HEALTH	HEALTH EDUCATION, NUTRITION EDUCATION
INNER HEALING MINISTRY	HIV EDUCATION & REFERRAL
WAYNE ACTION TEAM FOR COMMUNITY HEALTH	PRIMARY HEALTH CARE & COMMUNITY EDUCATION

WILKES

Name of the Community Based Organization	Areas of Partnership or Focus
WILKES COMMUNITY HEALTH COUNCIL	HEALTHY CAROLINIANS
COMMUNITY HEALTH CONNECTION	TEEN PREGNANCY
COMMUNITIES IN SCHOOLS	TEEN HEALTH
OUR HOUSE	INFANT/CHILD MORTALITY
SMART START	CHILD HEALTH

WILSON

Name of the Community Based Organization	Areas of Partnership or Focus
OIC	GENERAL HEALTH SERVICES
POSITIVE CHANGE FOR YOUTH	GENERAL HEALTH SERVICES
YOUTH OF WILSON	F.P./STD/HIV
WESLEY SHELTER	F.P./STD/HIV

YADKIN

Name of the Community Based Organization	Areas of Partnership or Focus
HOOTS MEMORIAL HOSPITAL	HEALTHY CAROLINAS LAB & XRAY SERVICES
CANCER SERVICES INC	CANCER
SMART START	CHILDRENS SERVICES
YMCA	PHYSICAL FITNESS RECREATION
SENIOR SERVICES	CHRONIC DISEASES FLU VACCINATIONS
SCHOOL SYSTEM	FAMILY PLANNING FAMILY LIFE SKILLS
DOWNTOWN BUSINESS ASSOCIATION	DOWNTOWN WALKING TRACK
HOSPICE	TERMINAL CARE

CBO Partnerships with LHDs

Q1.	Please list the Local Health Departments with an ongoing working partnership with your Community Based Organization.

CBO	Name of Local Health Department
ALFA	CATAWBA BURKE ALEXANDER CALDWELL WILKES
ANSON COUNTY PARTNERSHIP FOR CHILDREN	ANSON
CALDWELL COUNCIL ON ADOLESCENT HEALTH	CALDWELL
CASWELL COUNTY PARTNERSHIP FOR CHILDREN	CASWELL
CATHOLIC SOCIAL SERVICES	FORSYTH
CHATHAM SOCIAL HEALTH COUNCIL	CHATHAM
COALITION TO IMPROVE THE QUALITY OF LIFE	LEE
COASTAL CAROLINA HIV CARE CONSORTIUM	ONSLOW PENDER NEW HANOVER CARTERET BRUNSWICK
EASTERN NC HIV/AIDS CONSORTIUM (ENCHAC)	PAMLICO BEAUFORT CRAVEN
EXCHANGE CLUB FAMILY CENTER IN ALAMANCE	ALAMANCE
FAITH ASSEMBLY CHRISTIAN CENTER	CHILD CARE SERVICES
FAMILY FIRST	GRANVILLE
GASTON FAMILY HEALTH SERVICES	GASTON
GUILFORD CTY COALITION ON INFANT MORTALITY	GUILFORD
HEALTHY MOTHERS, HEALTHY BABIES COALITION OF WAKE COUNTY	WAKE
HERTFORD COUNTY QUOLA	NORTHAMPTON
INNER HEALING MINISTRY	WAYNE COUNTY: WE DO NOT HAVE A PARTNERSHIP. IF THE HEALTH DEPT. HAS SERVICE IN PLACE, THEN WE OBTAIN SERVICES FROM THE HEALTH DEPT.

CBO	Name of Local Health Department
LIVING WATER FAMILY RESOURCE	FORSYTH
LUMBEE REGIONAL DEVELOPMENT ASSOC., INC.	ROBESON
LUMBEE REGIONAL DEVELOPMENT ASSOC., INC.	SAMPSON
MOTHER WIT, INC.	FORSYTH INFANT MORTALITY REDUCTION COALITION OF FCHD HEALTH EDUCATION & COMMUNITY OUTREACH
MT ZION COMMUNITY DEVELOPMENT	BUNCOMBE
NEW JERUSALEM MISSIONARY BAPTIST CHURCH MINISTRY OF HEALTH	FORSYTH
NIA COMMUNITY ACTION CENTER	GUILFORD
OPPORTUNITIES INDUSTRIALIZATION CENTER OF WILSON, INC.	WILSON WILSON COMMUNITY HEALTH CENTER
PIEDMONT HIV HEALTH CARE CONSORTIUM	PERSON LEE CHATHAM
PRESENT DAY CARES, INC.	MECKLENBURG
SICKLE CELL DISEASE ASSOC OF THE PIEDMONT	GUILFORD RANDOLPH ALAMANCE CASWELL FORSYTH ROCKINGHAM
SOZO MINISTRIES, INC./ROCKY MOUNT, NC	NASH EDGECOMBE
STEP ONE	FORSYTH
TODAY'S WOMAN HEALTH & WELLNESS CTR.	FORSYTH
TRIAD HEALTH PROJECT	GUILFORD
UNITED WAY OF CAROLINA/REGIONAL CONSORTIA	MECKLENBURG ANSON GASTON CABARRUS HEALTH ALLIANCE CLEVELAND
YWCA	GUILFORD

Appendix C. Efforts to Recruit Professional Staff – Text Responses

Q7. Other	What efforts are done in your local health department to recruit management, professional, and clinical staff from minority groups?

Local Health Departments

ADVERTISE ON WEBSITE & NEWSPAPER

EMPLOYMENT SECURITY COMMISSION

MAKE HIRING PRACTICES KNOWN IN ADD & LINE UP TO THEM

NO PARTICULAR FOCUSED EFFORT YET. I HAVE A TASK FORCE DEVELOPING A PLAN

MEETINGS WITH MINORITY GROUP'S LEADERSHIP

ADVERTISE FOR BILINGUAL APPLICANTS

ADVERTISE IN LOCAL NEWSPAPER, WITH EMPLOYMENT SECURITY COUNCIL & ON COUNTY WEBSITE

ADVERTISE THROUGH CO PERSONNEL

ADVERTISE IN SPECIFIC DEPARTMENT AT HBUC

"SPANISH ABILITY PREFERRED" ON ALL JOB ANNOUNCEMENTS

TRY TO HIRE THE MOST QUALIFIED APPLICANT. USE LOCAL NEWSPAPER & REGIONAL PAPERS

EMPLOYMENT SECURITY COMMISSION

BULLETIN BOARDS IN COUNTY OFFICES & PUBLIC LIBRARY, ANNOUNCEMENTS TO MINORITY CHURCHES

ADVERTISE IN AREA PAPERS; HIRE BASED ON QUALIFICATION

ON LINE JOB BANKS, EMPLOYMENT SECURITY

STATEWIDE ADVERTISING THROUGH EMPLOYMENT SECURITY COMMISSION LISTING & INTERNET;

MEDIA THAT SERVES ALL GROUPS

ADVERTISE IN LOCAL NEWSPAPER

OUTREACH THROUGH TARGET POPULATION & LEADERSHIP & TARGETED NEIGHBORHOOD ASSOCIATION

REWRITE SOME SUPPORT STAFF POSITIONS TO REQUIRE BILINGUAL

TRY TO PROMOTE FROM WITHIN WHENEVER POSSIBLE.

EMPLOYMENT SECURITY COMMISSION JOB FAIRS AT LOCAL UNIVERSITY COMMUNITY COLLEGE

INTERNET POSTING

OUTREACH THROUGH MINORITY STAFF & VOLUNTEERS

ADVERTISE WITH EMPLOYMENT SECURITY COMMISSION

EMPLOYMENT SECURITY COMMISSION

ESC, NEWSPAPER

ADVERTISE IN LOCAL NEWSPAPER – SEEK SPANISH INTERPRETERS BUT NO OUTREACH FOR THE OTHERS

WE ADVERTISE TO THE GENERAL POPULATION

Q7. Other	What efforts are done in your community based organization to recruit management, professional, and clinical staff from minority groups?

Community Based Organizations

STAFF REFERRALS

OUR ONE NEWSPAPER THAT IS READ BY ALL

CHURCHES

ADVERTISE IN OUR NEWSLETTER

EMPLOYMENT SECURITY COMMISSION

CHURCHES, SOCIAL ORGANIZATIONS

OUTREACH THROUGH CURRENT EMPLOYEES

Appendix D. LHDs – After-Hours Services

Q10.	Which services (including clinical services, case management, education, advocacy or others) do you provide after 5:00PM or on weekends?

(Note: Random identification numbers have been assigned to LHDs and CBOs listed in this Appendix.)

LHD 87

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	4	Monday 7AM-6PM Weekends
Case management	2-3	Varies on need
Education classes	1-2	Varies due to weekend events – Health Fairs, etc.

LHD 76

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	WIC/2	Monday 5-7PM
Case management	8	Mon-Thurs (CSC Staff)
Education classes	4-10	Weeknights & Sat. & Sun. (Health Ed. Staff)

LHD 17

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	10	After 5PM
Education classes	2	After 5 PM

LHD 11

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	10	After 5PM
Education classes	2	After 5PM

LHD 1

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	WIC/Family Planning	Until 6PM
Case management		
Education classes	Varied	Nights, Weekends

LHD 20

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Immunization WIC & Preg testing – 1	5-7PM 1st & 3rd Wed each Month
Case management	1	Times differ
Education classes	2	Times differ

LHD 32

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1.5	6
Case management		
Education classes	1	4 hrs/month

LHD 52

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	7	7:30AM-8:00 Mon.-Thurs.
Case management		
Education classes	12	Various

LHD 62

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	6	Tu-Th-Sat.
Case management	15	M-F
Education classes	25	M-F

LHD 37

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	20 Home Health	Tuesday-6:00PM
Case management	10-CSC/MCC	After Hours/Weekends
Education classes	10	After Hours/Weekends

LHD 47

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1	24/7
Case management		
Education classes	5-10	Varies

LHD 19

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	2	Mainly Sat. 8-2 – Health Fairs Some evenings 2-3 hrs.

LHD 8

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Gen. Clinic 4	Tu/Th 5-7
Case management	10	M-F 5:00-7:00
Education classes	20	M-F 5:00-8:00 Sat. 10:00-3:00

LHD 46

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	2	Varies

LHD 74

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	Child Birth – 2 Parent/Youth – 2	Tuesday 6-8, Varies 6-8

LHD 15

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	Occasional	
Education classes	10	Varied

LHD 89

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	2 1/2	M-F 5:00-5:30PM
Case management	3	M-F
Education classes	2-4	

LHD 69

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

LHD 16

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1.75	Saturday 8:30-Noon
Case management	1.0	Varies
Education classes	2.0	Wednesday 5-7:00PM

LHD 78

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Dental	4/6
Case management		
Education classes		

LHD 75

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	STD 2 hr/wk	5-7:00PM Tuesday
Case management	TB	Occas. weekend hrs, case relate
Education classes	STD/CEE, ST/B 3 hr/wk	As needed 5-8:00PM Monday (El Centro Hisp)

LHD 85

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

LHD 6

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	1	Usually 6:30-8:00PM

LHD 30

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	All H.D. Svs. – 3	Monday Evening Clinics
Case management	3-5	Various
Education classes	5-10	Various

LHD 22

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	2	Not Regularly Scheduled
Education classes	5	Not Regularly Scheduled

LHD 60

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	4	Tues. & Wed. 5-7:00PM
Case management	1	Varies M-Th
Education classes	6 (Avg.)	M-F 6-9:00PM

LHD 96

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1.5	Thursday - 8:00AM-6:30PM
Case management	80 min.	20th/Day X 4 Mon-Fri & some weekends
Education classes	10	Varied

LHD 23

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	N/A	
Case management	N/A	
Education classes	N/A	

LHD 49

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1	Thursday 6:00PM
Case management	5-Mar	Varies
Education classes	4	PM Weeknights & Weekends

LHD 64

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	6	Varies every other Thursday
Case management		
Education classes		

LHD 72

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	4	4 / 1 hour
Case management	As Needed (PRN)	As Needed (PRN)
Education classes	2-4	2 / 2-8 hours

LHD 86

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	1	Saturday

LHD 91

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Dental Clinic – 9	Monday-Friday 3-6:00PM
Case management		
Education classes	Animal Central Health Educ. – 22	Saturday-Friday (24/7)

LHD 41

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

LHD 98

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Eve. Clinic WIC – 2	Tuesday 5-7:00PM
Case management	CSC/MCC Flex	M-F 5-6PM & 7-8AM
Education classes	2-8	Sat/Sun Ex. 1-4PM or 12-4PM

LHD 28

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	WIC 1.0 Family Plan. 2.0	
Case management		
Education classes		

LHD 51

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	1	1 Day 4 Hrs/Month
Case management		
Education classes	Varies	4 Days 3 Hrs/Month

LHD 97

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	4	2 Days (2 hrs. ea.)
Case management	18	3 1/2 Hr/Day
Education classes	24	M-F 6-8:00PM/Weekends 9-3:00PM

LHD 5

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	FP, Maternity Child Hlt Clinic 1.5	Open to 5:30PM M, Tu, Th
Case management	30 min - TB DOT	Weekends
Education classes	1	Fairs, Parenting Classes, Invited Presentations

LHD 70

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	FP/MAT/WIC	6 hrs/week
Case management		
Education classes		10 hrs/week

LHD 80

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	4	M-Th 5:00-5:30PM
Case management	12	M-Th 5:00-6:00PM
Education classes	15	Days Vary/Times Vary

LHD 42

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Monthly 2-3	
Case management	Varies 1-5 hr./wk	Varies
Education classes	Varies	Varies

LHD 44

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	5	5-10:00PM Thursday
Case management	4 – As needed	2 hrs/week
Education classes		

LHD 94

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	3/week	Wednesday night
Case management		
Education classes	10/month	Weekends/nights

LHD 33

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	2.5	Mon. 4:30-7:00PM
Case management	19	M-F 6:30-8:00PM M-Th 4:30-6:30PM
Education classes	2	Varies

LHD 66

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	3	Tues. 5-8:00PM
Case management	6	Tues. & Weekends 5-8:00PM
Education classes	30	Sun-Sat/Day & Evening

LHD 56

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	3	Varies
Case management	2	Varies
Education classes	3-5	Varies

LHD 90

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	M-T 5-6	4 hrs/week
Case management	M-T 5-6	4 hrs/week
Education classes	8 hrs/month	Sat. & Sun.

LHD 54

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	5	Open til 5:30PM
Case management	5	
Education classes	10	Varies

LHD 99

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Adult Hlth – 4 Family Plan. – 4 Child Hlth. – 4 Immunization – 4	Thursday 5-9:00PM
Case management		
Education classes	Classes, Seminars Health Fairs by Request	No set hours

LHD 25

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	.75	3rd Monday 5-8:00PM
Case management		
Education classes	5	All days incl. weekends & holidays

LHD 4

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	1.5	

LHD 73

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	3 hrs/month	5-8:00PM/monthly
Case management	Varies	As Needed
Education classes	Varies	As Needed

LHD 2

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Dental – 2	M-Th 8-5:30
Case management	As Needed	
Education classes	As Needed	When Requested

LHD 35

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Family Planning Child Health Immunization	Third Thursday/Month 5-7 PM
Case management		
Education classes	8-10/month	Varies

LHD 95

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	1	1

LHD 57

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Maternity & Family Plan.	Thursday 5-7
Case management	Health Prod. Day Care Edu.	Upon Demand
Education classes		

LHD 58

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	Occasionally	
Education classes	6	Varies

LHD 93

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	10	2/20
Case management	10	2/10
Education classes	10	10/2

LHD 40

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	WIC – 2	M-F 8-6
Case management		
Education classes	As Requested	

CBOs – After-Hours Services

Q10.	Which services (including clinical services, case management, education, advocacy or others) do you provide after 5:00PM or on weekends?

(Note: Random identification numbers have been assigned to each CBO listed in this section.)

<u>Community Based Organizations</u>

CBO 20

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	CTR 4-5	
Case management	2	
Education classes	4-5	

CBO 46

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	3	Various Days 5-8:00PM

CBO 26

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	1	

CBO 31

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	3	Sat 9-12
Case management		
Education classes		

CBO 21

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	40	After Hours/Weekends

CBO 84

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	4	7
Education classes	1	2

CBO 69

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

CBO 38

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	N/A	
Case management	N/A	
Education classes	N/A	

CBO 54

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	24-Hr. On Call Line	365 Days
Education classes	3-6	2 days

CBO 48

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	8	2/20

CBO 14

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	None	
Case management	None	
Education classes	None	

CBO 56

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	N/A	
Case management	N/A	
Education classes	N/A	

CBO 68

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

CBO 8

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	5-8:00PM	M-F
Education classes	5-8:00PM	M-F

CBO 73

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	10	3
Education classes	10	3

CBO 77

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	10	Sun-Sat between 6:00-10:00
Education classes	1	Monday 5:30-6:30

CBO 23

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Dental Care – 3 Prenatal – 3	Sat. 9-12, Wed. 5-8
Case management		
Education classes	Support Group for Parents – 3	Tues. 6-7:30, Thurs. 6-7:30

CBO 9

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	2	6-8:00PM

CBO 80

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	8	2 days
Case management	3	1 day
Education classes	8	2 days

CBO 81

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	3	2 days

CBO 59

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	2	2 days
Education classes	8	5 days

CBO 86

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	None	None
Case management	2	When Needed
Education classes	10-20	Sunday or Afternoons

CBO 62

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	15	

CBO 55

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	2	Thursday 5-7:00PM
Case management	4	M-Th, 5-6:00PM
Education classes	6	Fri-Sat, Varies

CBO 28

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	8	As Needed
Education classes	8	Tues & Thurs 5-9

CBO 53

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	N/A	
Case management	N/A	
Education classes	N/A	

CBO 17

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	N/A	N/A
Case management	N/A	N/A
Education classes	10	M-F 6-9PM

CBO 39

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	HIV/STD – 8	Sat. 9-12, Thurs. 5-7 & Others
Case management		
Education classes	HIV/Sub. Abuse	10 hours a week

CBO 45

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	5-10	Thursday-Sunday

CBO 32

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	Group Therapy – 24	Mon.-Thurs. 6-9PM
Case management	Methadone	Every Sat. 7-10:30AM
Education classes		

CBO 92

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management	8	2 hours a day
Education classes	Outreach – 14/Bi-Mon.	14 hours - weekends

CBO 95

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	8	M-F (5-9)
Case management	8	M-F (5-9)
Education classes	15	7

CBO 66

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical	No Entry	
Case management		
Education classes		

CBO 93

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes		40

CBO 3

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	2-3 When Planned	Saturday When Planned

CBO 52

Services provided after 5:00 PM or on weekends		
Services	**After hours per week spent on this activity**	**Day/Hours**
Clinical		
Case management		
Education classes	5	M-Th 3-6PM, Mondays 6-8

Appendix E. Barriers to Providing After Hours-Services – Text Responses

Q11. Other	Check the top three factors that are a major barrier to providing after-hour's services?

Local Health Departments

NOT SURE IF LACK OF CLIENTS A FACTOR. I KNOW AFTER SERVICES WAS DISCONTINUED

NEED TO SHIFT FROM DAY HOURS THAT ARE WELL UTILIZED

FACILITY NOT CONCLUSIVE

TRANSPORTATION

NO PUBLIC TRANSPORTATION AFTER HOURS

BUDGET CUTS HAVE FORCED US TO REDUCE OFF SITE AND EVENING SERVICES

Community Based Organizations

TRANSPORTATION & CHILDCARE

TRANSPORTATION

DEPENDENT ON HEALTH DEPT TO PROVIDE CLINICAL SERVICES (WE DO ONLY EDUCATION)

TRANSPORTATION

MAINLY STAFF STATUS

TRANSPORTATION

LACK OF FUNDING

RESOURCES AS TRANSPORTATION & FOOD & INCENTIVES FOR CLIENTS

CLINIC NOT OPEN ON WEEKENDS

Appendix F. Actions to Improve Relationships

Q12a.	What actions can help to establish and improve: A. Relationships between Local Health Departments and Community Based Organizations?

Local Health Departments

WE HAVE EXCELLENT RELATIONSHIPS. BEING SMALL HAS MANDATED THE NEED FOR ALL AGENCIES TO WORK TOGETHER. I DON'T HAVE ANY SUGGESTIONS FOR IMPROVEMENT UNLESS IT WOULD BE MORE STAFF TO DO MORE OUTREACH TOGETHER.

MORE TIME TO MEET/PLAN ACTIVITIES.

AVERY COUNTY NEEDS HEALTHY CAROLINIANS. WE NEED START-UP FUNDS AND A FULL TIME COORDINATOR TO COMMIT AND PROMOTE HEALTHY CAROLINIANS.

NOT SURE. NEED TO BE ABLE TO TRUST THE ACTIONS/SERVICES OF CBOS & MEDICAL/LEGAL COMPLIANCES.

1. IMPROVED COMMUNICATION BETWEEN STATE, LOCAL HEALTH DEPT & CBO 2. LESS RESTRAINTS TIED TO FUNDING

1. RUN THEIR CONTRACTS $ THRU US – MONEY TALKS. 2. STOP THE SOCIAL WORK APPROACH OF YOUR PROGRAM CONTRACTING DIRECTLY WITH A CBO WITHOUT EVEN THE KNOWLEDGE, LET ALONE SUPPORT OF LOCAL HEALTH DIRECTOR.

LESS COMPETITION FOR RESOURCES, I.E. GRANTS, ETC. ALSO, IF A SERVICE IS ALREADY BEING ADEQUATELY PROVIDED, IT IS NOT NECESSARY FOR A NEW CBO TO DECIDE THAT THEY WANT TO ALSO PROVIDE THE SERVICE. THAT COMPETITION IS A DRAIN ON RESOURCES AND YOU CAN NEVER REALLY PROVIDE THE BEST SERVICES TO THE CLIENT BECAUSE THE FUNDS ARE SPLINTERED.

FUNDING FOR PROJECTS, STAFF AVAILABLE TO WORK WITH COMMUNITY

DEVELOP A STATEWIDE VISITING OF COMMUNITY BASED ORGANIZATIONS TO PROVIDE TO HEALTH DEPARTMENTS–- AS WELL AS GETTING INFORMATION TO CBOS ABOUT PUBLIC HEALTH & SERVICES PROVIDED IF CBOS & LHD'S KNOW ABOUT EACH OTHER – GOALS, PURPOSES, PROJECTS – THEN MORE LIKELY TO CONTACT EACH OTHER TO COORDINATE OR COLLABORATE ON A COMMON GOAL OR PROJECT

MORE DIVERSITY IN LHD MGMT/ADMINISTRATION. MORE FUNDING FOR LHDS TO CONTRACT WITH CBOS TRAINING FOR COMMUNITY LEADERS TO BE EFFECTIVE ADVOCATES

RESOURCES (FINANCIAL/HUMAN), SHARED VISIONS, CONTINUED DIALOGUE WITH CBOS KNOWING YOUR COMMUNITY PARTNERS AND ACTIVELY SEEKING OPPORTUNITIES TO COLLABORATE ON ACTIVITIES AND PROJECTS THAT IMPACT ON COMMUNITY HEALTH IMPROVEMENT.

WE HAVE ALREADY ESTABLISHED A GOOD WORKING RELATIONSHIP WITH MANY OF THE CBOS IN DURHAM

RELATIONSHIPS ARE OK – BUT ALL ARE BUSY. TO ACCOMPLISH GOALS, NEED ADEQUATE FUNDING COMMUNITY BASED & PERSONAL INITIATIVES.

SINCE WE DO NOT HAVE ANY MAJOR PROBLEMS (OTHER THAN LIMITED FUNDING TO ENHANCE THEIR EFFORTS) WITH OUR CBO'S, WE DO NOT HAVE SUGGESTIONS ON WAYS TO ESTABLISH & IMPROVE RELATIONSHIPS WHICH WOULD INITIATE AT THE STATE LEVEL.

ORGANIZATIONAL STABILITY (CBO) AND STABLE STAFF MEANINGFUL COLLABORATIONS & WILLING TO ACTUALLY SHARE RESOURCES AND INFORMATION AND OVERCOME TURF.

MORE STAFF TIME TO ATTEND THEIR EVENTS (RECIPROCATE). INVOLVEMENT IN THE CHA. LET THE CBO KNOW HOW WE CAN ASSIST THEM. NOT BE SO CONCERNED WITH $. MORE FREE TEACHING WHERE THERE IS GREAT NEED. GIVE SPACE TO CBO TO HOLD EVENTS TO BETTER REACH OUR CLIENTS AND MORE JOINT PROJECTS.

OPPORTUNITIES TO INCREASE COMMUNICATIONS AND NETWORKING ACTIVITIES. COORDINATING GOALS AND OBJECTIVES TO MAXIMIZE HEALTH CARE DELIVERY OF SERVICE. SHARED FUNDING AND RESOURCES; IE., $10,000.00 TO EACH COUNTY TO FUND HEALTHY CAROLINIANS.

THE JONES COUNTY HEALTH DEPARTMENT HAS SPEARHEADED THE ESTABLISHMENT OF THE HEALTHY CAROLINIAN TASK FORCE WITHIN THE JONES COUNTY COMMUNITY. THE HEALTHY CAROLINIAN TASK FORCE IS AN INTERAGENCY ORGANIZATION, WHICH CONDUCTS NEEDS ASSESSMENT AND DEVELOPS PLAN WHICH RESULTS IN IMPLEMENTATION OF PROGRAMS, WHICH ADDRESSES, IDENTIFIES HEALTH PROBLEMS.

THE HEALTH EDUCATION SECTION PROVIDES COMMUNITY OUTREACH & EDUCATION & PROGRAM PLANNING IMPLEMENT & EVALUATION.

WE DON'T HAVE ANY CBOS IN LINCOLN COUNTY UNLESS NON-PROFIT DENTAL CLINIC MEETS THE DEFINITION OF A CBO. IF SO, WE ALREADY HAVE GREAT RELATIONSHIPS W/ THESE 2 CLINICS BECAUSE WE HELPED ESTABLISH THEM & MAINTAIN HD SEATS ON THEIR BOARDS.

DEVELOP WIN-WIN SITUATIONS

IMPROVED COMMUNICATION – IMPROVED COLLABORATION

TASK FORCE – SYPHILIS ELIMINATION – WORK WITH WIN PROGRAM – INCREASE OPPORTUNITIES FOR PARTICIPATION/DIALOGUE BETWEEN LHD, MGMT, CLIENTS & CBO'S. TRAININGS: CULTURAL COMPETENCE, RELATIONSHIP BLDG ETC... – PROVIDE ADDITIONAL TECHNICAL ASSISTANCE TO CBO'S – INVOLVE MORE REPRESENTATIVES FROM CONSUMERS OF POPULATIONS SERVED – HEALTH FAIRS

VERY GOOD WHEN THERE IS A CBO. WE LACK CBOS IN OUR COUNTY. IT IS HARD FOR OUR HEALTH DEPARTMENT TO BE BYPASSED WITH FUNDING GIVEN TO HEALTHY CAROLINAS, SMART START, WHEN WE HISTORICALLY HAVE DONE ALL OF THE WORK. AND WE ARE STILL ACCOUNTABLE BUT HAVE FEWER RESOURCES.

KNOWLEDGE OF CBOS GOALS & OBJECTIVES. MORE FINANCIAL RESOURCES FOR BOTH. SERVE ON BOARD.

1. CBOS NEED TO RECOGNIZE THAT HEALTH DEPTS ARE NATURAL PARTNERS – NOT THE ENEMY. 2. CBOS NEED TO UNDERSTAND THAT "AFTER HOURS" AVAILABILITY OF SERVICE IS NOT A GUARANTEE CLIENTS WILL COME IN AN ALTERNATE HOURS. 3. HEALTH DEPARTMENTS NEED TO RECEIVE EQUITABLE TREATMENT IN HIV FUNDING.. CURRENTLY CBOS HAVE ALL MONEY PRACTICALLY.

FUND LOCAL INITIATIVES/CBOS THROUGH LOCAL HEALTH DEPTS – WOULD ENCOURAGE COOPERATION, TRULY PREVENT DUPLICATE SERVICES.

1. COALITIONS OR COMMITTEES INVOLVING BOTH. 2. SERVING ON BOARDS FOR BOTH. 3. SUPPORTING ACTIVITIES FOR EACH. 4. PROVIDING EDUCATION OPPORTUNITIES. 5. MAINTAINING OPEN COMMUNICATIONS. 6. SHARING RESOURCES WHEN POSSIBLE.

CONDITION CBOS CONTRACT AGREEMENT THAT THEY COORDINATE/COLLABORATE, INCLUDE, AND PROVIDE PROOF OF PARTNERING WITH LHD.

INCREASE RESOURCES FOR STAFF. INCREASE COMMUNICATION. ESTABLISH GUIDELINES FOR WORKING WITH CBOS.

REPRESENT PUBLIC HEALTH AT MEETINGS OF CBO ORGANIZATIONS.

INCLUSION OF CBOS IN DATA COLLECTION FOR LHDS COMMUNITY ASSESSMENT. CONGRATULATORY COMMUNICATIONS TO CBOS WHEN THEY DO SOMETHING THAT IMPROVES PUBLIC HEALTH.

RELATIONSHIPS ARE GOOD. COMMUNICATION IS REGULAR AND PLANNED.

CONSTANT INTERACTION AND COMMUNICATION. KEEPING EACH OTHER AWARE OF SERVICES.

REQUIRE LHD REMAIN IN THE LOOP VIA FORMAL LETTERS OF SUPPORT FOR SPECIFIC ACTIVITIES.

MORE STAFF TIME DEVOTED TO NURTURING & DEVELOPING RELATIONSHIPS W/CBOS. NEED MORE STAFF TO WORK ON PROJECTS W/THE CBOS. NEED MORE DIVERSE STAFF TO SERVE ON COALITIONS.

GREATER STATE FUNDING FOR HEALTHY CAROLINIANS.

TRI COUNTY RELATIONSHIP IS FINE – WE WORK ON MANY ISSUES TOGETHER. RELATIONSHIP WITH GOSHEN IS STRAINING.. THEY ARE ON AN EMPIRE BUILDING MISSION. EXPANDING IN TRADITIONAL PUBLIC HEALTH AREAS AND TRYING TO TAKE OVER.

GET INVOLVED WITH ISSUES ALL CONCERNED WITH BY PROVIDING FINANCIAL RESOURCES.

RESOURCE – RESOURCES – RESOURCES

REQUIRE THAT CBOS WORK WITH LOCAL HEALTH DEPARTMENT AS A CONDITION FOR STATE FUNDING AWARDS.

STOP PROVIDING SO MUCH MONEY TO CBOS. MOST OF THE TIME THEY USE IT FOR INFRASTRUCTURE WHEN AT THE SAME TIME THE HEALTH DEPT IS PINCHING PENNIES & HAVING TO DEAL WITH LOW SALARIES. MOST CBOS ARE UNACCOUNTABLE & OUT OF CONTROL.

COMMON INTEREST, PROBLEM OR NEED IN COMMUNITY.

Q12a.	What actions can help to establish and improve: A. Relationships between Local Health Departments and Community Based Organizations?

Community Based Organizations

WILLINGNESS – COMMUNICATION – OPPORTUNITIES. WE DO NOT COLLABORATE WITH SOME HEALTH DEPARTMENTS VERY WELL.

WE ALREADY ENJOY A VERY STRONG COLLABORATIVE RELATIONSHIP WITH OUR LOCAL HEALTH DEPARTMENT.

ON-GOING COMMUNICATION. INVITE CBOS TO PARTICIPATE IN PLANNING PHASES. USE CBOS EXPERIENCE WITH DIVERSE POPULATIONS – THEY ARE OFTEN EXPERTS IN THIS AREA.

IT SEEMS THAT OUR LOCAL HEALTH DEPT. IS CONSISTENTLY CHALLENGED BY LACK OF FUNDING & STAFF TO BE ABLE TO SUFFICIENTLY MEET THE NEEDS OF THE COMMUNITY. THEY HAVE SO MANY PROJECTS/PROGRAMS THAT NEED ATTENTION. THEY DO THE BEST THEY CAN WITH WHAT THEY HAVE & ARE OPEN TO COLLABORATION, BUT UNDERSTANDABLY, THEY CANNOT ALWAYS SHARE THE PRIORITIES OF OUR CBO.

CONSTANT COMMUNICATION & NETWORKING. PERSONABLE STAFF. SHARED MISSION – BOTH AGENCIES HAVE POSITIVE REPUTATION.

MORE REFERRALS TO LOCAL RYAN WHITE ENTRY PORTALS.

OUR RELATIONSHIP WITH THE ALAMANCE COUNTY HEALTH DEPARTMENT IS VERY STABLE. AT THIS TIME, WE ARE PARTNERING WITH THEM ON A TEEN OUTREACH PROGRAM.

IF LHD CAN PROVIDE RESOURCES SUCH AS TRANSPORTATION, AND MATERIALS FOR CLASSROOMS, WE WILL BE BETTER EQUIPPED TO SERVICE OUR CLIENTS.

WE WORK VERY CLOSELY WITH OUR HEALTH DEPARTMENT IN GRANVILLE COUNTY. OUR PROGRAM PROVIDES MORE FOLLOW-UP ALONG WITH HOME VISITS AS NEEDED. THERE ARE SUPPLIES THAT WE PROVIDE THAT MAY NOT BE AVAILABLE AT THE CLINIC SUCH AS CLOTHING, PAMPERS, HEALTH & BEAUTY AIDS, ETC. WE HELP EACH OTHER WITH FILLING GAPS WE BOTH MAY HAVE.

1) BETTER COMMUNICATION ABOUT WHAT EACH ARE DOING. 2) MORE SHARED PROGRAMMING – PLAN IMPLEMENT PROGRAMS TOGETHER – FUND TOGETHER.

IT IS DIFFICULT TO PARTICIPATE IN COMMUNITY BASED PROJECTS. WITH THE LOCAL HD (HEALTH-GATES) WE HAVE PARTNERSHIP WITH THE NEIGHBORING LHD (NORTHAMPTON COUNTY) TO ASSIST THE LOCAL COMMUNITY PROJECTS.

HEALTH DEPT. PROVIDES MORE SERVICES TO THE HIV POPULATION. CURRENTLY THE HEALTH DEPT. PROVIDES TESTING AND SOME HIV MATERIALS.

FEWER MEETINGS INVOLVING FRONT LINE EMPLOYEES. ALLOW MORE INPUT ON STAFF SELECTION AND EVALUATION. MAKE RELEVANT TRAININGS AVAILABLE TO CBO STAFF.

DON'T MAKE GRANT DOLLARS WHERE THE CBOS HAVE TO COMPETE WITH THE HEALTH DEPT.

ONE THING THAT WOULD HELP IS 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.

WE HAVE A WONDERFUL WORKING RELATIONSHIP WITH OUR LHD.

THERE NEEDS TO BE MORE BILINGUAL STAFF AT HEALTH DEPT SO PEOPLE CAN BE SERVED EQUALLY & FAIRLY. NEEDS TO BE OPEN NIGHTS AND WEEKENDS.

FIND A WAY TO GET THE COMMUNITY AND COMMUNITY BASED ORGANIZATION A BIGGER PART IN DECISION MAKING PROCESS. HOW CAN YOU HELP PEOPLE YOU DON'T KNOW? A LOT OF COMMUNITY BASED ORGANIZATIONS ARE NOT AWARE OF HOW TO PARTNER WITH THEIR LOCAL HEALTH DEPT. BE WILLING TO MEET WITH COMMUNITY BASED ORG AND HELP MEET THE NEEDS OF THE PEOPLE IN THE COMMUNITY INSTEAD OF JUST OTHER AGENCIES.

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. TO HELP ESTABLISH AND IMPROVE OUR RELATIONSHIP WITH HEALTH DEPARTMENTS, THERE SHOULD BE BETTER COMMUNICATION AND CAPACITY BUILDING TO ADVOCATE THE SERVICES PROVIDED AS A WHOLE.

MORE OUTREACH TO LOCAL AGENCIES TO COLLABORATE ON EVENTS

WE HAVE AN EXCELLENT RELATIONSHIP WITH PETE SAFIR.

ENCOURAGE OR REQUIRE COLLABORATION ON ALL COMMUNITY HEALTH INITIATIVES. HAVE CBOS AS ADVISORY BOARD MEMBERS ON STATE SUPPORTED PROJECTS AT THE LOCAL LEVEL.

BETTER PARTNERSHIP EFFORTS – TRUST ISSUES WITHIN COMMUNITY BASED ORGANIZATION FOR LHD.

CONDUCT ANOTHER COMMUNITY BUILDING WORKSHOP TO COME TOGETHER AGAIN WITH FOLLOW-UP. PULL RESOURCES TOGETHER. WORK MORE COLLABORATIVE AROUND GRANTS.

OPEN FORUMS FOR EXCHANGE IDEAS. COLLABORATION IN EVENT PLANNING & EXPLANATION. REGULAR MEETINGS OF TOP LEVEL ADMINISTRATION & BOARDS.

HAVE ENFORCEABLE EXPECTATION THAT LOCAL HEALTH DIRECTORS TREAT CBOS WITH RESPECT AND AS PEERS. REQUIRE THAT LOCAL HEALTH DEPARTMENTS DEMONSTRATE WORKING RELATIONSHIPS WITH CBOS. CBOS ARE REQUIRED TO DEMONSTRATE THIS, WHY NOT HEALTH DEPARTMENTS.

THE ADOLESCENT PREGNANCY PREVENTION PROGRAM AND TEEN MOM PROGRAM APP UTILIZE THE HEALTH DEPARTMENT QUITE A BIT. MANY HEALTH EDUCATORS ARE USED AS SPEAKERS FOR THE YOUTH SERVICE DEPARTMENT. ALSO MANY OF THE TEEN MOMS ARE INVOLVED IN MANY PROGRAMS AT THE HEALTH DEPARTMENT SUCH AS WIC, CHECK UPS FOR THEMSELVES AND BABIES AND OTHER TESTING.

Appendix G. Actions to Improve Services for Diverse Populations

Q12b.	What actions can help to establish and improve: b. Services for Diverse Populations?

Local Health Departments

INCREASED FUNDING FOR TRANSLATORS – COMMUNICATION IS OUR GREATEST BARRIER – LACK OF INTERPRETERS.

MORE MINORITY PROVIDERS WILLING TO SERVE OWN FOLKS.

$ FUNDING $

CULTURAL INTERVENTION.

FUNDS TO ASSIST WITH TRANSLATION AND OUTREACH.

INCENTIVES FOR DUAL LANGUAGE STATE, MEASURING WHAT EXISTS NOW & TRACKING CHANGE.

I THINK WE'RE ALREADY DOING A PRETTY GOOD JOB – COME LOOK AT MY WAITING ROOM AND YOU'LL SEE AND HEAR (SPANISH, UKRAINIAN, ETC.).

HELP WITH LEARNING SPANISH.

INCREASED RESOURCES AND GREATER AWARENESS OF THE SERVICES WE PROVIDE.

ADDITIONAL STAFF, HISPANIC, OUTREACH WORKER, EXTENDED WORKING HOURS (MORE EVENINGS, POSSIBLE SATURDAYS).

THE DIVISION HAS TO TAKE A LEAD ROLE IN ENSURING ALL MATERIALS (FORMS, EDUCATIONAL PAMPHLETS) ARE TRANSLATED IN APPROPRIATE LANGUAGES. ALSO, ENSURE THAT DURING PROGRAM DEVELOPMENT INCLUSION OF DIFFERENT CULTURES IS MADE A PART OF THE PROGRAM. POSSIBLY A STATEWIDE CAMPAIGN THAT TARGETS SPECIAL/DIVERSE POPULATIONS.

MORE CONSUMER ADVOCACY BOARDS – BILINGUAL/BICULTURAL PROVIDERS

NEED TRANSPORTATION AND TRANSLATORS (ON STAFF)

CONTINUED CULTURAL DIVERSITY TRAINING, RESOURCES TO CREATE EXTENDED HRS OR WEEKEND SERVICES, BILINGUAL EMPLOYEES, ESTABLISH NEED THROUGH FOCUS GROUPS, AND THEN COMMUNITY ASSESSMENT METHODOLOGIES.

EVALUATE DATA REGARDING IDENTIFIED HEALTH NEEDS OF DIVERSE POPULATIONS. INITIATE PROJECTS AND PROGRAMS TO ADDRESS THE IDENTIFIED NEEDS. BE CULTURALLY SENSITIVE TO THE NEEDS OF MINORITY POPULATIONS.

IN THE ABSENCE OF STATE UNCOMPENSATED CARE DOLLARS, IT WOULD BE BENEFICIAL TO ALLOW A MINIMUM CHARGE – AT LEAST A 20% FEE FOR EACH PRENATAL VISIT. AS A SAFETY NET, CARE COORDINATION STAFF CAN WRITE A WAIVER FOR PRENATAL MOTHERS THAT TRULY HAVE NO MEANS OF PAYMENT. THIS WOULD CREATE SOME MODEST INCOME FOR A MUCH NEEDED SERVICE & IT HAS BEEN OUR EXPERIENCE THAT THE CLIENTS WILLINGLY PAY THIS FEE.

IN ORDER TO MAXIMIZE SERVICE DELIVERY TO THE DIVERSE POPULATION GROUPS IN DURHAM, THE DPH NEEDS TO ALLOCATE ADDITIONAL RESOURCES.

ASSISTANCE TO LHDS ON HIRING MINORITY PUBLIC HEALTH WORKFORCE.

FUNDING! & WILLINGNESS TO PARTICIPATE ON PART OF TARGET POPULATION.

GRANTS TO FUND INTERPRETERS – GRANTS TO FUND INTERNATIONAL HEALTH SERVICES WITH SEPARATE STAFF THAT REFLECT THE NATIONALITY OF THE CLIENTS SERVED.

INCREASED FUNDING, EXTENDED HOURS, MORE BILINGUAL STAFF, NEW FACILITY.

MORE MATERIALS IN SPANISH. ADVERTISING/OUTREACH TO DIVERSE POPULATION. BILINGUAL SPEAKING STAFF IN EACH DEPT., ESPECIALLY AT FRONT DESK. OFFER & HOLD CLASSES IN OTHER LANGUAGES. HOLD MORE CLASSES/OFFER PROGRAMS THAT APPEAL TO THAT GROUP THAT THEY HAVE MORE INTEREST IN.

RECRUIT DIVERSE STAFF. COLLABORATION WITH COMMUNITY LEADERS. IMPROVE LANGUAGE BARRIER. PUBLIC TRANSPORTATION.

THE JONES COUNTY HEALTH DEPARTMENT MEETS THE CARE OF A LARGE PERCENTAGE OF THE COMMUNITY'S CHILDREN. MOST CHILDREN WHO ARE FOLLOWED BY THE HEALTH DEPARTMENT ARE INSURED THROUGH MEDICAID AND HEALTH CHOICE. THE MAJORITY OF THE MINORITY CLIENTS SEEN AT THE JONES COUNTY HEALTH DEPARTMENT ARE ILLEGAL IMMIGRANTS WITH NO INSURANCE. THE PERCENTAGE OF HEALTH DEPARTMENT CLIENTS WHO ARE WITHOUT INSURANCE IS 25% …

ALL SERVICES PROVIDED BY THE HEALTH DEPARTMENT SERVES DIVERSE POPULATIONS.

DELIVERING THE SERVICE TO THEM IN THEIR NEIGHBORHOODS IS THE METHOD BY WHICH WE HAVE THE BEST SUCCESS W/AFRICAN AMERICAN POPULATIONS. NEED TO DE-CENTRALIZE. BUT THAT TAKES EXTRA RESOURCES WHICH WE DON'T HAVE. (THIS WOULD HELP W/ HISPANICS TOO).

NC STATE PERSONNEL NEEDS TO REVISE CLASSIFICATION OF INTERPRETERS, INCLUDING INCREASING THE PAY GRADE.

ACCESS TO INTERPRETERS.

HIRE MORE BILINGUAL STAFF (HISPANIC/ASIAN) – INCREASE DIVERSITY AT MANAGEMENT LEVELS (ETHNIC & GENDER) – WORK IN NEIGHBORHOODS WITH CHURCHES, CENTERS ETC. …

OUR HEALTH DEPT HAS THE BEST RELATIONSHIP WITH DIVERSE POPULATION AND WE ARE SOUGHT AFTER TO SUPPLY LINKS WITH OTHER COUNTY & PRIVATE AGENCIES. WE HAVE TROUBLE RECRUITING MINORITIES ONLY BECAUSE OF OUR NON-COMPETITIVE LOW PAY SCALE.

QUALIFY MORE HISPANIC/LATINOS FOR MEDICAID OR MORE GRANT FUNDS. MORE INTERPRETERS.

INTERNSHIPS

WE NEED TO CONTINUE TO WORK WITH CHURCHES & LOCAL BUSINESSES TO LOCATE & PROVIDE EDUCATION/SERVICES TO ALL OUR COMMUNITY.

1. ASSESSING COMMUNITY HEALTH NEEDS. 2. SOLICITING IDEAS & INFORMATION FROM SPECIFIC DIVERSE POPULATIONS. 3. OFFERING BASIC HEALTH CLINICS AS WELL AS WELLNESS & INTERVENTION STRATEGIES. 4. TEACHING SELF-EMPOWERMENT.

ALL SERVICES ARE AVAILABLE TO ANYONE THAT MEETS DHHS ELIGIBILITY. INTERPRETER ON STAFF, PART-TIME, AS NEEDED.

NOT A PROBLEM FOR US.

DIVERSITY TRAINING – INTERPRETER TRAINING – TRANSLATE ALL DPH CLIENT-BASED MATERIALS – FUNDING.

NEED MORE INTERPRETERS. NEED MORE BILINGUAL STAFF. CULTURAL DIVERSITY TRAINING FOR STAFF.

FUNDING, STAFF.

SURVEYS, DIVERSE STUFF, AWARENESS CAMPAIGN.

OVER 1/2 OF SERVICE POPULATION IS HISPANIC WITH NO REIMBURSEMENT – IF FUNDED COULD EXPAND STAFF & HOURS. HAVE NURSING SCHOOLS/DENTAL HYGIENE HAVE MORE MINORITY GRADUATES – RETURN TO RURAL AREAS.

NEED MORE DIVERSE STAFF TO WORK ON COALITIONS – NEED TO ESTABLISH A MINORITY HEALTH COALITION – CURRENT STAFF NEEDS MORE TRAINING IN CULTURAL SENSITIVITY/ COMPETENCE.

STATE FUNDING FOR INTERPRETER SERVICES – STATE FUNDING FOR UNCOMPENSATED CARE (MAJORITY OF UNCOMPENSATED CARE ARISES FROM HISPANIC RESIDENTS).

HAVING THE ABILITY TO HIRE A FULL-TIME TRANSLATOR WOULD IMPROVE ACCESS TO SERVICES FOR THE HISPANIC POPULATION.

BY PROVIDING TRANSPORTATION.

PROVIDE FUNDS TO SUPPORT STAFF AND SERVICE LOST TO PROVIDE MORE SERVICES. FUND PROGRAMS FOR MEN'S PROTECTIVE HEALTH.

THAT IS JUST THE PRETENSE FOR CBOS TO "ROB" $$ FROM LHDS.

BETTER TRANSPORTATION – LANGUAGE CAPABILITIES – CULTURAL COMPETENCY.

FUNDING FOR PROJECTS – STAFF AVAILABLE TO WORK WITH COMMUNITY.

THE HEALTH EDUCATION SECTION PROVIDES COMMUNITY OUTREACH & EDUCATION & PROGRAM PLANNING IMPLEMENT & EVALUATION.

Q12b.	What actions can help to establish and improve: b. Services for Diverse Populations?

Community Based Organizations

MORE FUNDING – MORE STAFF.

SERVICES FOR DIVERSE POPULATIONS REALLY NEED TO BE WRAPPED AROUND FAMILY AND FOOD FOR THE BEST TURN OUT.

INCREASE FUNDS FOR TRANSLATION/INTERPRETATION CLASSES FOR PROVIDERS IN LANGUAGE OTHER THAN ENGLISH. NON-TRADITIONAL HOURS OF OPERATION. TRAIN HEALTH DEPT ON DIVERSITY/SENSITIVITY & FLEXIBILITY. LH DEPTS TOO “UPTIGHT” & BOUND TO TRADITION – ADJUST! ADAPT! MAKE IT WORK!

MORE BILINGUAL CLINICAL STAFF ARE DESPERATELY NEEDED. AFTER HOURS CARE IS ALSO A MAJOR NEED – NEITHER OF WHICH ARE BEING SUFFICIENTLY ADDRESSED CURRENTLY.

NETWORKING WITH LEADERS IN THE DIVERSE POPULATION – EXTENDED HOURS – CULTURAL SENSITIVITY TRAINING.

LANGUAGE BARRIERS.

WE WOULD BE BETTER EQUIPPED TO REACH OUR LATINO NEIGHBORS IF WE HAD AN INTERPRETER FROM LHD TO HELP US INTRODUCE OUR SERVICES TO FAMILIES IN NEED. ALSO THEY COULD BETTER BENEFIT FROM LHD HEALTH ASSISTANCE PROGRAMS AVAILABLE TO THEM.

CULTURAL COMPETENCY TRAINING.

THE LHD DESIRES TO MAINTAIN ALL RESOURCES IN HOUSE, AND DOES NOT PARTNERSHIP WITH CBOS TO EFFECTIVELY SERVE THE DIVERSE POPULATIONS.

HEALTH DEPT. TO PROVIDE MORE SERVICES TO THE HIV POPULATION. CURRENTLY THE HEALTH DEPT. PROVIDES TESTING AND SOME HIV MATERIALS.

AFRICAN AMERICAN CULTURAL COMPETENCE TRAINING FOR LHD STAFF.

INCREASE BILINGUAL PROVIDERS AT LHD LEVEL.

HAVING MORE DIVERSE POPULATION WORKING IN BOTH THE HEALTH DEPARTMENTS & COMMUNITY BASED ORGANIZATIONS.

OFFER PROGRAMS WHERE COMMUNITY BILINGUAL CAN BE TRAINED TO WORK AT LHD IN FRONT OFFICE OR SOMETHING SIMILAR.

REVISE DIVERSITY TRAINING TO EMPLOYEE, EMPLOYER AND MAKE IT MORE OF A PART OF JOB REQUIREMENT. WHAT HAPPENS WHEN THE BOTTOM AND TOP DON’T WORK TOGETHER? IT CREATES A LACK & GAP IN SERVICES. YOU CAN’T SERVICE PEOPLE YOU DON’T KNOW! SOMEHOW IT WOULD HELP TO HAVE AN EVALUATION TEAM THAT VISITS HEALTH DEPT AGENCIES, FUNDED COMMUNITY BASED ORG. AND SORT THEM ON DIVERSITY SERVICE …

IT IS VERY DIFFICULT IN MANY CASES TO SERVE INDIVIDUALS OF VARIOUS DIVERSE POPULATIONS. ISSUES SUCH AS CULTURAL COMPETENCE AND MULTICULTURALISM ARE TOP FACTORS THAT NEED TO BE ADDRESSED. WE AS LHDS & CBOS CAN COLLABORATE ON A MULTI-ETHNIC APPROACH LEVEL AND ENCOURAGE ONE ANOTHER TO PARTICIPATE IN DEVELOPING MINORITY SUPPORT MECHANISMS.

MORE BILINGUAL STAFF IN ALL TYPES OF POSITIONS; FREE CLASSES TO IMPROVE SPANISH FOR NON-SPANISH SPEAKERS; ALL BROCHURES, PAPERWORK, FORMS, ETC TRANSLATED INTO SPANISH; MORE SERVICE PROVIDERS WHO REPRESENT THE POPULATIONS BEING SERVED; COLLABORATIVE ARRANGEMENTS THAT ALLOW CLIENTS TO ACCESS MORE SERVICES IN OUR PLACE, HEALTH CARE EMERGENCY FINANCIAL ASSISTANCE, MENTAL HEALTH CARE, DOMESTIC VIOLENCE.

PROVIDE RESOURCES FOR LANGUAGE TRANSLATION. PROVIDE TRAINING ON “WHAT IS” CULTURALLY COMPETENT CARE.

MORE FUNDING.

MORE FUNDS AVAILABLE FOR HIRING PERSONS INDIGENOUS TO THE COMMUNITY – TRANSLATORS/INTERPRETERS.

HIRING MORE MINORITIES BOTH BY LOCAL HEALTH DEPT. & CBO AND HAVING MORE PEOPLE ON BOARD THAT CAN SPEAK SPANISH FLUENTLY.

SHARE RESOURCES. DEVELOP PROGRAMS TO SERVE EVERYONE AT EACH CBO AND ROTATE LOCATIONS.

CULTURALLY SENSITIVE STAFF REPRESENTATIVE – STAFFING PATTERNS – CONSUMER INVOLVEMENT IN AGENCY PLANNING.

SERVICES ARE PROVIDED TO ALL POPULATIONS. MOST OF OUR YOUTH SERVED UNDER THE YOUTH SERVICE ARE AFRICAN AMERICANS, BUT I KNOW THE HEALTH DEPARTMENT MEETS THE NEEDS OF ALL AND ANY RACE THAT NEEDS TO BE ASSISTED.

CBO/PUBLIC HEALTH PARTNERSHIP SURVEY OF LOCAL HEALTH DEPARTMENTS MARCH 2003

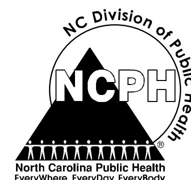
Local Health Department:

____

Date:

Month	Day	Year

North Carolina
Department of Health and Human Services
Division of Public Health
State Center for Health Statistics



Part I. Relationships with Local Health Departments (LHD's) and Community Based Organization (CBO's)

NOTE: **For the purposes of this survey a community based organization (CBO) will be defined as *"any nongovernmental, nonprofit, grass roots organization that works on public health and human services issues where the control and decision-making powers are local."***

1. Please list the names of up to 10 Community Based Organization with an ongoing working partnership with your local health department.

Name of the Community Based Organization (CBO)	**List Areas of Partnership or Focus** (Example: diabetes, family planning)
A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	
I.	
J.	

2. What were the **three most important** reasons that you initiated your partnership with a Community Based Organization? *(Check three)*

- ❑ A. Knew the organization's Director or one of its Board members personally
- ❑ B. My staff spoke highly of the organization's community work
- ❑ C. Had an initial meeting with staff from the CBO and was left with a favorable impression
- ❑ D. Has established a positive reputation in the community
- ❑ E. Knew organization's mission was compatible with ours
- ❑ F. Knew organization could reach diverse population
- ❑ G. Collaborated on community health assessments
- ❑ H. Work in a Healthy Carolinians partnership
- ❑ I. Other

3. Overall, how would you rate your ongoing working relationship with community based organizations in your county?

Needs Improvement 1 2 3 4 5 Strong Relationship

4. Check ways your LHD has worked with a CBO. ***(Check all that apply.)***

- ❑ A. Underwrite the cost of printing materials
- ❑ B. Donate supplies for community activities
- ❑ C. Staff assist with planning and implementing projects
- ❑ D. Staff provide technical assistance
- ❑ E. Attend and participate in event planning
- ❑ F. Invite CBO to attend Local Board of Health meetings
- ❑ G. Carry out joint community education programs
- ❑ H. Carry out health screening/counseling with CBO
- ❑ I. Assist CBO with staff training and orientations
- ❑ J. Have health fairs with CBO
- ❑ K. Collaborate with CBO's on health initiatives
- ❑ L. Coordinate providing free space for the CBO to hold meetings or conduct outreach
- ❑ M. Other

5. What are the **three most important benefits/advantages** of working with a Community Based Organization? *(Check three)*

- ❑ A. Local control
- ❑ B. Opportunity to extend resources
- ❑ C. Maximize resources – leverage
- ❑ D. Build health care capacity
- ❑ E. Community unity focus on public health issues
- ❑ F. Generate support for public health issues
- ❑ G. Community advocacy
- ❑ H. Community ownership
- ❑ I. Public/private bridge
- ❑ J. Credibility to public health activities/focus – shared credibility
- ❑ K. Other

6. What are the **three top challenges** of working with your county's Community Based Organizations? *(Check three)*

- ❑ A. Communications
- ❑ B. Capacity of CBO's/HD's
- ❑ C. Resource availability
- ❑ D. Coordination between agencies
- ❑ E. Loss of control
- ❑ F. Accountability
- ❑ G. Organizational stability (staffing stability/turnover)
- ❑ H. Other

Part II. Serving Diverse Populations

7. What efforts are done in your local health department to recruit management, professional, and clinical staff from minority groups? ***(Check all that apply)***

- ❑ A. Advertise in career offices of Historical Black Colleges and Universities
- ❑ B. Advertise in career offices of Community Colleges
- ❑ C. Advertise in minority owned newspapers
- ❑ D. Advertise in radio stations targeting significant numbers of minority populations
- ❑ E. Advertise in TV stations serving minority populations
- ❑ F. Student Intern opportunities
- ❑ G. Outreach through grass roots Community Based Organization
- ❑ H. Outreach through clients served
- ❑ I. Other ____

8. What are the **top three barriers** that affect your organization's ability to serve **racial and ethnic minority** populations. *(Check three)*

- ❑ A. Lack of Insurance or other means to pay for services
- ❑ B. Low literacy
- ❑ C. Inadequate number of staff
- ❑ D. Language between clients and provider
- ❑ E. Client's lack of transportation
- ❑ F. Waiting time
- ❑ G. Facilities open too few hours or inconvenient hours
- ❑ H. Client's cultural beliefs
- ❑ I. Client's attitudes
- ❑ J. Lack of minority staff
- ❑ K. Lack of information and/awareness about service availability

9. Please fill in the **percentages of FTE staff** belonging to a particular race or ethnicity within each occupational level.

Type of Staff	**White Non-Latino %**	**African American Non-Latino %**	**Asian %**	**American Indian %**	**Other Non-Latino %**	**Latino/ Hispanics %**	**Total %**
Management/ Supervisory FTE's							100%
Admin. Support/ Clerical FTE's							100%
Service delivery/all other Service Providers FTE's							100%

After hours are defined as those times after 5:00 PM or before 8:00 AM on Mondays through Fridays, weekends and holidays.

10. Which services (including clinical services, case management, education, advocacy or others) do you provide after 5:00 PM or on weekends?

Name of Services	Estimate after hours per week spent on this activity	Day/Hours
Clinical – specific type of clinic		
Case management		
Education classes or activities in the community		

11. Check the **top three factors** that are a major barrier to providing after hours services? *(Check three)*

- ❑ A. Safety of providers
- ❑ B. Lack of Resources
- ❑ C. Lack of Staff
- ❑ D. Cost of services or operations
- ❑ E. Lack of clients
- ❑ F. Staff scheduling challenges
- ❑ G. Other ___________________________________

(Go to next page ☞)

Part III. Feedback to the Division of Public Health

12. What actions can help to establish and improve:

A. Relationships between Local Health Departments and Community Based Organizations?

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B. Services for Diverse Populations?

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Thank you!

If you have questions about completing this form,
call Harry Herrick at (919) 715-4471

Please return form to:
Gustavo Fernandez, Director
State Center for Health Statistics
1908 Mail Service Center
Raleigh, NC 27699-1908

by April 18, 2003

CBO/PUBLIC HEALTH PARTNERSHIP SURVEY OF COMMUNITY BASED ORGANIZATIONS MARCH 2003

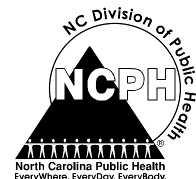
Organization Name:

____

Date:

Month	Day	Year

North Carolina
Department of Health and Human Services
Division of Public Health
State Center for Health Statistics



Part I. Relationships with Local Health Departments (LHD's) and Community Based Organization (CBO's)

NOTE: **For the purposes of this survey a community based organization (CBO) will be defined as *"any nongovernmental, nonprofit, grass roots organization that works on public health and human services issues where the control and decision-making powers are local."***

1. Please list the Local Health Departments with an ongoing working partnership with your Community Based Organization.

   A. ____________________

   B. ____________________

   C. ____________________

   D. ____________________

   E. ____________________

2. What were the **three most important** reasons that you initiated your partnership with the Local Health Department? *(Check three)*

   - ☐ A. Knew the organization's Director or one of its Board members personally
   - ☐ B. My staff spoke highly of the organization's community work
   - ☐ C. Had an initial meeting with staff from the LHD and was left with a favorable impression
   - ☐ D. Has established a positive reputation in the community
   - ☐ E. Knew organization's mission was compatible with ours
   - ☐ F. Knew organization could reach diverse population
   - ☐ G. Collaborated on community health assessments
   - ☐ H. Work in a Healthy Carolinians partnership
   - ☐ I. Other

3. Overall, how would you rate your ongoing working relationship with the Local Health Departments in your county?

   Needs Improvement 1 2 3 4 5 Strong Relationship

4. Check ways your CBO has worked with the LHD. ***(Check all that apply.)***

- ❑ A. Underwrite the cost of printing materials
- ❑ B. Donate supplies for community activities
- ❑ C. Staff assist with planning and implementing projects
- ❑ D. Staff provide technical assistance
- ❑ E. Attend and participate in event planning
- ❑ F. Invite CBO to attend Local Board of Health meetings
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- ❑ L. Coordinate providing free space for the CBO to hold meetings or conduct outreach
- ❑ M. Other

5. What are the **three most important benefits/advantages** of working with the Local Health Department? *(Check three)*

- ❑ A. Local control
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- ❑ C. Maximize resources – leverage
- ❑ D. Build health care capacity
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- ❑ G. Community advocacy
- ❑ H. Community ownership
- ❑ I. Public/private bridge
- ❑ J. Credibility to public health activities/focus – shared credibility
- ❑ K. Other

6. What are the **three top challenges** of working with your county's Local Health Department? *(Check three)*

- ❑ A. Communications
- ❑ B. Capacity of CBO's/HD's
- ❑ C. Resource availability
- ❑ D. Coordination between agencies
- ❑ E. Loss of control
- ❑ F. Accountability
- ❑ G. Organizational stability (staffing stability/turnover)
- ❑ H. Other

Part II. Diversity in the Workforce

7. What efforts are done in your community based organization to recruit management, professional, and clinical staff from minority groups? ***(Check all that apply)***

- ❑ A. Advertise in career offices of Historical Black Colleges and Universities
- ❑ B. Advertise in career offices of Community Colleges
- ❑ C. Advertise in minority owned newspapers
- ❑ D. Advertise in radio stations targeting significant numbers of minority populations
- ❑ E. Advertise in TV stations serving minority populations
- ❑ F. Student Intern opportunities
- ❑ G. Outreach through grass roots Community Based Organization
- ❑ H. Outreach through clients served
- ❑ I. Other ______________________________________

8. What are the top **three barriers** that affect your organization's ability to serve **racial and ethnic minority** populations. *(Check three)*

- ❑ A. Lack of Insurance or other means to pay for services
- ❑ B. Low literacy
- ❑ C. Inadequate number of staff
- ❑ D. Language between clients and provider
- ❑ E. Client's lack of transportation
- ❑ F. Waiting time
- ❑ G. Facilities open too few hours or inconvenient hours
- ❑ H. Client's cultural beliefs
- ❑ I. Client's attitudes
- ❑ J. Lack of minority staff
- ❑ K. Lack of information and/awareness about service availability

9. Please fill in the **percentages of FTE staff** belonging to a particular race or ethnicity within each occupational level.

Type of Staff	**White Non-Latino %**	**African American Non-Latino %**	**Asian Non-Latino %**	**American Indian Non-Latino %**	**Other Non-Latino %**	**Latino/ Hispanics %**	**Total %**
Management/ Supervisory FTE's							100%
Admin. Support/ Clerical FTE's							100%
Service delivery/all other Service Providers FTE's							100%

After hours are defined as those times after 5:00 PM or before 8:00 AM on Mondays through Fridays and holidays and weekends.

10. Which services (including clinical services, case management, education, advocacy or others) do you provide after 5:00 PM or on weekends?

Name of Services	Estimate after hours per week spent on this activity	Day/Hours
Clinical – specific type of clinic		
Case management		
Education classes or activities in the community		

11. What are the **top three factors** that are a major barrier to providing after hours services? *(Check three)*

- ❑ A. Safety of providers
- ❑ B. Lack of Resources
- ❑ C. Lack of Staff
- ❑ D. Cost of services or operations
- ❑ E. Lack of clients
- ❑ F. Staff scheduling challenges
- ❑ G. Other ___________________________________

(Go to next page ☞)

Part III. Feedback to the Division of Public Health

12. What actions can help to establish and improve:

A. Relationships between Local Health Departments and Community Based Organizations?

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B. Services for Diverse Populations?

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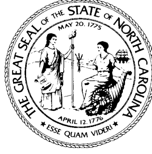
Thank you!

If you have questions about completing this form,
call Harry Herrick at (919) 715-4471

Please return form to:
Gustavo Fernandez, Director
State Center for Health Statistics
1908 Mail Service Center
Raleigh, NC 27699-1908

by April 18, 2003

Appendix J. Survey Introductory Letter to LHDs (signed by State Health Director)



North Carolina Department of Health and Human Services
Division of Public Health • Office of the State Health Director
1915 Mail Service Center • Raleigh, North Carolina 27699-1915
Tel 919-733-7081 • Fax 919-715-3144

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Leah Devlin, DDS, MPH
Acting State Health Director
Director, Division of Public Health

Dear: Local Health Director:

Achieving healthy communities requires more effort and resources than our local and state public health system can marshal alone. It is clear that working in partnership with other organizations is absolutely essential if we are to successfully achieve our collective public health objective of promoting and protecting the health of all North Carolinians. The stronger our partnerships are the more we can accomplish.

Please tell us what we should and can do to improve the local public health department-community based organization partnership and strengthen our combined public health response by completing the brief questionnaire and returning it in the postage-paid envelope. The questionnaire also addresses diversity in local health departments – a factor which increases the opportunity to reach and serve minority groups who are often experiencing the most significant health disparities. We estimate that the survey should take no more than 15 minutes to complete.

The same questionnaire is being sent to every local health department and every community based organization that the Division of Public Health funds. It would be helpful to have these surveys returned by April 18 as directed on the survey. We will combine the survey results and get them back to you and the community based organizations. This information will hopefully become a tool for new and strengthened innovations in our work together to improve health.

Thank you for your participation in completing this survey. Thank you, also, for your numerous contributions to improve the public's health in North Carolina.

Sincerely,

Leah Devlin, DDS, MPH
Acting State Health Director
Director, Division of Public Health

Jim Baluss, President
NC Association of Local Health Directors

Cc: DPH Management Team

EveryWhere, EveryDay, EveryBody

Location: *1330 St Mary's Street • Raleigh, NC 27605*

Department of Health and Human Services
State Center for Health Statistics
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Raleigh, N.C. 27699-1908
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