An FPHS-Based Health Equity Evaluation for Pacific County Health & Human Services

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Abstract

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This evaluation explored how a local health department is implementing Washington State's Foundational Public Health Services (FPHS) framework, with a focus on advancing health equity in a rural context. The project aimed to assess the department's internal capacity, examine alignment between FPHS investments and local priorities, and identify opportunities for more strategic and equitable public health delivery. A mixed-methods approach was used to capture a comprehensive picture of the health department operations and context. Data sources included a review of Community Health Assessments, Community Health Needs Assessments, and FPHS Annual Reports from State Fiscal Years 2023 and 2024. In addition, a 48-question staff survey was designed and administered to gather both quantitative and qualitative data from employees across the department. The findings were synthesized to inform a set of phased, equity-focused recommendations tailored to the county's rural public health context.

COMMUNITY-ORIENTED PUBLIC HEALTH PRACTICE
UNIVERSITY of WASHINGTON | SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF URBAN DESIGN & PLANNING
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ABBREVIATION KEY

ACA	Affordable Care Act
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
DOH	Department of Health
EPHS	The 10 Essential Public Health Services
FPHS	Foundational Public Health Services
IOM	Institute of Medicine
LHD	Local Health Departments
LHJ	Local Health Jurisdictions
OBHMC	Ocean Beach Hospital and Medical Clinics
PCHHS	Pacific County Health & Human Services
PHAB	Public Health Accreditation Board
PHNCI	Public Health National Center for Innovations
PHWINS	Public Health Workforce Interests and Needs Survey
SBOH	State Board of Health
WHH	Willapa Harbor Hospital

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EXECUTIVE SUMMARY

Pacific County Health and Human Services (PCHHS) partnered with the University of Washington School of Public Health and College of Built Environments to support a capstone thesis project evaluating how the department implements Washington State's Foundational Public Health Services (FPHS) framework to advance health equity. This project, led by a Master of Public Health and Urban Planning student, aimed to assess internal capacity, identify system gaps, and offer strategic recommendations for using FPHS funds more effectively in a rural setting.

The evaluation used a mixed-methods approach, combining a review of FPHS annual reports, Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs), and a 48-question staff survey representing a cross-section of PCHHS employees. Analysis was guided by public health systems thinking and grounded in staff perspectives and community data to ensure alignment with local priorities.

Findings showed that PCHHS has expanded staffing and programming, especially in communicable disease response and language access, but challenges remain. These include fragmented planning between North and South County, limited collaboration with housing and transportation sectors, and underdeveloped infrastructure for evaluation, emergency preparedness, and workforce retention. While staff expressed a commitment to equity and local communities, survey results revealed inconsistent stakeholder engagement, unclear equity roles, and limited internal collaboration. Many emphasized the need for a clearer strategy, better coordination, and stronger evaluation to ensure FPHS funds effectively advance equitable outcomes.

Recommendations from this evaluation are organized into short-medium and long-term phases to support actionable phased progress. Short-term priorities (through 2025) focus on foundational improvements such as internal coordination, document access, and staff cross-training. Medium-term actions (2025–2027) aim to build infrastructure, strengthen collaboration with external partners, and deepen the integration of the FPHS framework across programs. Long-term goals (2027 and beyond) are sustaining systems-level change through embedded evaluation, expanded data use, and ongoing cross-sector strategies.

By addressing structural gaps and aligning FPHS implementation with community needs and staff insight, PCHHS can strengthen its public health infrastructure and advance long-term, equitable health outcomes in Pacific County.

INTRODUCTION

Local health departments (LHDs) across the United States are at a crossroads. As the landscape of healthcare access and public health needs and funding continue to shift, LHDs are grappling with how to best fulfill their role in protecting and promoting the health of their communities.

A LHD is a government-run organization that works at the city, county, or regional level responsible for protecting the health and wellbeing of the community it serves.[1] Historically, many have functioned as safety nets, offering primary care and limited clinical services.[2] With more access to healthcare through policy changes and systemic reforms, for many communities the necessity of these departments to providing direct clinical care is less of a requirement.[2,3] This shift has caused LHDs to take on different roles based on their available resources. Some departments have reduced or discontinued clinical services, which can leave gaps in care for vulnerable populations, while others continue to devote resources to direct clinical services, resulting in not investing in broader foundational public health functions.[2–4] While public health is working to shift LHDs toward broader roles in addressing social determinants of health, they still face resource and structural barriers that limit their ability to achieve this transformation fully.

The broader public health system in the United States faces significant structural and financial challenges.[2,3,5,6] Chronic underfunding and a fragmented system of governance where it is spread across federal, state, Tribal, local, and territorial levels have resulted in inconsistencies in access to essential services.[5,7] The COVID-19 pandemic has highlighted these weaknesses, exposing gaps in the system and amplifying public distrust in health agencies. Many have argued that rebuilding trust in public health requires agencies to realign their focus on their core mission of promoting health and preventing disease from a population health and upstream approach, particularly in the post-pandemic era.[5]

Workforce reductions have compounded the decrease in public health infrastructure. Since 2008, budget cuts have led to a loss of 10–12% of local and state health department staff, further straining their capacity to deliver clinical and population-based services.[6] These workforce challenges have deepened disparities in public health funding, staffing, and service availability, particularly in rural and underserved areas, where departments often need more capacity, data, and resources.[6,8] Due to this decline in capacity, there is limited ability to effectively address day-to-day and systemic public health needs.

Pacific County is a rural area in Washington State with approximately 24,000 residents.[9] The county faces unique public health challenges driven by demographic, economic, and systemic factors. It has a low-density population, with 62.9% of residents living in sparsely populated regions, contributing to limited access to healthcare services and resources.[9] Significant issues include a shortage of primary care providers, inadequate coordination among service agencies, and a lack of chronic disease prevention and wellness programs.[10] Additionally, rising housing costs and an aging population have increased the demand for healthcare while exacerbating disparities in access to essential services.[10]

These challenges reflect broader difficulties rural LHDs face, which often operate with fewer financial and human resources than LHDs in urban areas.[11] Rural LHDs are frequently required to prioritize direct health services over population-based prevention efforts, such as mobile health units, community health workers, telehealth services, further straining their capacity to address systemic public health issues.[6,11]

Recognizing these gaps, national and state-level efforts have increasingly focused on creating frameworks to standardize and strengthen core public health services across all communities. One of these frameworks is the Foundational Public Health Services (FPHS) which was developed to define a minimum set of public health capabilities and services that every community should expect from its public health system. Understanding how well LHDs are implementing FPHS is essential to strengthening public health infrastructure and advancing health equity, especially in rural areas like Pacific County. This capstone aims to strengthen public health infrastructure and ensure equitable health outcomes for Pacific County, using the FPHS framework, to identify gaps and develop strategic, community-informed recommendations to improve service delivery and support equitable health outcomes.

ORGANIZATIONAL PROFILE

Pacific County Health & Human Services
Director: Gracie Minks

Pacific County Health & Human Services (PCHHS) is the county health department of approximately 24,000 residents across a largely rural landscape in southwest Washington.[10] PCHHS has a staff of 21 people and is committed to enhancing its residents' health and well-being through various health services.[8] These services include behavioral health, maternal and child health, immunizations, sexual and reproductive health, COVID-19 testing, and communicable disease prevention and control. [8] The department also focuses on school nursing, vital records, veterans services, and community health promotion programs. In recent years, the

department has strategically expanded its approach to reflect a Public Health 3.0 model, integrating upstream factors, such as housing insecurity into its core services.[9] This approach positions PCHHS as not only a service provider, but also a coordinator of broader systems change with the purpose of helping to address the root causes of health disparities.

Figure 1. Map of Pacific County in Washington State (Source: University of Washington URBDP 507).

According to County Health Rankings, Pacific County is faring worse than the average county in Washington regarding overall health outcomes and factors, such as length of life, quality of life, health behaviors and clinical care, but better than the average county in the nation.[10] This suggests that Pacific County faces challenges that are common to rural, under-resourced areas compared to Washington's overall higher health standards.Still, compared to national standards, Pacific County performs relatively well, suggesting that effective local interventions and public health strategies are making an impact despite limited resources.

However, delivering equitable services across Pacific County remains complex. Geographic and structural divides, such as the distinct service areas of Willapa Harbor Hospital in the north and Ocean Beach Hospital in the south highlight the complexity of delivering equitable services across a dispersed region. These divisions further emphasize the importance of PCHHS's evolving role in convening partners, coordinating services, and addressing health disparities across the county.

Despite resource limitations common to rural health departments, Pacific County has strong commitments to community engagement and adaptability. PCHHS' 2023–2024 Community Health Improvement Plan (CHIP) highlights a strong relationship between the department and its

community stakeholders. Informed by local input and secondary data, the CHIP identified key priorities such as the shortage of primary care providers, the need for better service coordination, and the expansion of chronic disease prevention and wellness efforts.[9] These community-identified priorities, combined with broader population health data, provide important context for understanding Pacific County's systemic challenges and the opportunities for strengthening its public health infrastructure.

LITERATURE REVIEW

The FPHS framework outlines a minimum set of public health capabilities and essential services that every community should expect from its governmental public health system.[14] Developed nationally by the Public Health National Center for Innovations (PHNCI) at the Public Health Accreditation Board (PHAB), FPHS was designed to create a standardized foundation for public health practice across local, state, Tribal, and territorial health departments.[14,15] The framework focuses on building the necessary infrastructure for health departments to deliver population-based services, prioritize equity, and collaborate across sectors to address the broader determinants of health.[14,15]

In Washington State, the FPHS framework has been formally adopted and funded in 2019 to strengthen the public health infrastructure at both state and local levels.[16] While aligned with national FPHS principles, Washington's model has been adapted to meet the needs of its communities, particularly rural and tribal populations.[17,18] Through this funding model, local health departments are expected to build capacity in core public health areas, address systemic health inequities, and modernize service delivery to better respond to emerging public health challenges.[17,18]

This literature review draws from various academic, governmental, and practice-based sources. It is organized into five sections to better understand the FPHS framework and its relevance to Pacific County. First, **The Evolution of FPHS traces** how the framework developed from earlier public health models, including the 10 Essential Public Health Services (EPHS) and the Public Health 3.0 movement. Second, **Defining FPHS** clarifies the specific structure, goals, and expectations of the FPHS framework at the national level. Third, **FPHS in Washington State** explores how Washington has adapted and operationalized FPHS principles for the state's needs. Fourth, **Pacific County Context,** looks at the unique needs of the county. Fifth, **Rural Characteristics and Challenges for Local Health Departments (LHDs)** examines rural departments' barriers in building foundational public health capabilities. Sixth, **Health Equity in LHDs**, examines health equity challenges and frameworks for health departments. Finally, **Evaluating FPHS: Findings and Case Studies** reviews how different states and local jurisdictions have assessed FPHS implementation. These sections provide background for understanding the broader policy environment and the challenges PCHHS must navigate to align more fully with the FPHS framework. They also explain how this capstone evaluation for PCHHS was structured and why specific methods were selected to respond to these realities.

The Evolution of FPHS

The FPHS framework, developed from the 10 Essential Public Health Services (EPHS), and the Public Health 3.0 model are interconnected approaches designed to modernize and strengthen public health practice. They all aim to address the evolving challenges of public health through a population health lens to build a more robust public health infrastructure.[2] Although different, each framework has built off one another to create the current iteration of FPHS but has the broader goal of improving health outcomes by focusing on equity, population-level interventions, and cross-sector collaboration.[19]

The 10 EPHS framework was developed in 1994 as a guide of core public health activities communities should undertake.[20] Created by the Centers for Disease Control and Prevention (CDC), the approach is organized around the three core functions of public health: assessment, policy development, and assurance. The 10 EPHS served as a roadmap for aligning public health practice with community needs.[20] Figure 2 below illustrates the updated version of the 10 Essential Public Health Services, emphasizing equity as a central component.

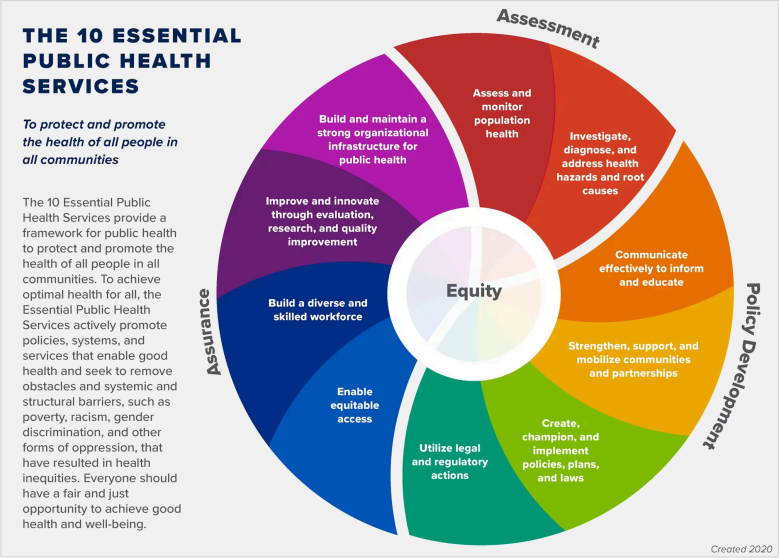

Figure 2. The revised 2020 CDC 10 Essential Public Health Services.[20]

Over the years, as the public health landscape evolved, the EPHS framework was revised to reflect emerging priorities, particularly equity. The updated framework centers equity as a driving principle, recognizing that achieving optimal health outcomes requires addressing systemic health disparities and social determinants of health.[20,21]

The 10 EPHS and FPHS were developed for different reasons, but provides a broad foundation for what FPHS is based on and operationalized from. The 10 EPHS was developed to describe the activities the public health system should undertake in all communities, while FPHS was

developed as part of the Institute of Medicine (IOM) Minimum Package framework to represent a minimum package of governmental public health services to make the case for sustainable funding and to describe what is needed everywhere for public health to function anywhere.[21] Both frameworks complement one another: the 10 EPHS describes what public health systems should achieve, while FPHS focuses on achieving these goals through adequate infrastructure and capabilities.[21]

From there, Public Health 3.0 builds on the successes of earlier public health eras while emphasizing a new model of enhanced and expanded public health practice.[3] It calls for LHDs to transition from direct clinical services to population-level interventions focusing on upstream factors such as policy, systems, and environmental changes.[3] The revised framework emphasizes listening to and involving those disproportionately affected by public health challenges, reflecting a more substantial commitment to equity and acknowledging that public health efforts must be grounded in local contexts.[2,3,19] This approach aligns with FPHS by ensuring that health departments have the foundational capabilities needed to act as "chief health strategists" in their communities.[2] Figure 3 below illustrates the evolution from Public Health 1.0 to Public Health 3.0, highlighting the growing emphasis on equity, cross-sector collaboration, and systems-level change.

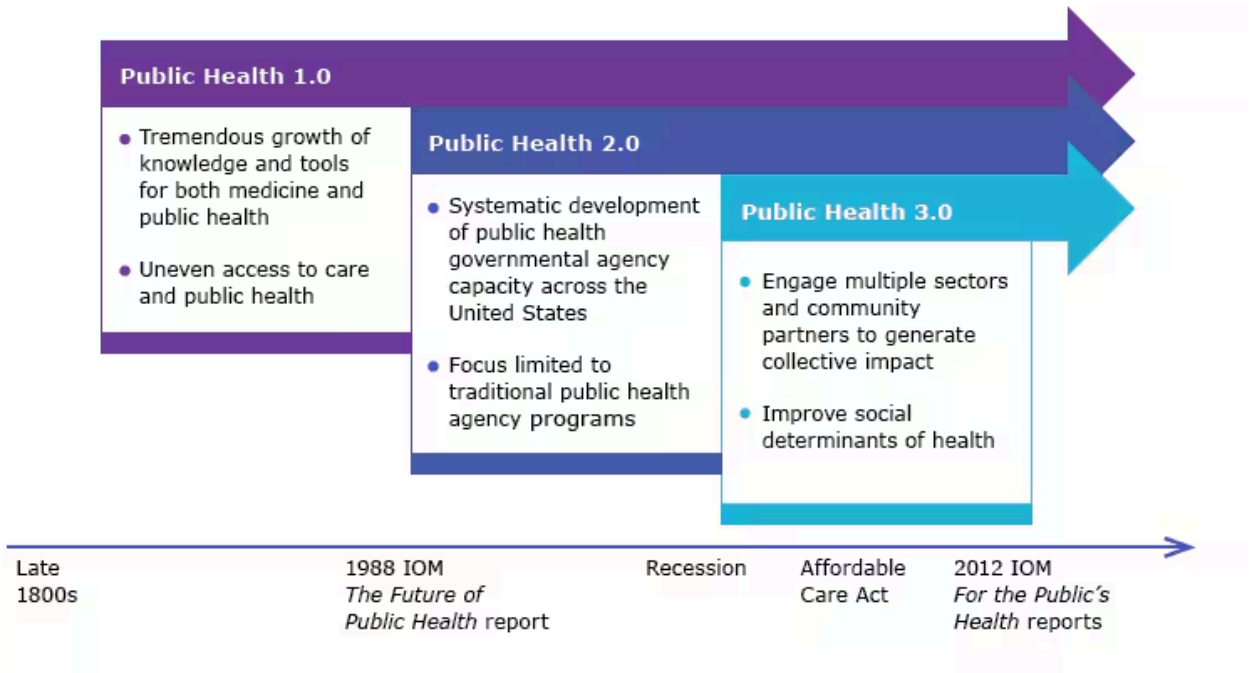

Figure 3. The history of Public Health 3.0 and how the frameworks build off one another.[3]

Public Health 3.0 aims to reduce health disparities and foster equity by shifting focus from primarily delivering direct clinical services to addressing social determinants of health (such as

housing, education, and economic stability).[3] For example, the Lincoln Trail District Health Department in Kentucky successfully integrated Public Health 3.0 principles into its efforts, which using a social determinants of health framework resulted in improving disease prevention, environmental health, and maternal and child health outcomes.[22] This approach ensures that public health interventions are informed by data, responsive to community needs, and aligned with broader efforts to improve population health.[22]

The transition to population-level interventions and the current adoption of FPHS reflect a broader effort to think from a more systemic perspective about public health, and how best LHDs should respond.

Defining FPHS

The FPHS is a framework created in 2012 that was designed to ensure equitable and consistent public health protection and improvement across the United States.[5,14] It establishes a minimum set of foundational capabilities and essential areas for all health departments, regardless of location, to effectively address core public health needs.[14] The FPHS approach addresses the long-standing challenges faced by public health systems, including funding gaps, workforce shortages, and inequities in service delivery, and aims to modernize public health infrastructure to meet current and emerging health crises, such as the COVID-19 pandemic.[5,7,8]

The FPHS concept originated from recommendations made by the IOM in its 2012 report *For the Public's Health: Investing in a Healthier Future*.[23] The report underscored the need for a standardized set of public health services and capabilities to reduce inconsistencies in health department performance nationwide based on what they assessed.[23] The IOM proposed the development of a "minimum package" of services and programs, which would act as a foundational baseline for public health efforts.[23] The purpose is to standardize the practice across geographic regions in the United States. Standards describe the level of achievement expected of a health department, and are the same for all health departments whether they are local, county, state or Tribal.[15] This package was intended to complement the clinical healthcare services outlined in the Patient Protection and Affordable Care Act (ACA) by addressing upstream determinants of health through population-based strategies.[6] IOM and public health officials' argument for FPHS is that without such foundational support, public health responses would be uneven and often insufficient to meet community needs.[23,24]

Following the IOM's recommendations, public health officials and organizations collaborated to develop the FPHS framework. FPS is now housed at the Public Health National Center for

Innovations (PHNCI) at the PHAB.[25] The framework comprises eight (8) public health infrastructure foundational capabilities and five (5) public health programs, or foundational areas.[14] The idea is that together, these components create a cohesive system that all health departments should use as a baseline to address essential public health needs. FPHS emphasizes that these services and capabilities "must be available by health departments everywhere for the public health system to work anywhere."[7]

FPHS has critical cross-cutting skills, termed “foundational capabilities," as the infrastructure necessary for public health systems to function effectively. These foundational capabilities aim to provide the infrastructure needed to protect and provide fair and just opportunities and are: 1) Assessment & Surveillance, 2) Community Partnership Development, 3) Equity, 4) Organizational Competencies, 5) Policy Development & Support, 6) Accountability & Performance Management, 7) Emergency Preparedness & Response, and 8) Communications.[14]

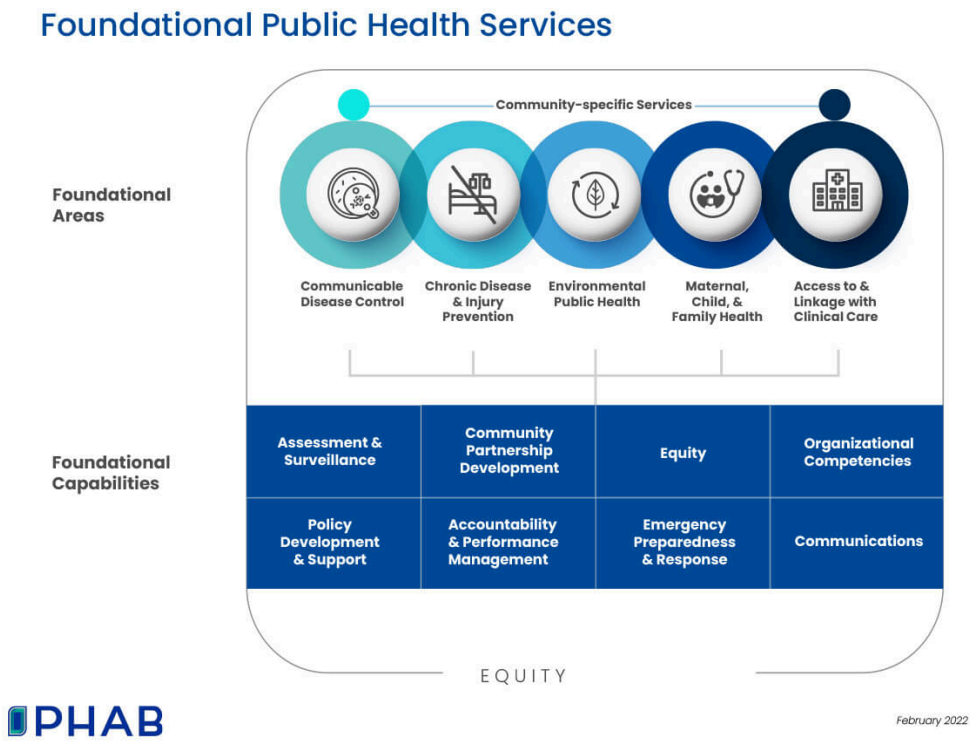

Figure 4. Most recent iteration of the FPHS framework and how the capabilities and areas interact with one another.[14]

The framework also has foundational areas, which are essential public health programs and services that focus on improving the health of communities impacted by specific diseases or public health threats. These areas include chronic disease and injury prevention; communicable disease control; environmental public health; maternal, child, and family health; and access to

and linkage with clinical care.[14] In the 2022 revision of the FPHS framework, equity was further integrated as a central element throughout the framework.[15] Equity was elevated as a stand-alone Foundational Capability and embedded across all Foundational Areas, symbolizing its role as an active guiding principle that influences every aspect of public health.[14,15] The concept is centered within FPHS to highlight the overarching goal of public health to protect and promote the health of all people in all communities.[14] Figure 4 above depicts the most recent iteration of the FPHS framework, illustrating the relationship between foundational capabilities, foundational areas, and their shared focus on achieving health equity.

At its foundation are the Foundational Capabilities, which show the role of a strong infrastructure in supporting public health systems. These capabilities serve as the base upon which Foundational Areas and Community-specific Services are built. While highlighted as its own Foundational Capability, equity is also represented as a unifying element that encircles the entire framework.

FPHS in Washington State

The FPHS framework in Washington State represents a strategic effort to close gaps in public health infrastructure, funding, and service delivery. As one of the pioneering states, alongside Oregon and Ohio, Washington has played a leading role in implementing and refining this framework to a more localized level.[7,26] Its approach has been tailored to address the needs of its populations, including rural communities and Tribal Nations.[17,18,27–29]

Washington's focus on FPHS began in response to years of underfunding by the state and nation to LHDs for core public health duties.[29] The 2008 recession exacerbated these challenges, leading to significant staff reductions, up to 50% in some LHDs, and a diminished capacity to meet growing public health demands in the state.[17,24] In response, recognizing the need for stable funding and a unified strategy, Washington leaders initiated the Agenda for Change in 2010, which recommended long-term strategies for sustainable public health funding.[27] By 2012, a workgroup had outlined a package of core services based on the Institute of Medicine's report, *For the Public's Health: Investing in a Healthier Future*, identifying FPHS as essential to the governmental public health system.[23] The Robert Wood Johnson Foundation provided the initial funding that enabled Washington to conduct baseline assessments and define the foundational services that would become the backbone of the FPHS framework for the state.[17]

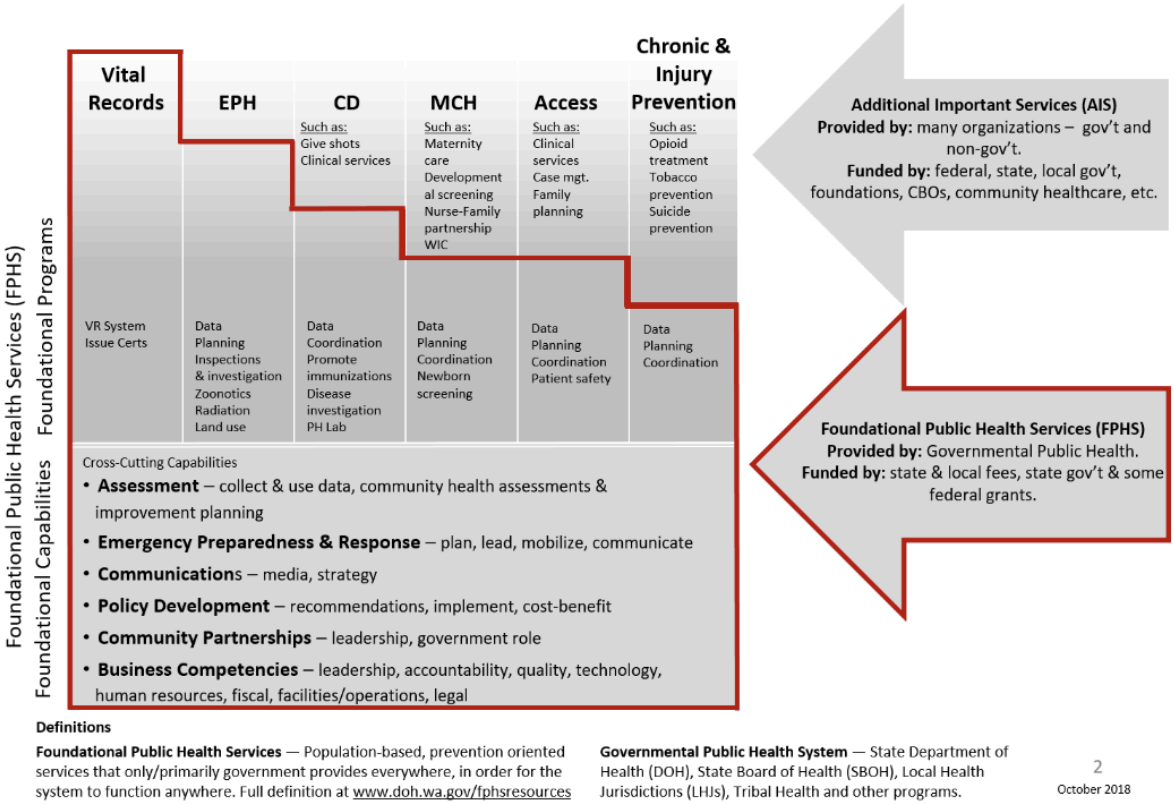

Figure 5. Conceptual diagram illustrating Washington State's FPHS, in the red box, as a subset of public health services and examples of services that are "foundational" and services that are not.[18]

Washington's FPHS framework aligns with the national FPHS model under the PHAB in its core principles but reflects adaptations based on the structure and needs of the state.[17,18] They share the same minimum set of essential public health services and foundational capabilities. Additionally, equity is a priority in both frameworks, and both as an area and woven throughout.[17,18,27,28] Figure 5 above provides a visualization illustrating how Washington State's FPHS model fits within the broader spectrum of public health services, highlighting which services are considered foundational and which extend beyond that core.

One key difference lies in funding and resource allocation. While the national framework allows jurisdictions flexibility in determining resource needs, Washington has conducted detailed assessments to estimate the cost of fully implementing FPHS statewide.[29] Washington has given each department funding to implement FPHS based on their needs but does require that they report on how the funds are being spent.[28,29] In 2019, Washington State passed RCW 43.70.512, which provides financial support for FPHS as described by PHAB.[16]

The 2018 baseline assessment revealed significant gaps in FPHS availability across Washington's governmental public health system. It found that no foundational program or capability was fully implemented statewide, and only two-thirds of the resources needed to

deliver FPHS were being spent.[14] The estimated funding shortfall was $225 million annually, demonstrating the need for additional state investment.[14]

Following this assessment, the Washington legislature began appropriating funds for FPHS, starting with a $12 million initial investment in 2017 and continuing with more substantial allocations in subsequent years.[27,29] By 2023, 50% of the identified funding gap had been addressed, with $112 million allocated annually.[14] This funding has been distributed through a collaborative decision-making process involving the FPHS Steering Committee, which includes representatives from the Washington State Department of Health (DOH), local health jurisdictions (LHJs), the State Board of Health (SBOH), and Tribal Nations.[17,18,27–29]

Washington's FPHS framework also further integrates Tribal Nations into its public health system. Tribal Nations are recognized as key governmental public health system partners, participating in funding allocations and decision-making processes.[17,18,27–29] This goes further than what is outlined in the national FPHS model, which provides general guidance on Tribal health systems without specific implementation details.[14] Washington also targets state-specific challenges, such as rural health disparities, chronic disease, and the opioid epidemic, to meet the particular needs of the state's communities.[17,29] These efforts are significant given that rural communities experience different and often greater barriers to care and wellness than their urban counterparts and, therefore, require tailored strategies to meet their specific needs.

Investments in FPHS have led to measurable improvements in the availability of foundational services across Washington. Between 2018 and 2023, significant progress was made in areas such as communicable disease control, environmental public health, and foundational capabilities like emergency preparedness and community partnerships.[29] In 2021, Engrossed Second Substitute House Bill 1152 was enacted to enhance the diversity of local boards of health by incorporating more representation from the scientific community and community members, aiming to address equity as part of public health transformation efforts.[18] The legislation also created the PHAB at the state level, tasked with providing guidance, making recommendations, and overseeing the performance of the governmental public health system.[30] The PHAB began its work in 2022, with a particular focus on equity-related issues; research conducted for this literature review did not find any updates on the advisory board for Washington.

The overall goal and direction of Washington has been moving toward thinking of the governmental public health system holistically, rather than as individual agencies, from a population-based understanding of health.[17] With that said, challenges remain in fully

implementing FPHS across Washington. The state continues to face funding shortfalls, with only 50% of the necessary resources allocated as of 2023.[29] Rural areas and underserved communities often experience the most significant gaps in service availability, emphasizing the need for sustained investment and targeted support.[29]

In 2025, under the current Washington State Governor's administration, the state's proposed 2025–2027 budget includes significant cuts to FPHS, with reductions of $5–8 million in 2025 and $22 million each year in 2026 and 2027.[31] Although spending authority increases by $10 million in 2026 and 2027, the actual funding shortfall may limit local health capacity and service delivery.Description based on publisher supplied metadata and other sources.[32]

WSALPHO is currently working to determine the best approach for distributing these reductions, but it remains unclear how they will implement changes across LHJs. Options being considered include a 7% across-the-board cut and two stratified reduction models based on LHJ population size, each offering different methods with pros and cons for managing limited funds.[33]

Pacific County Context

Pacific County, Washington, is a geographically diverse and rural county located in the state's southwestern corner, bordered by the Pacific Ocean and the Columbia River. With approximately 24,000 residents, the county is marked by scenic coastal communities, small scattered towns, and unincorporated communities.[10] The county is known for its oyster farming, tourism, and natural resources.

Pacific County has four main communities: Raymond, South Bend, Long Beach, and Ilwaco.[10,34] The county's geography and economy reveal a clear north-south divide, which shapes access to services, economic opportunities, and population demographics. Northern communities like Raymond and South Bend are more closely tied to traditional industries such as logging, fishing, and oyster farming, with a predominantly working-class population.[48] In contrast, southern communities like Long Beach and Ilwaco are driven by tourism and seasonal economies, attracting more retirees, remote workers, and visitors.[48] This divide influences economic development, healthcare access, infrastructure investment, and community needs across the county.[10]

Figure 6. Map of Pacific County, Washington (Source: Google Maps 2025).

Pacific County's main towns reflect the diversity and complexity of its geography, economy, and population. Raymond is a working-class town of approximately 3,000 residents in the northern part of the county. The population is 67% White (Non-Hispanic), with 12.7% identifying as Hispanic and 10.4% identifying as two or more races.[35] The local economy is rooted in logging and shellfish production, and the area experiences higher poverty rates and lower educational attainment levels than state averages.

Just southeast of Raymond is South Bend, the county seat, where 90.2% of residents identify as White (Non-Hispanic), and 16.1% of the population was born outside the United States.[36] South Bend is known as the "Oyster Capital of the World" and is largely supported by farming, forestry, and marine-based industries.

In the southern region of the county, Ilwaco is a coastal community characterized by its marina and growing tourism economy. It attracts seasonal visitors and retirees, with vacation rentals and recreational boating serving as economic drivers. However, the town also experiences social

tension between long-time residents and newer arrivals, particularly as gentrification reshapes housing and community dynamics.[34] Nearby Long Beach is the southern hub of tourism in Pacific County. It is known for hosting major events like the Washington State International Kite Festival and features numerous attractions tied to its beachside location. Since the COVID-19 pandemic, Long Beach has seen an influx of remote workers relocating to the area, contributing to rising housing demand and economic shifts.[34]

Additionally, while Tokeland, home to the Shoalwater Bay Tribe, is geographically located within Pacific County, it operates under tribal sovereignty. As a result, the Pacific County Health Department does not provide services to the reservation, and public health responsibilities are managed through tribal governance and partnerships. The table below outlines the distinct characteristics and key features of each community within Pacific County:

Region	Towns/Communities	Economic Focus	Population Profile	Key Features
Northern Pacific County	Raymond, South Bend, Willapa Valley, Naselle	Logging, shellfish farming, farming, seasonal work	Predominantly White, aging population, working-class	County seat located here (South Bend); lower tourism; limited healthcare and jobs; more resource-dependent industries
Southern Pacific County	Long Beach, Ilwaco, Ocean Park, Seaview	Tourism, local businesses, recreation	Seasonal visitors, retirees, higher recent population growth	Long Beach Peninsula is the tourism hub; Cape Disappointment; influx of remote workers post-COVID
Tribal Community	Tokeland (Shoalwater Bay Tribe)	Tribal government, fishing, some tourism	~100 residents on reservation; ~373 enrolled members	Facing land loss due to sea level rise; limited healthcare; own police, but rely on county jail

Rural Characteristics and Challenges for LHDs

LHDs are government entities responsible for delivering public health services at the local level.[37] Rural LHDs serve populations in non-metropolitan areas and often play a dual role by providing both clinical services and population-based public health initiatives.[2,38] For many rural residents, these departments are the only source of essential services, such as immunizations, communicable disease control, and maternal and child health programs.[38] These departments operate within a more extensive public health system that includes state and federal oversight, but their direct engagement with communities, which often happens in rural communities, places them at the forefront of public health delivery.

Rural communities comprise 14–19% of the U.S. population, or approximately 46.2 to 59 million people.[39] One in five Americans live in rural areas, making up 97% of the nation's land mass.[40] In contrast, urban areas covering only 3% of the land are home to over 80% of the U.S. population, highlighting the differences in population density and access to services across these regions.[40] These areas face significant demographic and environmental challenges, including higher rates of poverty, lower educational attainment, limited access to transportation, and older populations.[39] Rural residents experience elevated rates of chronic conditions such as diabetes, cardiovascular disease, and cancer, as well as higher rates of mental health needs.[38,39] Compounding these health challenges is the "double disparity" that rural communities and LHDs face.

The double disparity was coined in a 2016 study and refers to two interrelated issues: the poor health outcomes of rural residents and the inadequate resources of rural LHDs.[11] Rural residents are more likely to engage in high-risk health behaviors, contributing to poorer health outcomes.[11] These behaviors are shaped not only by environmental and systemic factors such as limited access to healthcare and socioeconomic challenges but also by the industries in rural economies.[11] Many rural areas rely on primary resource-based workforces, such as agriculture, fishing, and mining, which often involve physically demanding labor, exposure to hazardous conditions, and irregular hours.[41]

At the same time, rural LHDs operate with fewer resources and finances compared to their urban counterparts.[2–4,7,11] They face significant economies of scale challenges, as basic infrastructure costs remain fixed regardless of population size.[38] While per capita spending might appear comparable or even higher than in urban areas, total funding is typically modest and insufficient to cover the required comprehensive services.[38] Unlike urban LHDs, rural departments lack the funding base provided by clinical fees, fines, and larger tax bases, and instead they rely heavily on state and federal funding, which can be unpredictable and insufficient.[38] In the case of Pacific County Health & Human Services (PCHHS) in 2019, Washington State passed RCW 43.70.512, which provides financial support for FPHS for the LHD, and last year, PCHHS received $1.8 million to fulfill these services.[16] As of now, they will not continue to receive that funding.

The resource limitations of rural LHDs also impact their ability to address population health effectively.[38,42] Rural LHDs frequently struggle with staffing shortages due to smaller budgets and populations which limit their ability to recruit and retain skilled workers.[42,43] Rural locations also make recruitment difficult, as remote areas may lack the amenities and higher salaries offered by urban settings.[38] One study found that for nearly all LHDs studied with population sizes less than

50,000, a staff's ability to fill multiple roles was influential in staffing decisions. One respondent summarized, *"Being a rural county…we have to consider people's abilities to wear those multiple hats because we don't have the luxury of specialization here."*[42] Therefore, that speaks to the work that staff members are able to do, this can also lead to burnout and inefficiencies.

In many rural communities, LHDs act as the safety net for clinical services, providing care where private providers or hospitals are unavailable.[38] It was found that this further complicates recruitment and retention efforts, as LHDs' direct competition with the private health care sector has historically been a losing proposition; nurses can make some $15,000 more per year for the same job class in a private health care setting compared with LHDs.[38] This dual responsibility places additional strain on limited resources and may detract from population-level health initiatives.

The vast geographic areas covered by rural LHDs present logistical challenges.[38] Staff often spend significant time traveling to reach remote communities, reducing efficiency and limiting service delivery, as in the case with Pacific County.[12,13,38] In some cases, rural areas are served not by local departments but by regional or state health agencies, which can further complicate coordination and responsiveness.[38] It's also important to note that service delivery in rural areas impacts costs differently, with unique financial and operational burdens that urban counterparts may not face.

Limited data collection, analysis, and sharing capacity hinders rural LHDs' ability to address public health issues effectively.[44] The lack of consistent definitions and measures for rurality also complicates research and funding decisions. Additionally, during the COVID-19 pandemic, misinformation and disinformation presented significant challenges, as rural LHDs struggled to disseminate accurate health information amid widespread skepticism and political tensions.[5,7,44]

Despite these challenges, rural LHDs demonstrate resilience and adaptability. They excel in leveraging community relationships and partnerships to address local health needs. The close-knit nature of rural communities often allows LHDs to engage directly with residents, fostering trust and collaboration. Rural LHDs are deeply embedded in their communities, which enables them to build strong relationships with local stakeholders, including schools, businesses, and faith-based organizations. These partnerships are critical for implementing health initiatives that reflect the unique needs of rural populations. With limited resources, rural LHDs often adopt innovative approaches to service delivery. For example, telemedicine has become a valuable tool for overcoming geographic barriers and improving access to care, this is also complementary to ongoing efforts to improve broadband access in rural areas as well.

Additionally, many rural LHDs have embraced cross-jurisdictional sharing, collaborating with neighboring counties to pool resources and expertise. While the dual role of providing clinical and population-based services can be challenging, rural LHDs are often the only providers of critical services like immunizations, communicable disease control, and maternal health care. These efforts have a tangible impact on improving health outcomes and reducing disparities in underserved areas.

Health Equity in LHDs

Health equity refers to the fair and just opportunity for all individuals to attain their highest possible level of health.[45] This involves removing obstacles such as poverty, discrimination, and deep-rooted structural barriers that influence access to good jobs, quality education, safe environments, and adequate healthcare. The CDC defines health equity as a situation where "everyone has a fair and just opportunity to be as healthy as possible."[45] This concept underscores the need to address structural and social determinants of health (SDoH), such as housing, transportation, education, and employment, which shape the conditions in which people are born, grow, live, work, and age.[45,46]

In public health, particularly within LHDs, health equity has become a strategic priority aligned with the 10 Essential Public Health Services.[20,21] Each of these services, from assessing community needs to policy development and assurance, must now be delivered with an equity-centered approach. PHAB, the national accrediting body for LHDs, has integrated health equity into its standards and measures (notably in the 2022 revision), reinforcing that promoting equity is a foundational function of public health practice.[15]

LHDs are on the frontlines of addressing community health challenges and promoting equity.[47] Their responsibilities extend beyond clinical services, including policy development, community engagement, emergency preparedness, environmental health, disease prevention, and health promotion.[1] LHDs act as liaisons between state agencies and local populations, and they are uniquely positioned to apply a geographic, community-informed lens to policy and planning.[1]

In the post-COVID-19 era, the recognition of health equity as a core responsibility of LHDs has intensified.[47–49] The pandemic spotlighted systemic disparities, not just by race and ethnicity but also by income, disability, immigration status, and geography. In response, many LHDs embed equity into their internal policies, training, and community engagement strategies.[39]

According to recent studies, a large proportion of accredited LHDs (nearly 90%) report engaging in health equity work, though the scope and depth of that work varies.[47,48] Successful strategies include:

- Integrating equity language into program goals and funding proposals
- Using community data to identify at-risk populations
- Revising hiring and training practices to foster a diverse and inclusive workforce
- Building cross-sector partnerships to address SDoH
- Embedding health equity into strategic plans and CHIPs. A recent study found that, CHIPs scored low on both social determinants of health (49/100) and equity orientation (35/100), often overlooking areas like economic stability, social context, and education. Strengthening data infrastructure, increasing resources, and centering equity in planning could improve their impact and inclusiveness.[50]

To guide their equity efforts, LHDs often draw from established public health planning frameworks:

1. **MAPP (Mobilizing for Action through Planning and Partnerships)**: Widely used for Community Health Assessments (CHAs) and CHIPs, MAPP helps agencies engage communities and identify health priorities.
2. **Healthy People 2030**: Offers evidence-based national goals, including equity-related benchmarks.
3. **County Health Rankings & Roadmaps**: Provides data on health outcomes and SDoH at the county level.
4. **GARE (Government Alliance on Race and Equity)**: Offers tools to normalize equity as standard practice, operationalize equity using data, and build cross-sector partnerships.
5. **CDC's Health Equity Science (HES) Framework**: Encourages agencies to move beyond documenting disparities to addressing root causes through co-design, evaluation, and qualitative data collection.

Accreditation by PHAB also is a driver for equity-forward planning.[15,50] According to PHAB, accredited LHDs are generally more likely to incorporate disparity measures, community voice,

and SDoH into their strategic documents.[15,50] However, challenges remain, especially among rural and under-resourced LHDs that may lack the funding or capacity to meet these accreditation standards.

Despite increased attention, LHDs continue to face significant obstacles in implementing health equity strategies:

- **Defining Equity Beyond/For Race and Ethnicity:** Many LHDs struggle to interpret PHAB's equity requirements in homogenous populations. Tribal health departments, for example, serve communities where nearly all residents qualify as historically marginalized, making it difficult to designate priority subgroups. At the same time, considerations need to be made specifically for Tribal populations.[49,51]

- **Data Limitations:** Smaller and rural health departments often lack access to granular, disaggregated data necessary to identify disparities or evaluate interventions. Language barriers and limited analytic capacity further complicate needs assessments.[52]

- **Political and Funding Constraints:** In politically conservative areas, use of terms like "equity" or "systemic racism" may trigger opposition or funding threats. As a result, LHDs often reframe equity language into more politically neutral terms like "access to care" or "fairness."[51]

- **Workforce Capacity:** Many LHDs report challenges recruiting diverse staff or implementing workforce equity policies due to lack of diversity in their applicant pools, restrictive hiring criteria, and inadequate training in cultural competence.[53]

- **Evaluation Gaps:** While LHDs collect some health data, they often lack capacity to evaluate the long-term impact of their equity interventions due to resource limitations, short grant cycles, and competing demands.[54]

- **Interagency Silos:** Siloed departments and disconnected governance structures make it difficult to integrate health equity into areas like housing, education, the environment and transportation, which are sectors critical to addressing root causes.[54]

As LHDs work to institutionalize health equity and address the root causes of health disparities, they do so within an increasingly fraught political landscape. Recent actions by the Trump administration, including efforts to dismantle diversity, equity, and inclusion (DEI) initiatives, defund equity-related programs, and federal investigations on DEI, pose a direct threat to LHDs

and other public institutions' progress.[51] Legislation like the proposed Dismantle DEI Act and changes to data reporting requirements threaten to hide inequities and restrict public health's ability to respond to them.[51] LHDS must embed equity into their structures in this climate, partner with communities, and advocate for evidence-informed, inclusive policies.

Evaluating FPHS: Findings and Case Studies

Evaluating the implementation and impact of FPHS has proven to be a multifaceted challenge due to variations in methodologies, resources, and the unique contexts of LHDs.[55] Over time, various tools and methods have been developed to assess FPHS implementation. However, from my own research, challenges persist due to differences in approaches and their overlap with public health accreditation efforts, particularly with the integration of FPHS into the PHAB standards. While this alignment facilitates standardization and accreditation, it often obscures FPHS-specific evaluations by blending them with broader organizational assessments.

The complexities of FPHS evaluation are compounded by variations in how different LHDs conduct assessments. Surveys conducted in-house or through external partnerships often lack uniformity, resulting in inconsistent reporting and limited public accessibility. This inconsistency poses challenges for benchmarking and comparing FPHS outcomes across jurisdictions. FPHS-funded positions across LHJs aren't necessarily the same. For example, in King County Environmental Public Health, most FPHS-funded staff conduct food inspections, whereas other counties may use those funds to hire onsite sewage inspectors. Both LHJs are hiring environmental health sanitarians for different tasks. Additionally, LHJs identify key subject areas with the FPHS Steering Committee to highlight or prioritize funding. For example, Pacific County has an epidemiologist because specific funding was allocated for epi work. The complexities of FPHS evaluation are compounded by variations in how different LHDs conduct assessments. Recent studies and initiatives have sought to address these issues and refine evaluation methodologies, most often through collaborations with the de Beaumont Foundation, PHAB, and CDC.

A national survey conducted is the Public Health Workforce Interests and Needs Survey (PH WINS) supports FPHS evaluation by providing nationally representative data on public health workforce demographics, engagement, morale, training needs, and emerging trends.[56] Conducted by the de Beaumont Foundation in partnership with the Association of State and Territorial Health Officials, PH WINS supports the governmental public health workforce by conducting national surveys. These have been done 2014, 2017, 2021, and 2024.

One notable initiative is the Public Health Workforce Calculator development by the Staffing Up initiative, launched in 2021.[57] This tool, aimed at helping health departments estimate workforce needs based on FPHS requirements, was piloted in a case study with Northern Nevada Public Health in 2022.[57,58] While the tool did not perfectly align with the agency's perceived staffing gaps, it provided a valuable starting point for workforce planning. It highlighted the need for guided discussions around its use. However, challenges such as recruitment difficulties, funding limitations, and the time-intensive nature of aligning workforce efforts with FPHS metrics were noted.[57] Despite these issues, the study found that the calculator demonstrated potential for encouraging workforce cross-training and enhancing expertise.[57]

At the state level, Indiana was among the first states to conduct a comprehensive public health workforce assessment, providing insights for future efforts.[59] Key findings found the need to identify employees' primary tasks and aligning them with standardized titles based on national data to address this.[59] Additional challenges included discrepancies in time allocation reporting and a perceived misalignment of job responsibilities with FPHS areas, which complicated workforce capacity assessments.[59] Despite these difficulties, Indiana's approach underscored the importance of detailed guidance and structured methodologies in aligning workforce activities with FPHS goals.

Washington State's 2018 FPHS Baseline Assessment serves as another key example of comprehensive evaluation. Funded by the state legislature, the assessment examined the capacity of local and state systems to deliver FPHS and identified financial gaps. It found pervasive service gaps across jurisdictions, with no FPHS fully implemented anywhere.[28] The report estimated an annual funding shortfall of $225 million to achieve full FPHS implementation statewide, emphasizing the need for additional investment and strategic resource allocation.[28]

At a more local level, Snohomish County recently conducted its own FPHS gap analysis, building on Washington's 2018 FPHS assessment framework.[60] The evaluation examined progress since adding FPHS funding in 2022 and identified remaining gaps. With a population of approximately 840,000 and a health department staff of 200, the county faced significant public health demands, particularly during the COVID-19 pandemic when staffing was just 106 employees.[60]

Listed below are several tools and methodologies developed to evaluate FPHS implementation and workforce capacity, each addressing specific aspects of the framework:

Toolkit/Framework	Description	Purpose
FPHS Capacity and Cost Assessment Tool	Developed by the University of Washington and the University of Minnesota, this tool evaluates workforce needs and assesses public health capabilities and funding gaps based on FPHS requirements.	Provides a standardized approach to evaluate capacity, identify gaps, and advocate for necessary funding.
Public Health Workforce Calculator	Estimates full-time employee (FTE) needs for FPHS implementation based on population size and service requirements.	Assists health departments in planning and justifying workforce investments, especially for rural areas.
PH WINS (Public Health Workforce Interests and Needs Survey)	Nationally representative survey capturing public health workforce demographics, training needs, and perspectives.	Provides insights for workforce planning, recruitment, retention, and training aligned with FPHS priorities.
Performance Measures and Equity Toolkits	Includes resources like NACCHO's Health Equity Toolkit and the Council on Linkages Core Competencies for evaluating and enhancing workforce skills and equity-focused initiatives.	For LHDs who are curious about health equity performance measures (HEPM) but have not yet taken steps to design HEPM, or who are in the beginning steps of designing performance measures to assess progress and support improvement in health equity programs and initiatives at their LHD.
Community Health Improvement Frameworks (e.g., MAPP 2.0)	Mobilizing for Action through Planning and Partnerships (MAPP) focuses on community-driven health assessments and improvement planning, emphasizing equity	Guides communities in identifying health priorities and developing strategic plans aligned with FPHS goals.

	and stakeholder engagement.	
PARTNER Tool	A social network analysis tool that tracks and evaluates collaborative activities among public health partners.The tool includes a survey that is linked to an analysis tool, making it simple for anyone to send out a survey to their partners and analyze the data. The PARTNER tool is free.	Helps LHDs monitor partnerships, resource exchange, and trust within their networks to improve FPHS delivery.

While varied in scope and approach, these tools collectively provide a framework for understanding and addressing the challenges of FPHS implementation, helping LHDs align their activities with foundational public health goals while identifying areas for improvement and investment.

The purpose of this literature review was to explore the framework of FPHS and its application within LHDs, as well as how it can be applied to the needs of Pacific County. The review examined the challenges and opportunities of evaluating FPHS, including workforce capacity, gap analyses, and funding needs. By analyzing existing methodologies, tools, and case studies, this review highlights effective practices for assessing FPHS. This understanding provides a clearer perspective on how FPHS can be leveraged to address health disparities and operational challenges in rural communities.

METHODS

This evaluation explores how Washington's FPHS framework is being implemented in Pacific County, focusing on how it addresses the county's evolving needs and promotes health equity. Specifically, it seeks to answer two primary research questions:

1. How does the FPHS framework address the challenges that LHDs face, particularly in rural areas like Pacific County?
2. How is Pacific County aligning with Washington's FPHS framework in a way that addresses its specific local needs and advances health equity?

To answer these questions, a mixed-methods approach was used, drawing from quantitative data, qualitative feedback, and document analysis across multiple sources. These include: (1) a comparative review of community-identified priorities using the most recent Community Health Needs Assessments (CHNAs) from Willapa Harbor Hospital (WHH) and Ocean Beach Hospital and Medical Clinics (OBHMC), as well as the 2025–2027 Pacific County Community Health Improvement Plan (CHIP) Initial Presentation; (2) analysis of FPHS Annual Reports submitted by Pacific County to the state for State Fiscal Years 2023 and 2024; and (3) findings from the PCHHS Staff Health Equity Survey, which included 48 multiple-choice and open-ended questions distributed via Google Docs. The evaluation integrates both state-level frameworks and localized insights to assess PCHHS progress and alignment with FPHS. The specific methods and data sources used for each component of the analysis will be detailed in the sections that follow.

Community Health Assessments and Community Health Improvement Plans

A comparative review of community-identified priorities was conducted through analysis of the most recent Community Health Needs Assessments (CHNAs) from Willapa Harbor Hospital (WHH) and Ocean Beach Hospital and Medical Clinics (OBHMC). These CHNAs provided insight into the distinct health concerns and service gaps across Pacific County's northern and southern regions.

In addition, the latest 2025-2027 Pacific County Community Health Improvement Plan (CHIP) Initial Presentation was reviewed to understand emerging priorities. Because the CHIP was still in development during this analysis, it was assessed separately to capture updated community feedback and identify overlaps with hospital CHNAs. This comparative analysis helped assess

how community-defined needs inform FPHS priorities and where gaps remain between goals and capacity.

FPHS Annual Reports to the State (2023 and 2024)

Each county in Washington, including Pacific County, must submit annual FPHS reports to the state. These reports were reviewed for State Fiscal Year 2023 and 2024. Each submission includes two parts:

- The Services worksheet documents the county's self-assessed capacity, expertise, and service sharing across FPHS foundational areas using a 1–5 scale.
- The Spending worksheet details how FPHS funds were distributed across capabilities and programs.

These reports were analyzed to determine how PCHHS applies FPHS principles in practice, where they are building capacity, and which areas continue to face limitations. This review also helped identify how closely FPHS investments align with community health priorities as defined in the CHA and CHIP documents.

PCHHS Staff Health Equity Survey

To assess internal alignment with FPHS and better understand organizational capacity, a staff survey was designed and distributed through Google Docs. Administered by the PCHHS leadership team over two weeks, the survey achieved an 85% response rate, with 18 out of 21 staff members participating. The survey included 48 questions in both multiple-choice and open-ended formats, and participation was anonymous and voluntary.

This survey represents one component of a broader assessment grounded in the State Health Department Organizational Self-Assessment for Achieving Health Equity, an initiative developed in partnership with the Bay Area Regional Health Inequities Initiative (BARHII) and the National Association of Chronic Disease Directors (NACDD). Originally designed to help state health departments build institutional capacity to achieve health equity, the self-assessment includes tools such as staff and partner surveys, focus groups, and document reviews. BARHII's framework identifies organizational characteristics and workforce competencies necessary for advancing equity.

For this study, BARHII's criteria were modified to reflect the operational realities of a rural county, ensuring relevance to Pacific County's context. Five key focus areas were selected based on

FPHS domains and staff roles within the department to explore equity alignment, workforce capacity, and local implementation of state frameworks. The demographic breakdown of respondents is provided in the table below:

Category	Response Option	Count	Percentage
Race/Ethnicity	White or Caucasian	15	83.30%
	Hispanic or Latino	3	16.70%
	American Indian/Alaska Native	1	5.60%
	Asian	0	0%
	Black or African American	0	0%
	Middle Eastern or North African	0	0%
	Native Hawaiian/Pacific Islander	0	0%
	My race/ethnicity is not listed	0	0%
	I prefer not to answer	0	0%
Gender	Woman	15	83.30%
	Man	3	16.70%
	Bi-gender/Nonbinary	0	0%
	Transgender	0	0%
	My gender is not listed	0	0%
	I prefer not to answer	0	0%
Age Group	35–44 years old	6	33.30%
	25–34 years old	4	22.20%
	55–64 years old	3	16.70%
	18–24 years old	2	11.10%
	45–54 years old	2	11.10%
	65+ years old	1	5.60%

The survey collected insights across five areas:

- Staff Demographics and Perspectives
- Health Department Planning & Internal Collaboration
- Collaboration with External Partners
- Collaboration with Communities
- Staff Needs and Support

The survey aimed to gather perspectives on how PCHHS addresses health equity, supports its workforce, builds partnerships, and navigates internal and external barriers. Responses were analyzed for common themes.

By triangulating findings across these three methods; community-level assessments (CHAs/CHIPs), official FPHS reporting, and internal staff feedback, this evaluation aims to provide a comprehensive review of Pacific County's current position within the FPHS framework and to develop actionable recommendations for foundational public health capacity and improving health equity.

FINDINGS

Community Needs and Challenges in Pacific County

CHNAs Findings

This project focused on developing strategic recommendations for how the PCHHS can effectively leverage the FPHS framework to support their community better. To inform these recommendations, a comprehensive review of the community's health needs was conducted, drawing on insights from the available and most recent Community Health Needs Assessments (CHNA). While community health assessments provide valuable insight into local needs, the fragmented nature of these assessments highlights the underlying challenges of coordination and accessibility in Pacific County's public health landscape.

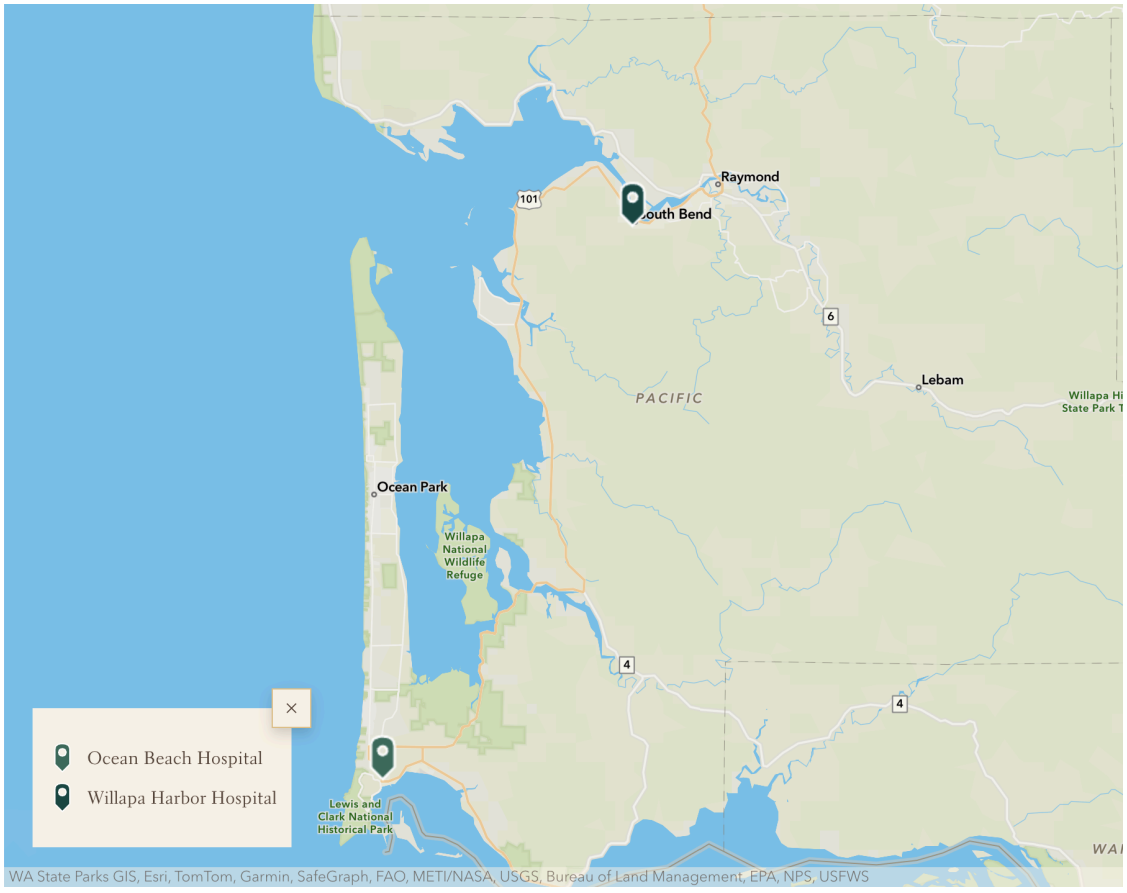

Figure 7. Pacific County map showing the locations of two hospitals (Source: GIS data compiled by the author, 2025).

Two CHNAs were conducted recently by local hospitals, Willapa Harbor Hospital (WHH) and Ocean Beach Hospital and Medical Clinics (OBHMC). However, these assessments underscore a division within the county, as they focus on the north and south regions, respectively. This geographic divide creates difficulties in forming a comprehensive view of the entire county's

health needs. PCHHS conducted its community health assessment, but accessing it proved challenging due to formatting and distribution limitations. The scanned format of the document made its use less practical to access the information conducted compared to the assessments produced by the hospitals.

The divided approach to assessments reflects broader issues common in rural counties: limited resources for centralized planning and different structures of health services.[44,61] Whether the perceived north-south divide in Pacific County is entirely accurate, the difficulty in synthesizing county-wide information suggests that there may be difficulties with unifying diverse community needs into a cohesive public health strategy.

The assessments reveal key areas where Pacific County residents face significant health-related barriers:[10,12,13]

1. **Transportation**: Transportation limitations are among the most critical issues in Pacific County. Inadequate public transportation options, such as limited bus routes and infrequent service, hinder access to healthcare. For example, WHH reported that its facilities are only accessible by one bus route with lengthy intervals between stops. It only operates during certain hours during the week and on weekends, with time intervals between bus stops varying from one hour to over two hours. Pacific Transit System also offers a service called Dial-a-Ride, limited to individuals with disabilities and seniors over 65. This lack of reliable transportation creates additional challenges in accessing medical appointments, specialty care, and emergency services. Stakeholders mentioned that the absence of private ambulance services and limited air medical transport further exacerbates the issue, leaving healthcare providers to manage patients in emergency departments while waiting for transport to other facilities.

2. **Access to Primary and Specialty Care**: Both CHNAs identified shortages of primary and specialty care providers as significant barriers to health access. County Health Rankings highlight a severe shortage of primary care providers compared to state and national benchmarks, with Pacific County needing an estimated 2.8 additional providers to meet demand.[9] This shortage results in long wait times, reliance on emergency services for non-emergent care, and poor continuity of care. Recruiting and retaining providers remains a challenge due to the rural nature of the county and limited housing options for medical staff.

    a. Access to specialty care is even more limited. Community stakeholders reported that patients must travel outside the county or even the state (to Oregon) to access essential specialties like cardiology, orthopedics, oncology, and urology. This burden disproportionately affects vulnerable populations, such as low-income families and older people, who may lack the means to travel long distances for care.

3. **Mental Health and Substance Use**: Mental health and substance use are critical issues in Pacific County. Per the Washington State Department of Health, adults in the Cascade Pacific Action Alliance, a geographic designation that consists of a seven-county region including Pacific County, report higher rates of poor mental health, depression, and drug use compared to state benchmarks. According to community stakeholders, the county's behavioral health resources are minimal, with only one organization providing mental health and substance abuse services. The CHNAs wrote that this gap shows a need to develop stronger referral partnerships with mental health and substance usage organizations and to train providers to offer mental health evaluations, medication management, and medication-assisted treatment in the primary care setting to facilitate better access to these services.

4. **Chronic Disease and Wellness Services**: Chronic disease management and prevention services are insufficiently available in Pacific County. Residents experience higher rates of preventable hospitalizations and chronic diseases, such as asthma, cancer, and coronary heart disease, compared to state benchmarks. The lack of preventative health screenings, wellness programs, and education initiatives further compounds these issues. Stakeholders mentioned that food insecurity and limited access to affordable, healthy food options contribute to high obesity and physical inactivity rates in the county.

5. **Coordination of Care**: Stakeholders emphasized the need for improved coordination between healthcare providers, social services, and public health organizations. Many residents face challenges navigating the healthcare system, which can result in unmet needs and poorer health outcomes. Coordination is especially critical for the elderly and low-income individuals who require access to multiple services but may lack the resources to connect with them effectively.

CHIP Findings

Pacific County Community Health Improvement Plan (CHIP) 2025–2027 Initial Presentation was reviewed separately, as it was not fully complete at the time of the initial analysis and was received at a later stage. The review focused on identifying overlaps and alignment with the most current information to ensure the evaluation reflects both emerging priorities and previously established goals. The CHIP supports and reflects many of the findings identified in the CHNAs.

The CHIP is being developed using the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. PCHHS is currently between Phase 3 and a new Phase 1 of the MAPP process with an expected date of the report done in the summer of 2025. The MAPP approach involves re-engaging advisory boards, subcommittees, and other community stakeholders to participate in identifying priorities and guiding action planning. Data collection includes community surveys available in both English and Spanish, which are distributed in electronic and paper formats to ensure broader accessibility. The process also includes focus group meetings and coordination with the CHNA processes at Ocean Beach and Willapa Harbor Hospitals to align assessments and planning efforts.

The findings support themes identified in both the hospital's CHNAs and past PCHHS assessment. Across all categories; healthy community factors, health problems, and risky behaviors, community responses highlight similar results found, as shown below:

Category	Top Concerns	Key Themes
Healthy Community Factors	1. Access to health care 2. Affordable housing 3. Good jobs and a healthy economy	Ongoing provider shortages, limited specialty care, impact of housing and economic stability
Health Problems	1. Mental health problems 2. Aging-related issues 3. Domestic violence 4. Child abuse/neglect	Limited behavioral health services, aging population needs, coordination gaps for vulnerable groups
Risky Behaviors	1. Alcohol and drug abuse 2. Poor eating habits 3. Being overweight 4. Dropping out school 5. lack of exercise	Concerns about substance use, chronic disease, and lifestyle-related health risks

In the category of Healthy Community Factors, the top three responses were access to health care (51.3%), affordable housing (49.6%), and good jobs and a healthy economy (37.8%). These findings reflect ongoing concerns in Pacific County and are also documented in recent CHNAs regarding limited access to primary and specialty care, persistent provider shortages, and the significant influence of housing and economic stability on health.

For Health Problems, the top concerns identified by respondents were mental health problems (79%), followed by aging-related issues (35.3%) and domestic violence (32.8%), as well as child abuse or neglect (26.9%). This aligns with themes that emphasized the limited availability of behavioral health services, the growing needs of an aging population, and the ongoing service coordination gaps for vulnerable groups.

In the category of Risky Behaviors, the most frequently identified concerns were alcohol and drug use (72.3%), followed by poor eating habits (31.1%), being overweight (26.9%), and dropping out of school or lack of exercise (20.2% and 18.5%, respectively). These responses reinforce concerns raised during the CHIP development process and in hospital assessments regarding substance use, chronic disease prevention, and the broader influence of lifestyle-related behaviors.

2023 & 2024 FPHS Annual Reports

As part of the evaluation of Pacific County Health and Human Services' alignment with the FPHS framework, annual FPHS reports submitted to the State of Washington for 2023 and 2024 were reviewed. Each county in the state is required to complete and submit these reports, which are composed of two primary components: a Services worksheet and a Spending worksheet. The Services worksheet includes a self-assessment of the county's capacity, expertise, and any shared services related to each FPHS area. Ratings are provided on a scale from 1 to 5, where 1 indicates the service is absent and 5 indicates it is fully implemented, with sufficient staffing, expertise, and system infrastructure in place. The Spending worksheet outlines how FPHS funding has been allocated across foundational capabilities and program areas, offering a detailed view of resource prioritization.

The reports for Pacific County have many notable strengths that the department is implementing via the FPHS funds:

- **Expanded Capacity & Expertise:** Pacific County has made notable progress in workforce development, using FPHS funding to hire epidemiologists, health educators, and a deputy director. By FY2024, several communicable disease response areas, such

as general disease investigation, immunizations, and HIV/Hepatitis/TB prevention were reported as being at full capacity with staff possessing proficient expertise.

- **Equity-Driven Outreach:** The department has invested in language access (including Spanish and Southeast Asian languages) and remote service delivery. Culturally responsive strategies have been implemented, particularly in maternal-child health programming and community navigation support.
- **Strong Community Integration:** The use of CHA and CHIP processes has helped integrate FPHS goals into broader planning efforts. Pacific County has built partnerships with schools, law enforcement, behavioral health providers, and healthcare organizations, particularly around opioid response efforts.
- **Use of Technology & Communication Tools:** The county has launched a new multilingual website, and virtual communication methods introduced during the pandemic have led to greater participation from partners and stakeholders.

PCHHS has made significant progress in building public health capacity, several challenges remain. These areas of limited capacity highlight ongoing barriers to fully implementing the FPHS framework across the county.

- **Limited Capacity in Emergency Preparedness & IT:** Despite active planning, emergency preparedness capacity remains basic, and expertise in this area is still emerging. IT infrastructure continues to be under-resourced, which limits the department's ability to modernize data systems and support cross-sector information sharing.
- **Community Partnership Development:** Although partnerships are improving, internal assessments show that staffing capacity in this area remains basic. This limits the department's ability to scale outreach efforts.
- **Access/Linkage Data & Planning:** There is a need to incorporate more qualitative input into data and planning.

Staff Survey Results

To better understand internal capacity and alignment with FPHS, a web-based staff survey consisting of 48 questions was distributed via Google Docs. Of the 21 staff members invited to participate, 18 responded. This survey aimed to gather feedback on the department's ability to

address health inequities, strengthen community collaboration, and support staff in their roles. Responses were collected anonymously to ensure candid input, with the survey designed to take approximately 10–15 minutes. Participation was voluntary and was a mix of short and long responses and multiple-choice questions. The following sections present a summary of responses and key themes that emerged across these areas.

Staff Demographics and Perspectives

Staff Roles and Program Areas

Among the 18 respondents, a range of roles was represented across PCHHS. Respondents self-identified their positions as administrative (n=4), program staff (n=5), management (n=4), nursing/clinical (n=4), and operations (fiscal-only) (n=2), with some noting role overlap, particularly between clinical and administrative responsibilities.

Respondents reported working within multiple program units, with representation across Fiscal (n=4), Behavioral Health (n=4), Clinical Services (n=3), Housing (n=2), Emergency Preparedness (n=2), and community-based services such as Schools, WIC, and Immunizations (n=3). This is shown in the table below:

Program Unit	Count	Percentage
Fiscal	4	22.20%
Behavioral Health	4	22.20%
Clinical Services	3	16.70%
Schools/WIC/Immunizations	3	16.70%
Housing	2	11.10%
Emergency Preparedness	2	11.10%

This indicates that there is broad coverage across the department's services. Most respondents (13 out of 18) reported having direct contact with community members. Four indicated they supervise staff who engage directly with residents, suggesting that many respondents occupy frontline or non-supervisory roles.

Experience levels varied widely. Respondents reported careers in public health ranging from less than 2 years to over 40 years, with several having more than three decades of experience. Time specifically at PCHHS also varied, from under two years to over 31 years. Overall, the tenure distribution was relatively even, indicating a balance of institutional knowledge and newer perspectives.

A notable theme among responses was the role of lived experience in shaping professional motivation and sensitivity to community needs. Personal experiences with poverty, housing insecurity, single parenting, or receiving government assistance were cited as formative, particularly among those working in housing and behavioral health roles. Several respondents described growing up in the local community directly informing their commitment to their current work. Others brought professional experience from other sectors, such as libraries, healthcare, and education, offering cross-sector insights that add to their public health approach.

When asked, *"In your opinion, how much does PCHHS focus on addressing health inequities?"* responses reflected a range of perspectives. A majority of respondents (n=10) felt the focus was "about the right amount," while six indicated there is "not enough focus," and one to two were unsure. These results suggest that while most staff see moderate alignment with equity goals, a notable portion believe there is room for PCHHS to strengthen its commitment to centering health equity. It is essential to note whether all staff fully understand the concepts of equity and inequity; explicit definitions or framing is needed to ensure a shared understanding of key terms.

Health Concerns in the Community

The most frequently cited health issues affecting the community included:

- Substance Use Disorder (SUD) (n=11)
- Limited access to care (n=11)
- Mental and behavioral health challenges (n=8)
- Shortage of healthcare providers (n=8)
- Chronic illness (n=6)

A recurring theme was the geographic disparity between North and South Pacific County. Multiple respondents noted that South County residents face greater challenges in accessing services and healthcare, despite often having higher needs:

> *In my opinion, the South part of the county is neglected when it comes to access to services and staffing. I strongly feel that the health issues that are very clearly more prominent in South County (and supported by data) are ignored or not deemed important. We have three nurses employed by PCHHS, however, they are all based out of North County and are only in the South County office once per week.*

One participant pointed out that treatment quality sometimes varied based on insurance type, with individuals holding public insurance reportedly receiving lower quality care.

Social, Economic, and Environmental Determinants of Health

Across the board, staff identified numerous social and economic conditions that adversely affect health (Figure 8), including:

- A lack of affordable housing
- Food insecurity
- Transportation limitations
- Rising utility costs and inflation outpacing wages
- Social isolation, especially in rural or aging populations
- Inadequate behavioral health and dental services
- Stigma and fear associated with receiving public assistance

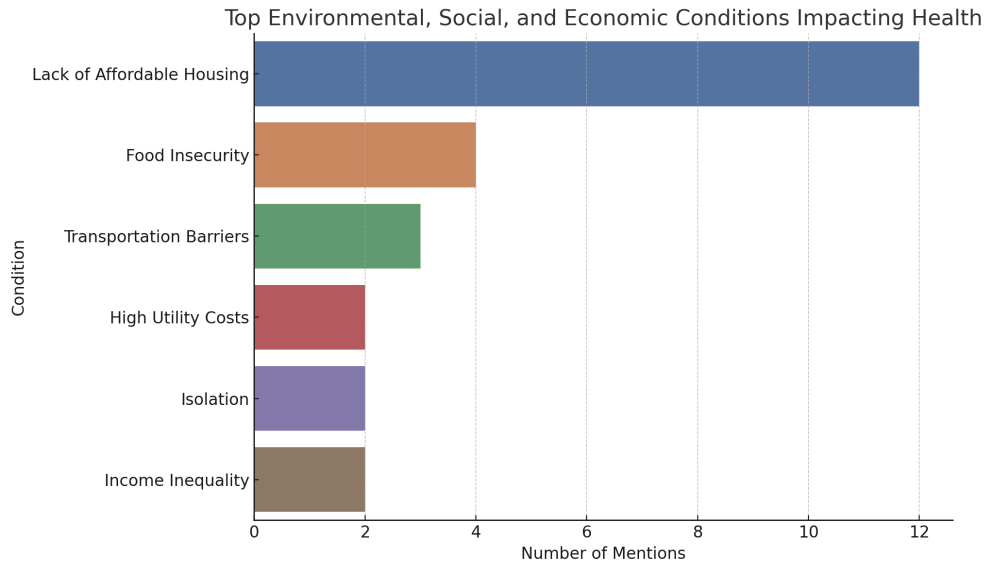

Figure 8. Top environmental, social and environmental factors identified by staff as influencing community health outcomes.

At the same time, a few respondents acknowledged environmental strengths in the region, such as relatively good air and water quality.

One response highlighted how benefits systems like EBT can inadvertently discourage residents from accessing support due to fears of disqualification, revealing the deeper complexities and unintended consequences of eligibility-based service models.

Health Department Planning and Internal Collaboration

Organizational Focus on Social Determinants of Health

Responses across multiple questions indicate that most staff perceive PCHHS as moving in a positive direction regarding efforts to address social, economic, and environmental determinants of health. Many respondents answered “Yes” or “Moving in that direction,” a small number of participants selected “Don’t know,” suggesting that some staff may not be fully aware of these efforts or how they are being implemented.

When asked about equity and access, responses followed a similar pattern, generally positive but not uniformly so. Most agreed that equity is being prioritized, but a few respondents selected “No,” over “Moving in that direction”. However, 16.7% selected “No,” suggesting that some staff perceive a lack of equitable access to policies, programs, and services across the department. These findings, illustrated in Figure 9, indicate that while progress is underway, perceptions of equity vary across roles and programs.

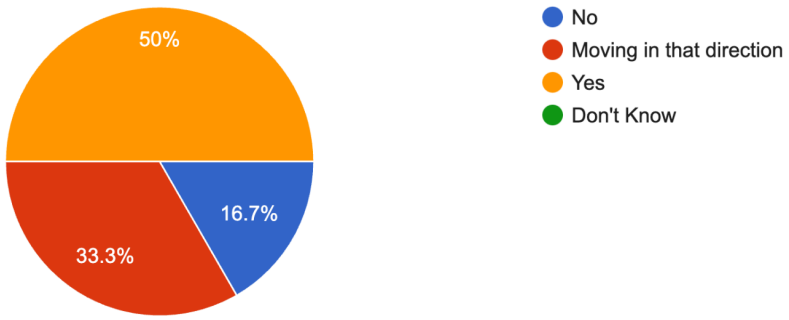

Figure 9. Staff perceptions of whether department policies, programs, and services are equitable and accessible to all, based on 18 responses.

There appears to be a disconnect between job function and equity engagement. Several staff selected “N/A: not relevant to my job” in response to questions about their role in advancing equity.

Only a few respondents strongly agreed that their work connected to broader systems of public health such as law enforcement, linkage to care, or workforce diversity. This points to an opportunity to expand cross-training or systems thinking approaches to help align individual roles with broader community impact.

Stakeholder Involvement

Engagement with community leaders varied widely. Some respondents reported that leaders only contribute input at the early stages of planning (n=7), while others observed more

comprehensive engagement, including participation in decision-making and communication with the broader community (n=6). It is important to note that one person responded “None” and three said “Don’t know,” suggesting that roles and expectations around community leader involvement may be unclear or inconsistent.

Residents were most often described as providing input at the beginning of planning processes, but their involvement appears to taper off during later stages, such as decision-making.

Community based organizations (CBOs) were described as more consistently engaged across planning efforts. They were recognized for ongoing collaboration and active input. However, fewer responses indicated that CBOs are regularly involved in decision-making.

“Don’t Know” was a common response in questions about involvement in strategic planning, particularly regarding community leaders and residents. This suggests that either the roles of external stakeholders are not clearly defined or that engagement efforts lack visibility to all staff.

Internal Collaboration and Communication

Responses to staff collaboration within PCHHS varied widely, from “Disagree” to “Strongly Agree”—highlighting significant variation in internal collaboration experiences depending on department, leadership, or individual roles. Notably, a very high percentage, over half of respondents (55.6%) selected “Neutral,” suggesting uncertainty or inconsistency in how collaboration is understood or practiced across programs. As shown in Figure 10, one-third of respondents (33.3%) agreed that they collaborate with staff in other programs to address social, environmental, and economic conditions impacting health, while a smaller proportion (11.1%) strongly agreed.

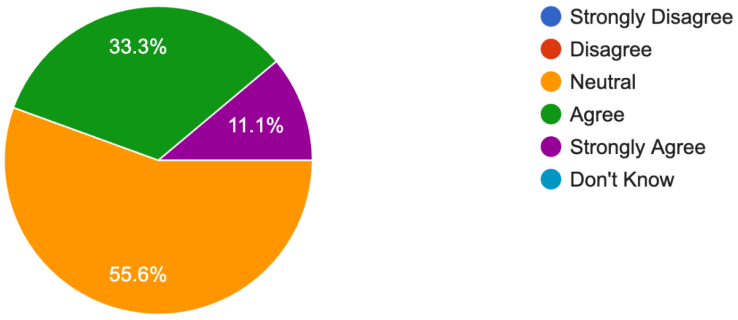

Figure 10. Staff perceptions of internal collaboration within PCHHS to address social, environmental and economic conditions impacting health.

When asked about communication within the organization, most responses clustered between “Neutral” and “Agree,” suggesting that while some staff feel communication efforts are accessible and inclusive, there is still room for improvement. A few participants strongly agreed, but others expressed concerns—selecting “Disagree” or indicating uncertainty with “Don’t Know.” As shown in Figure 11, 38.9% of respondents reported a neutral stance regarding whether department communication is accessible and inclusive to individuals with diverse needs and backgrounds, while only 22.2% agreed and 16.7% strongly agreed. Meanwhile, 22.2% of respondents expressed disagreement, reflecting concerns that not all communication practices are perceived as equitable or universally effective.

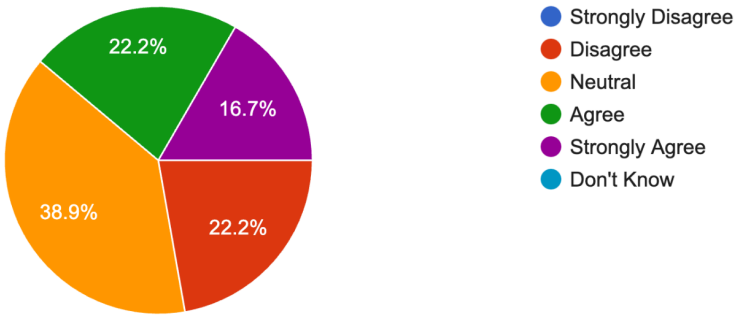

Figure 11. Department communication is accessible and inclusive to individuals with diverse needs and backgrounds.

Collaboration with External Partners

Staff perceptions of collaboration at PCHHS varied across issue areas, reflecting both well-established partnerships and opportunities for growth. As shown in Figure 12, the strongest reported collaboration was in the area of Substance Use Disorder (SUD), which 16 respondents identified as involving “a lot” of cross-sector coordination. Similarly, chronic disease prevention (n=9) and service coordination (n=13) were consistently rated as highly collaborative, suggesting these are areas where interagency work is deeply integrated. Health education and food security were also viewed positively, though a few “Don’t Know” or “None” responses were also indicated.

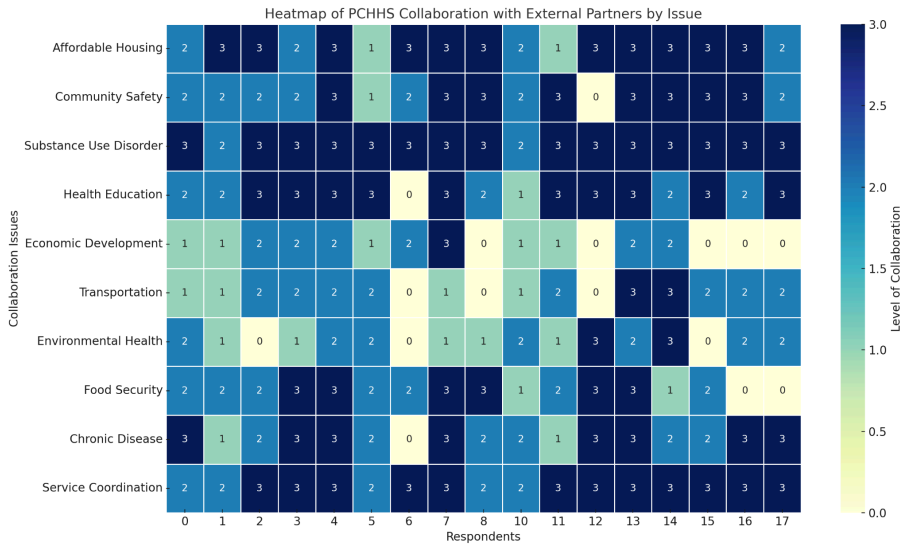

Figure 12. Heatmap of PCHHS collaboration with external partners by issue.

In contrast, areas such as community safety and violence prevention were more commonly rated as involving “some” collaboration. Affordable housing received mixed responses, with some indicating “a lot” of collaboration and others selecting “some”. Notably weaker collaboration was reported in the areas of environmental health, transportation, and community economic development. These domains received many “Don’t Know” or “None” responses, indicating that either collaboration is minimal or that efforts in these areas are not well communicated across the organization.

Trust in external partners was generally strong, with most staff selecting “Agree” (n=9) or “Strongly Agree” (n=4) when asked about their confidence in partner organizations. However, two respondents said “Strongly Disagree”, this might mean that trust is not universal and may vary based on past experiences or specific partnerships. When it comes to the representation of community needs, as shown in Figure 13, most respondents agreed (n=12) that external partners reflect the priorities and concerns of the populations they serve. Still, five respondents selected “Neutral” or “Don’t Know,” , and one said “Disagree”

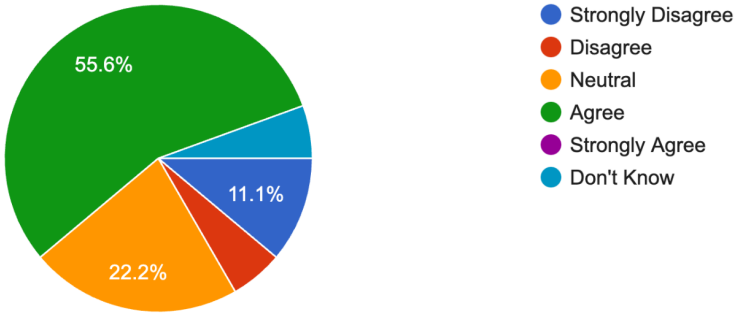

Figure 13. Chart showing staff's belief around PCHHS's external partners representing the interests and needs of local community residents.

Staff highlighted a wide array of collaborative partners, including:

- Willapa Behavioral Health
- Local hospitals
- Public schools
- Immigrant support networks
- Peace of Mind Pacific County

However, there were a few "Don't Know" responses across multiple issue areas that showed a gap in awareness of existing collaborations among staff. Respondents pointed out areas for potential growth in partnership strategy. One specifically noted the need for greater diversity in the types of organizations engaged, while others mentioned that emergency preparedness and maternal and youth health were important but underrecognized areas for collaboration.

Information Sources and Organizational Capacity

Familiarity and Community Awareness

Staff at PCHHS rely on a range of information sources to identify and understand the major concerns facing the community. Thirteen staff responded to this question, citing a mix of data-driven, community-driven, internal, and media sources. Mentioned data sources included the CDC, Department of Health (DOH), the Healthy Youth Survey, CHIP, and data shared by state agencies and local healthcare providers. These formal sources were often used alongside more community-driven inputs, such as participation in events, informal meetings with partners, direct communication with residents, and feedback gathered through (Women, Infants and Children Nutrition Program) WIC clients and front desk interactions.

Several respondents also noted internal channels, such as staff huddles and peer communications, as valuable ways to stay informed. Media sources, including local newspapers

like the *Chinook Observer* and *Willapa Harbor Herald*, as well as Facebook. Two staff reported using a combination of formal data and direct community insight.

When asked about their familiarity with community conditions, most staff reported strong awareness. In response to the statement, *"I am familiar with the major health inequities affecting residents in the community we serve"*, 61.1% (n=11) agreed, and 11.1% (n=2) strongly agreed. Only 11.1% were neutral, and 11.1% reported not knowing. Similarly, 50% (n=9) agreed and 16.7% (n=3) strongly agreed that they were familiar with the community's strengths and resources. A smaller proportion were neutral (22.2%), and only one respondent disagreed.

Familiarity with the demographic composition of the community was also high: 11 agreed, four strongly agreed, and only two respondents were neutral. These findings reflect a generally strong baseline of awareness.

Organizational Capacity for Engagement and Equity

Staff perceptions of PCHHS's ability to engage with communities and support equity-centered work were more mixed. For example, when asked whether strategies were in place to minimize barriers to community participation (e.g., childcare, transportation for meeting attendance), 38.9% (n=7) responded "Moving in that direction," another 38.9% said "Don't Know," and only 22.2% (n=4) said "Yes."

In terms of stakeholder engagement, it showed that fifteen responded "Yes" when asked if PCHHS actively engages with community networks and incorporates feedback into its work. Only one person responded "No," and two marked "Moving in that direction." Similarly, when asked whether PCHHS supports residents in addressing self-identified concerns and building leadership, 55.6% (n=10) responded "Yes," while 22.2% (n=4) said "Moving in that direction" and 16.7% (n=3) responded "Don't Know."

Responses to questions about organizational assessment and adaptation were more variable. When asked whether PCHHS evaluates its work against community-related benchmarks, only 33.3% (n=6) said "Yes," while 44.4% (n=8) said "Moving in that direction," and 22.2% (n=4) responded "Don't Know." A similar trend appeared regarding periodic assessment of cultural and linguistic needs, only 22.2% (n=4) said "Yes," while 27.8% (n=5) didn't know, and 33.3% (n=6) believed PCHHS was moving in that direction.

This pattern of responses, particularly the frequency of “Don’t Know” and “Moving in that direction” suggests awareness of areas for growth and a shared understanding that improvement is underway, but also highlights a lack of full implementation or communication across the organization.

Notably, staff who have frequent or direct contact with residents tended to report stronger familiarity with community issues and higher confidence in equity-related processes. The phrase “Moving in that direction” emerged as a recurring theme, underscoring an organization in transition, actively working to align with best practices, but still confronting uneven implementation and communication challenges.

Staff Needs and Support

Staff Experience

When asked whether they understand the reasons behind department-level decisions that affect their job responsibilities, a majority of staff reported moderate levels of transparency. Out of 18 respondents, 61.1% (n=11) indicated that they “usually” know why decisions are made, while 16.7% (n=3) responded “always,” and another 16.7% (n=3) said “sometimes.” Only one person (5.6%) selected “rarely,” and no one reported “never.”

When asked whether flexible or paid time is available to attend community meetings outside of normal business hours, 13 said “Yes,” while the remaining five responded “Don’t Know.” No one reported that this was unavailable.

Staff reported receiving a range of professional training and guidance during their time at PCHHS, though access appeared to vary across individuals and roles. The most commonly received topics included Foundational Public Health Services (FPHS) (76.5%, n=13), program planning (47.1%, n=8), understanding and using data (47.1%, n=8), advocacy and policy support (47.1%, n=8), and evaluating one’s work (35.3%, n=6). Less frequently accessed topics included conducting community needs assessments and empowering communities to improve social and physical conditions (17.6%, n=3 for each). Notably, one staff member indicated receiving no training, while others had participated in eight or more topics.

Perceptions of encouragement for professional development opportunities were mixed. For mentoring or coaching, 9 staff said “Yes,” while others selected “No” (n=3), “Don’t Know” (n=1), or “Not Applicable” (n=5). Tuition reimbursement showed similar variability, with 9 saying “Yes,”

but 7 selecting another response option. In contrast, formal professional development programs were more consistently encouraged (15 “Yes” responses), and support for conferences, training, and workshops all 18 staff reported being encouraged to attend.

Some respondents reported inconsistencies or confusion in accessing these opportunities. One staff member described ongoing frustration with the lack of clear procedures for booking travel and attending conferences. They noted receiving conflicting guidance from supervisors, which ultimately led them to stop asking altogether.

Equity and Inclusion Awareness

Seven staff elaborated on how their training related to environmental, social, and economic conditions impacting health. Topics mentioned included housing, nutrition, communicable diseases, and cultural awareness, with several linking their public health education directly to work addressing disparities. A few respondents noted that the question was not applicable to their job function.

Staff perceptions around equity and cultural awareness were largely positive, though a few areas reflected discomfort or uncertainty, specifically at the leadership level. When asked if they were aware of their own values, beliefs, and privilege and how that helps them understand others, 52.9% (n=9) agreed, and 29.4% (n=5) strongly agreed. Similarly, 52.9% (n=9) agreed and 35.3% (n=6) strongly agreed that understanding the beliefs and values of the community is important.

Regarding the work environment’s support for different cultural perspectives, 44.4% (n=8) agreed, and 22.2% (n=4) strongly agreed. However, 22.2% (n=4) were neutral, and 11.1% (n=2) disagreed. When asked about staff comfort discussing race and racism, 38.9% (n=7) agreed, 27.8% (n=5) were neutral, and 22.2% (n=4) disagreed or strongly disagreed. A similar trend was seen regarding class and classism, with 38.9% (n=7) agreeing, but a combined 38.9% expressing neutrality or disagreement.

Perceptions of senior leadership comfort in these conversations were different. For race and racism, only 27.8% (n=5) agreed that leadership is comfortable discussing the topic, and 38.9% (n=7) were neutral. For class and classism, 33.3% (n=6) agreed, but the majority were split across “Neutral” (27.8%, n=5), “Disagree” (11.1%, n=2), and “Don’t Know” (11.1%, n=2).

Finally, when asked about the diversity of their colleagues, 38.9% (n=7) agreed and 38.9% (n=7) were neutral in that they work with a culturally diverse staff. One person strongly agreed, and two disagreed.

Summary of Findings

The table below presents a high-level summary of key findings from the PCHHS staff survey, offering a condensed overview of insights explored in greater detail throughout this chapter. The summary is intended to offer a concise snapshot of strengths, challenges, and opportunities identified through the survey.

Section	Main Findings
Staff Roles & Program Areas	Respondents represented admin, clinical, management, and program staff; coverage across all major service units.
Community Contact & Experience	13 staff reported direct community contact; experience ranged from <2 to 40+ years, with many citing lived experience as shaping their work.
Equity Focus Perception	10 felt equity focus is “about right,” 6 said “not enough”; concerns raised about shared understanding of equity.
Community Health Concerns	Top concerns: substance use disorder, limited access to care, mental health, provider shortages, and chronic illness—especially in underserved areas.
Social & Economic Determinants	Housing, food insecurity, transportation, and inflation were key barriers; stigma and system complexity also cited.
Organizational Focus on SDoH	Most staff said PCHHS is “moving in that direction,” though awareness varies across staff.
Equity in Services & Policies	16.7% felt equity is not prioritized in services; responses suggest uneven implementation across departments.
Stakeholder Engagement	CBOs are actively engaged; resident and community leader involvement drops off during planning and decision-making stages.
Internal Collaboration & Communication	55.6% were neutral on internal collaboration; communication was rated between “Neutral” and “Agree,” with room for improvement noted.
External Collaboration	Strongest in SUD, chronic disease, coordination; weaker in environmental health, transit, and economic development.
Familiarity with Community	Majority reported strong awareness of local demographics, health inequities, and community strengths.
Capacity for Equity-Centered Work	Many responses were “Moving in that direction” or “Don’t Know,” suggesting progress but limited full implementation.
Staff Training & Development	Most had FPHS and planning training; equity-focused and advocacy training less common. Some frustration with inconsistent support for PD.
Equity & Inclusion Awareness	Most staff personally comfortable discussing equity; fewer felt leadership was prepared. Race and class remain difficult topics to address consistently.

DISCUSSION

The findings from this evaluation reveal that while PCHHS is actively working to align with the FPHS framework, significant opportunities remain to strengthen infrastructure, advance equity, and close service gaps further. The evaluation provides a multi-dimensional view of public health in a rural setting through a mixed-methods approach incorporating CHNAs, CHIPs, FPHS annual reports, and staff survey data.

One theme that emerged is the importance of context-specific implementation. While the FPHS framework provides a universal standard for public health, the realities of rural health delivery, such as geographic isolation, workforce shortages, and fragmented services need more specific approaches. Pacific County reflects on this challenge. It has shown strength in leveraging FPHS investments to expand its workforce, increase multilingual and remote service delivery, and deepen collaboration with external partners. However, rural-specific constraints, particularly in emergency preparedness, IT infrastructure, and community partnership development, limit full implementation.

The division of assessments and services between the north and south regions of the county illustrates structural fragmentation common in rural areas. This fragmentation complicates unified planning and resource distribution and reinforces geographic inequities. Additionally, the absence of a centralized, publicly accessible CHA hinders transparency and alignment across stakeholders.

Staff perspectives highlighted a department that is in transition toward making deliberate strides toward equity but still facing gaps in communication, cross-sector collaboration, and systems thinking. Many staff members see their work aligning with community needs but remain uncertain about if or how broader equity strategies are being operationalized. The frequent appearance of responses like “moving in that direction” suggests a shared understanding of necessary improvements and a lack of clear frameworks, accountability, or resources to implement them fully.

The staff survey further revealed inconsistencies in training access, decision-making transparency, and support for professional development. These internal challenges may contribute to uneven service delivery and hinder the department’s building lasting partnerships and trust with CBOs. Importantly, trust, both internal and external, merged as a foundational concern. While PCHHS has strong external relationships in areas such as substance use

disorder response, internal staff still expressed mixed feelings about communication, leadership engagement, and cultural responsiveness.

From an equity perspective, the evaluation highlighted positive intentions but identified a need for more intentional operationalization of equity as both a value and a practice. Staff responses revealed a depth of professional and lived experience, especially in housing, behavioral health, and maternal-child health. This diversity adds critical perspectives that improve the department's ability to understand and address complex community needs. Staff comfort in discussing race, class, and privilege varied, with noticeable hesitation about comfort in talking with leadership about this or whether leadership was equipped to lead these conversations.

The review of FPHS annual reports for 2023 and 2024 showed progress in several areas, including communicable disease response and community integration. Yet, limitations in IT systems, emergency preparedness, and access/linkage data planning continue to reflect the systemic underfunding and under-capacity many rural departments face statewide.

In conclusion, Pacific County is demonstrating important steps toward aligning with FPHS, but foundational infrastructure challenges remain, deepening staff engagement and ensuring that equity moves beyond intent into consistent practice.

LIMITATIONS

Several limitations shaped the scope and findings of this evaluation. One of them is that, as the author of this evaluation, my personal connection to Pacific County shaped my perspective throughout this project. While I have family ties to the county and have visited regularly, I do not currently reside there and am not embedded in the community's day-to-day realities. Because I experience Pacific County primarily as a visitor rather than a full-time resident, I recognize that my understanding is inherently limited.

Another limitation was access to complete and up-to-date data, which was a limitation of this evaluation. Some documents necessary to assess FPHS implementation in greater detail were unavailable, reflecting rural health departments' broader challenges with documentation and data accessibility. Finally, the reliance on self-assessed FPHS reports from the county introduces potential subjectivity. Departments may unintentionally overestimate or underestimate their capacity.

RECOMMENDATIONS

The following recommendations were developed based on key findings from this report and insights gathered through conversations with PCHHS staff. While not exhaustive, they offer a starting point for the department to strengthen foundational public health capacity and integrate equity.

Short-Term (Rest of 2025)

Foundational actions to improve coordination, visibility, and internal alignment.

- Digitize and centralize all CHAs, CHIPs, and CHNAs from PCHHS, Willapa Harbor Hospital, and Ocean Beach Hospital and Medical Clinics into a searchable, internal repository to support integrated planning. Ensure these documents are also publicly accessible and prominently displayed on the PCHHS website for transparency and ease of community access.
- Design, finalize, and publish a department-wide strategic plan that serves as a living document aligned with the FPHS framework and local health priorities. The plan should include SMART goals, a refreshed mission and values statement, and be accessible to all staff in both digital and print formats.
- Hold regular FPHS-funded cross-training for staff and leadership on systems thinking, rural public health, the FPHS framework, and equity principles. It is essential to note whether all staff fully understand the concepts of equity and inequity; explicit definitions or framing is needed to ensure a shared understanding of key terms Over time, expand to tailored, role-specific training on structural barriers to health to deepen shared understanding and align staff efforts with both departmental priorities and FPHS objectives.
- Establish a cross-sector collaboration with Community Development's Environmental Health division, where a portion of FPHS funding is also allocated. This partnership should ensure coordinated planning, prevent duplication of services, and promote a systems-thinking approach across departments. By aligning infrastructure goals and service delivery strategies, both divisions can more effectively address overlapping areas and maximize the impact of FPHS investments.

Medium-Term (2025–2027)

Build infrastructure, deepen external collaboration, and implement more specific FPHS integration.

- Create a countywide Community Advisory Board with representatives from North and South Counties, CBOs, and residents. This board would support ongoing collaboration, ensure balanced geographic representation, and embed community voices throughout planning, implementation, and evaluation. Findings from staff surveys and health assessments highlighted that stakeholder engagement is often limited to early planning phases. This board would strengthen transparency, build accountability, and reinforce shared ownership of FPHS-aligned goals.
- Begin a phased approach to upgrading IT infrastructure and building emergency preparedness capacity using FPHS foundational capability funds. Investing in these areas will enhance real-time communication, support cross-sector collaboration, and ensure the department can respond to acute emergencies and long-term health needs.
- Invest in workforce retention strategies that address barriers such as housing availability and professional development. Using FPHS infrastructure funding, PCHHS can collaborate with local housing partners and academic institutions to develop housing supports, rural residency programs, and career advancement opportunities that promote long-term staffing stability and community connection.
- Establish formal agreements with Pacific Transit, housing authorities, and local nonprofits to integrate transportation and housing access into core public health strategies. Aligning these sectors with FPHS goals will help address persistent barriers to care and ensure that social determinants are treated as essential service delivery components.
- Hire a part-time evaluator or capstone student to lead the development of an internal evaluation strategy, focusing on the effective use of FPHS funding for specific programs. This will help demonstrate accountability during potential budget cuts, strengthen the department's ability to track impact and ensure PCHHS meets community needs and state expectations.

Long-Term (2027 and Beyond)

Sustain systems change, scale evaluation, and fully embed cross-sector strategies.

- Adopt performance measures and analyze disaggregated data to track short- and long-term outcomes, ensuring services effectively reach and benefit all populations. This will help monitor interventions, track responsibilities and align efforts with FPHS infrastructure-building goals.
- Operationalize a comprehensive, impact evaluation across all programs supported by FPHS funds to measure the effect, strengthen accountability, and ensure continuous quality improvement. Incorporate regular participatory data reviews and feedback loops with staff and partners to support real-time learning and responsive public health strategies.
- Increase access to behavioral health services by investing in telehealth, embedding mental health professionals in primary care, and formalizing referral pathways. These efforts address provider shortages and improve continuity of care in a rural setting with high behavioral health needs and limited access.
- Implement a standardized tool to evaluate the equity implications of all significant funding, policy, and program decisions. This ensures that resources and strategies are intentionally aligned with community needs and do not inadvertently reinforce existing health inequities.

CONCLUSION

Pacific County Health and Human Services has made meaningful strides in aligning with the Foundational Public Health Services framework, especially in building workforce capacity, expanding community outreach, and integrating equity considerations into public health planning. However, persistent challenges, including transportation and housing barriers, limited behavioral health access, fragmented data infrastructure, and inconsistent stakeholder engagement, continue to hinder full implementation and impact.

This report highlights both the strengths and the structural gaps that shape public health outcomes in a rural context. A clear path forward emerges through mixed-methods analysis and collaboration with staff: deepen cross-sector collaboration, strengthen internal systems and planning, and embed continuous evaluation and equity into the fabric of all FPHS-funded work. By advancing the recommendations, the department can build a more responsive, unified, and resilient public health system that better serves all communities across the county.

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APPENDIX

Appendix A - Internal Staff Survey

Health Equity Staff Survey

This staff survey is part of a larger department-wide evaluation of Foundational Public Health Services (FPHS). The purpose of it is to help Pacific County Health and Human Services assess its capacity to address health inequities. The findings from this survey will help assess how FPHS principles—such as equity, essential public health capabilities, and service delivery—are being implemented within the department and county. The collected feedback will contribute to recommendations for strengths, challenges, and areas for improvement to ensure that the department is effectively meeting its public health responsibilities as outlined by FPHS.

This survey is **anonymous**—your responses will never be linked to you individually. This is not a test, and no survey response will be used against individuals, programs, or departments.

Your responses to this survey are valuable. Thank you for your time!

There are five sections of this survey:

A. Introductory Questions
B. Health Department Planning & Internal Collaboration
C. Collaboration With External Partners
D. Collaboration With Community Groups
E. Staff Needs and Support

Section A. Introductory Questions

First, please share a bit about yourself. We'd like to understand your role within the organizational structure.

Which best describes your position at PCHHS?

☐ Operations staff (fiscal staff who have no program duties)
☐ Program staff
☐ Administrative (who also do WIC, Vital records, some program work)
☐ Management staff

☐ Nursing and/or Clinical staff

☐ Other (please describe): _____

What program unit do you work in?

How long have you been working in the public health field?

(Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)

____ Years ____ Months

How long have you been at PCHHS?

(Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)

____ Years ____ Months

How long have you been in your current position?

(Please enter the number of months only if it has been less than one year. Otherwise, answer in years only.)

____ Years ____ Months

Do you work directly with community residents in your current position?

☐ Yes ☐ No

Do you supervise staff members who work directly with community residents?

☐ Yes ☐ No

What are the top five health issues in Pacific County that are unequally affecting certain populations? (example: substance use disorder, chronic illness access to healthcare services)

Please list what you think are the most important environmental, social, and economic conditions that impact health in Pacific County (example: lack of affordable housing/housing stock, air and water quality, food insecurity)

In your opinion, how much does PCHHS focus on addressing health inequities?
(Check only one box.)

☐ There is **no focus** on health inequities at all.
☐ There is **not enough focus** on health inequities.
☐ There is **about the right amount of focus** on health inequities.
☐ There is **too much focus** on health inequities.
☐ I don't know.

Section B. Health Department Planning & Internal Collaboration

We would like to know whether PCHHS's mission, vision, and values, in collaboration with internal teams, clearly communicate an organizational commitment to addressing health inequities.

Please answer the following questions based on your own impressions of your LHD's organizational principles, even if you don't know exactly what they say.

For each of the following statements, please indicate the response that most closely describes your LHD:

I think PCHHS as an organization demonstrates a commitment to addressing the environmental, social, and economic conditions that impact health.

☐ No
☐ Moving in that Direction
☐ Yes
☐ Don't know

Does PCHHS's strategic plan include an explicit commitment to addressing health inequities?

☐ Yes
☐ No

☐ I don't know whether the strategic plan addresses health inequities

☐ I don't know whether there is a strategic plan for the whole LHD

☐ Not applicable: There is not a strategic plan for the whole LHD

In your experience, what role(s) do community leaders, residents, and community-based organizations play in strategic planning? *(Check all that apply.)*

☐ Contribute input in the beginning of the strategic planning process

☐ Review strategic planning documents and give feedback

☐ Maintain active involvement throughout the strategic planning process

☐ Participate in the decision-making of the strategic planning process

☐ Collect feedback from larger groups of community members and communicate the feedback to PCHHS

☐ None

☐ Don't know

☐ Other (please describe) _____

I collaborate with staff in other programs within PCHHS to address the environmental, social, and economic conditions that impact health.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

There is support from management within PCHHS for collaborations between programs.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

The **Ten Essential Services of Public Health** provide a guiding framework for the responsibilities of local public health systems. The following set of questions focus on how each

of the essential services can contribute to addressing health inequities experienced by residents in Pacific County.

Your response should indicate the extent to which you think that your work in each area contributes to addressing health inequities. For those that do not describe any part of your job, please choose “N/A.

Please indicate how much you agree or disagree with the following statements:

My work has a role in monitoring health status and tracking the conditions that influence health inequities.

☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

My work contributes to diagnosing, investigating, and protecting people from health problems and health hazards that disproportionately impact vulnerable populations.

☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

My work has a role in informing, educating, and empowering people from populations that disproportionately experience poor health outcomes to act collectively in improving their health.

☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree

☐ Strongly Agree
☐ Don't Know

My work has a role in mobilizing community partnerships and action to identify and address the conditions that influence health inequities.
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

My work contributes to developing policies and plans that support individual and community health efforts to address the conditions that affect health inequities.
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

My work has a role in applying the enforcement of laws and regulations that protect health and ensure safety in order to reduce health inequities?
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

My work has a role in linking people from populations disproportionately experiencing poor health outcomes to needed personal health services.
☐ N/A: this component is not relevant to my job

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

My work has a role in assuring a competent, culturally sensitive, and diverse public health workforce that can effectively address health inequities.
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

My work has a role in evaluating the effectiveness, accessibility, and quality of health services provided to populations experiencing disproportionately poor health outcomes.
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

My work contributes to and applies new insights, innovative solutions, and the evidence base to address health inequities and community conditions that influence health.
☐ N/A: this component is not relevant to my job
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don’t Know

Section C. Collaboration with External Partners

The questions in this section are about the collaboration with other public agencies, institutions, and community-based organizations on the underlying conditions that impact health inequities.

To what extent does PCHHS collaborate with external partners on the following issues?

	None	Some	A lot	Do not know
Availability of quality affordable housing	☐	☐	☐	☐
Community safety and violence prevention	☐	☐	☐	☐
Substance use disorder	☐	☐	☐	☐
Health-related education	☐	☐	☐	☐
Community economic development (e.g., job creation, business	☐	☐	☐	☐

development, etc.)				
Transportation planning and availability	☐	☐	☐	☐
Environmental health	☐	☐	☐	☐
Food security	☐	☐	☐	☐
Chronic disease prevention and wellness programs	☐	☐	☐	☑
Coordination among service agencies	☐	☐	☐	☐

Are there other issues not identified here that PCHHS collaborates with external partners on?

_____

_____

_____

_____

PCHHS has trusting relationships with external partners.

☐ Strongly Disagree

☐ Disagree

☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I believe that PCHHS's external partners represent the interests and needs of local community residents.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

Which external partners come to mind when you think about organizations that collaborate with PCHHS to promote health equity?

Section D. Working with Communities

This section focuses on PCHHS's collaboration with residents of PCHHS's jurisdiction. We are interested in knowing how much staff feel they know about the health issues, concerns, and inequities experienced by those living in the community served by PCHHS.

What information sources help you identify and learn about major concerns in the community?

I am familiar with the major health inequities affecting residents in the community we serve.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I am familiar with the strengths and resources of the community we serve.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I am familiar with the demographic composition of the community we serve.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

LHD's priorities match the priorities of a community group we're working with.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

There are strategies in place to minimize barriers to community participation (e.g., it is possible to provide money for childcare and transportation to residents attending community meetings, etc.).

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS makes deliberate efforts to build the leadership capacity of community members.

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS is open and responsive to community stakeholders' feedback on its work.

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS has provided resources to community residents and groups to support their self-identified concerns.

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS sets standards and expectations for how we work with the community.

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS assesses its work against benchmarks that are set for how we work with the community.

☐ No

☐ Moving in that direction

☐ Yes

☐ Don't Know

PCHHS plays an active role in developing, maintaining, and supporting networks in the community.

☐ No
☐ Moving in that direction
☐ Yes
☐ Don't Know

Assessments of the cultural and linguistic needs of the community we serve are conducted periodically.

☐ No
☐ Moving in that direction
☐ Yes
☐ Don't Know

PCHHS is able to adapt to new communities and changes within the populations served.

☐ No
☐ Moving in that direction
☐ Yes
☐ Don't Know

Section E. Supporting Staff

In this final section of the survey, we'd like to understand how you are supported as a PCHHS staff member and how support could be improved.

When a department-level decision is made that affects you and your job tasks, do you know why it was made?

☐ Always
☐ Usually
☐ Sometimes
☐ Rarely
☐ Never

Since you have been working at PCHHS, have you ever received training or any mentoring or guidance on any of the following topics? *(Please check all that apply.)*

☐ Ten Essential Services of Public Health

☐ Foundational Public Health Services (FPHS)

☐ How to evaluate the work you do

☐ How to understand and use data to further your work

☐ Program planning

☐ How to conduct assessments of community needs and strengths

☐ How to research, understand, and develop policies that impact the social, economic, and physical conditions that impact health

☐ How to advocate for and/or support external partners and community groups advocating for policies that impact health

☐ How to empower communities to advocate for themselves and improve the social, economic, and physical conditions of their neighborhoods.

Is flexible and/or paid time available to allow staff to attend community meetings and otherwise engage with community residents outside normal business hours?

☐ Yes

☐ No

☐ I don't know

Have you been encouraged to use the following professional development opportunities:

	Yes	**No**	**Do Not Know**	**Not Available to Me**	**Not Applicable/ Not Offered**
Mentoring/ coaching	☐	☐	☐	☐	☐
Tuition reimbursement for a relevant	☐	☐	☐	☐	☐

class or certification					
A formal professional development or training program	☐	☐	☐	☐	☐
Professional membership or journal subscription	☐	☐	☐	☐	☐
Conferences, trainings, workshops	☐	☐	☐	☐	☐

Other (please specify)

☐ Yes

☐ No

If you checked “other” for the previous question, please specify what other professional development opportunities you have been encouraged to use:

_____

_____

_____

_____

Do any of the above relate to environmental, social, or economic conditions that impact health? If so, please list and explain.

I have opportunities to talk with my supervisor(s) about the impact of our work on the environmental, social, and economic conditions that impact health.

☐ Not Applicable to My Job Function
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

Within my unit, we have engaged in group discussions about how our work could address one or more of the environmental, social, and economic conditions that impact health.

☐ Not Applicable to My Job Function
☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I am aware of my own beliefs, values, and privilege helps me understand others' perspectives.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I believe it is important to understand the beliefs and values of the residents and community members served by PCHHS.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I have taken steps to enhance my own cultural humility, cultural competence, and/or cultural understanding (for example through trainings, self-reflection, personal relationships, etc.).

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

I feel my work environment is supportive of many different cultural perspectives.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

Staff I interact with at PCHHS are comfortable talking about race and racism.

☐ Strongly Disagree
☐ Disagree
☐ Neutral
☐ Agree
☐ Strongly Agree
☐ Don't Know

Senior management at PCHHS is comfortable talking about race and racism.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

Staff I interact with at PCHHS are comfortable talking about class and classism.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

Senior management at PCHHS are comfortable talking about class and classism.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

I work with a culturally diverse staff, i.e: class, race, gender.

☐ Strongly Disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly Agree

☐ Don't Know

You're almost done!

Demographic Information (optional):

What is your race and/or ethnicity? Select all that apply and enter any additional details in the space below.

- ☐ American Indian/Alaska Native
  What is your Tribal affiliation?:
  _____
- ☐ Asian - East
- ☐ Asian - Southeast
- ☐ Asian - South
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White or Caucasian
- ☐ My race/ethnicity is not listed:
  _____
- ☐ I prefer not to answer

What is your gender? Select all that apply and enter any additional details in the space below.

- ☐ Bi-gender/Nonbinary
- ☐ Agender
- ☐ Woman
- ☐ Man
- ☐ Transgender
- ☐ My gender is not listed:
  _____
- ☐ I prefer not to answer

Please select your age group:

- ☐ Under 18 years old
- ☐ 18-24 years old
- ☐ 25-34 years old
- ☐ 35-44 years old
- ☐ 45-54 years old
- ☐ 55-64 years old
- ☐ 65+ years old
- ☐ I prefer not to answer.

Thank you!