Factors that impede or promote the quality of Community Health Assessment (CHA) and Improvement Planning (CHIP) processes and outputs in Kansas

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Conflict of Interest Statement

Dr. Wetta and Dr. Pezzino

have no conflicts to report.

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Session Objectives

Describe

- Gains in completing CHA-CHIP in Kansas
- Changes in local health departments' self-perceived confidence in completing CHA-CHIP
- Disparities in capacity to complete CHA-CHIP in Kansas
- Direct and indirect impact of CHA-CHIP

Identify factors that can

- Affect the quality and timeliness of CHA-CHIP
- Improve the quality and timeliness of CHA-CHIP

Significance

- Community health assessment (CHA) and improvement planning (CHIP) is gaining attention as a process for collecting and analyzing health-related data to identify, prioritize and set goals for public health improvement [1].
- Obstacles to performing a quality CHA have been reported [2,3] and continue to pose a challenge for public health practitioners.
- To promote wider adoption of CHA-CHIP activities, practitioners should be better informed of: (1) factors that will make the CHA-CHIP process easier to accomplish, and (2) potential obstacles to the CHA-CHIP phases that practitioners might experience.

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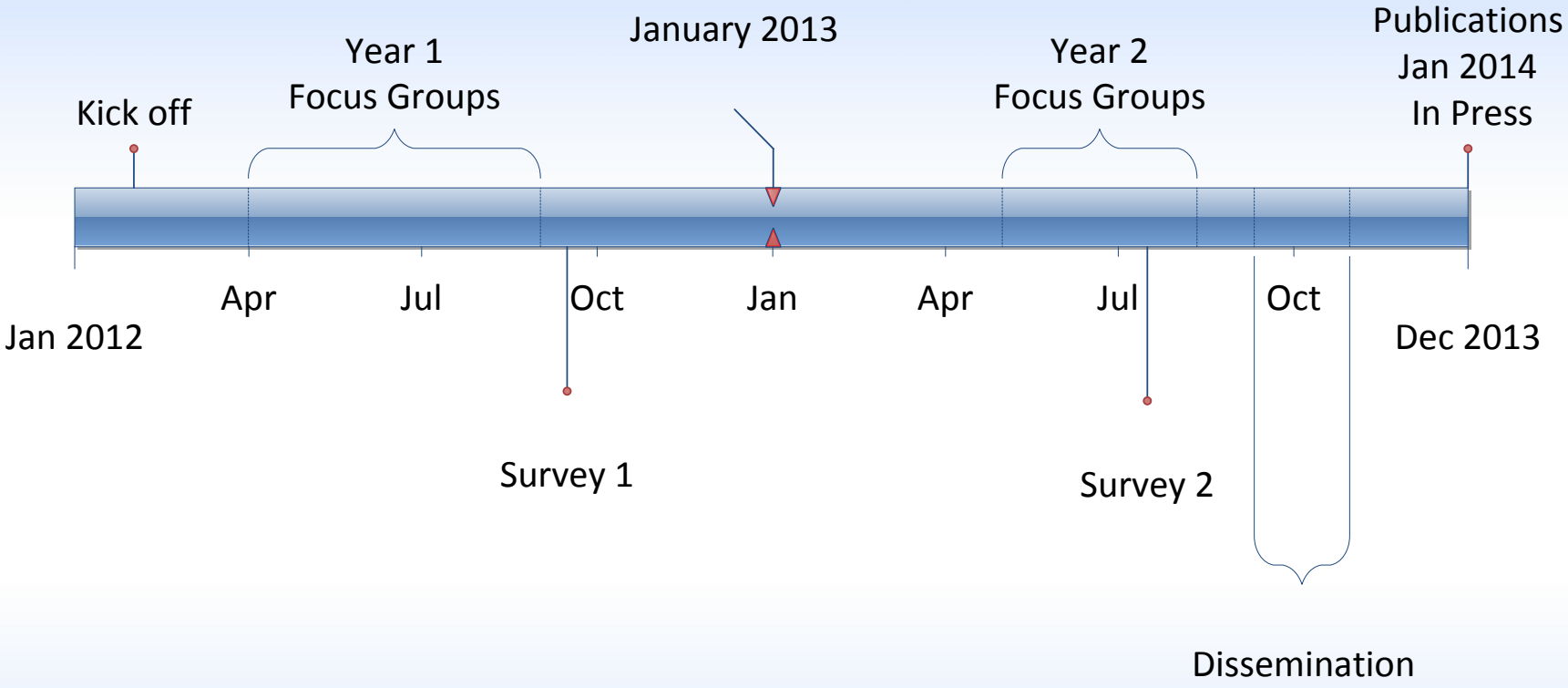
Purpose

This mixed methods study assessed the perceptions of CHA-CHIP stakeholders in Kansas communities about factors that:

1. contribute to or detract from the timeliness of CHA-CHIP completion and
2. the quality of a CHA-CHIP process.

Project Timeline



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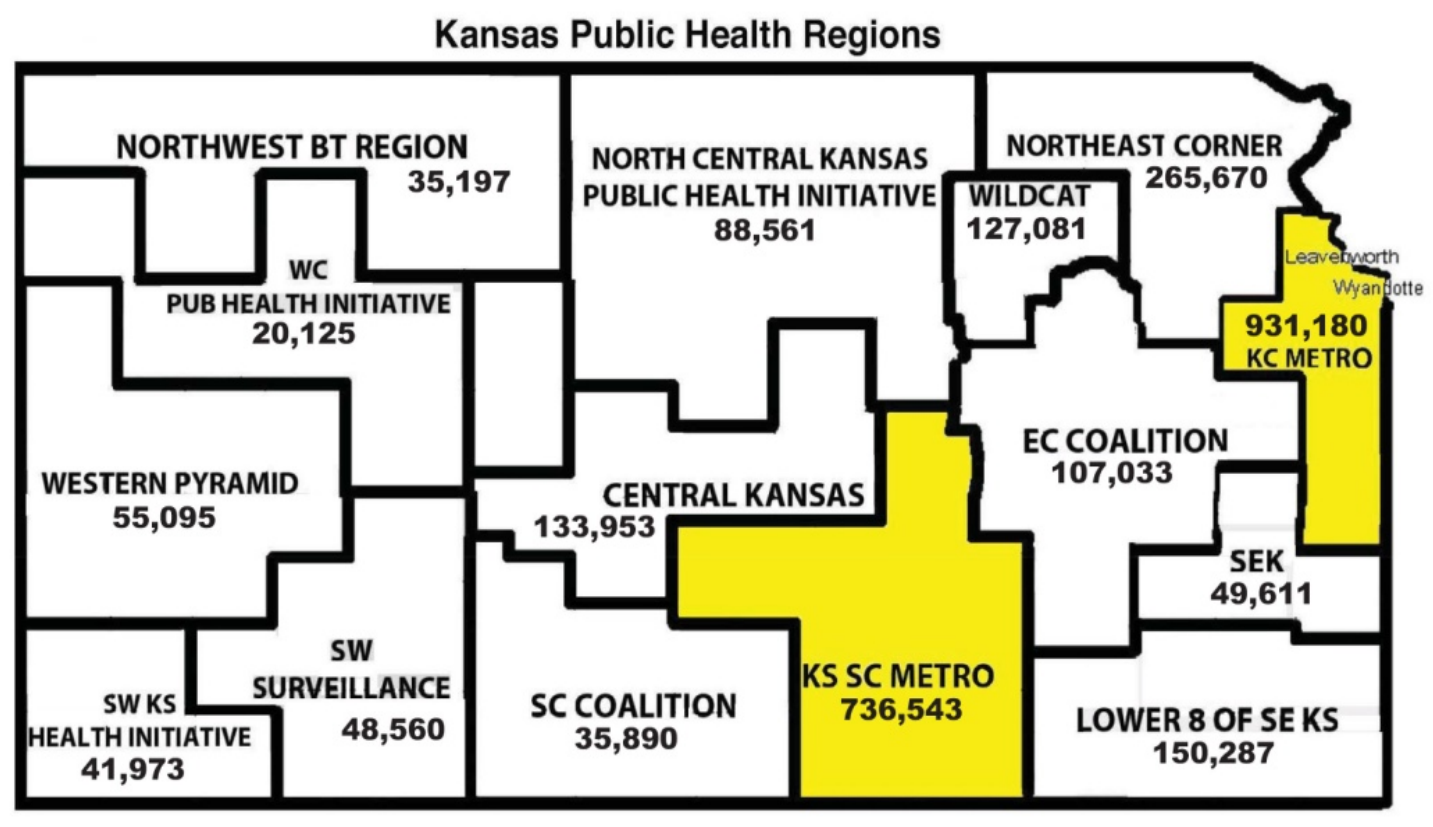
Kansas Public Health Regions



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Focus Group Interview and Participant Survey Results

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Mixed Methods: Qualitative

Focus groups were conducted via telephone and online and assessed opinions about inputs, process, outputs and outcomes of CHA-CHIP activities

Year 1: April-September, 2012 (N=15)

Year 2: May-August , 2013 (N= 21)

Participants: local public health/ hospital representatives and stakeholders in frontier, rural and urban settings in Kansas performing CHA-CHIP activities

Recruitment, facilitation, and analysis conducted according to Debus [4]

Convergence and divergence of themes across the state were identified

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Mixed Methods: Quantitative

- Survey: Demographic data collected included age, gender, and regional affiliation
- Self-efficacy measures the ability to complete tasks and reach goals [5] and key construct preceding the performance of a behavior
- Systematic literature review used to design a 12-item attitudinal survey that explored participants' confidence to perform CHA-CHIP activities
- Analysis: In addition to descriptive statistics, a multilevel regression analysis explored the effect of time period and rural-urban disparity on perceived confidence

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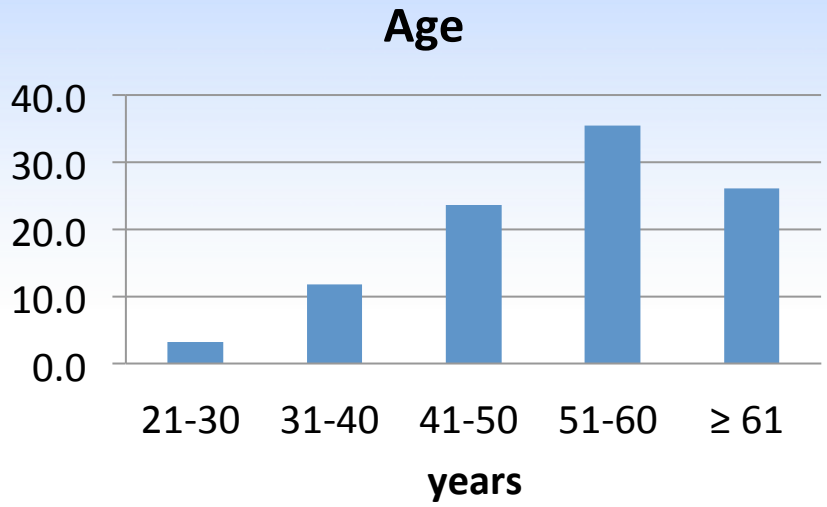
Focus Group Participant Demographics

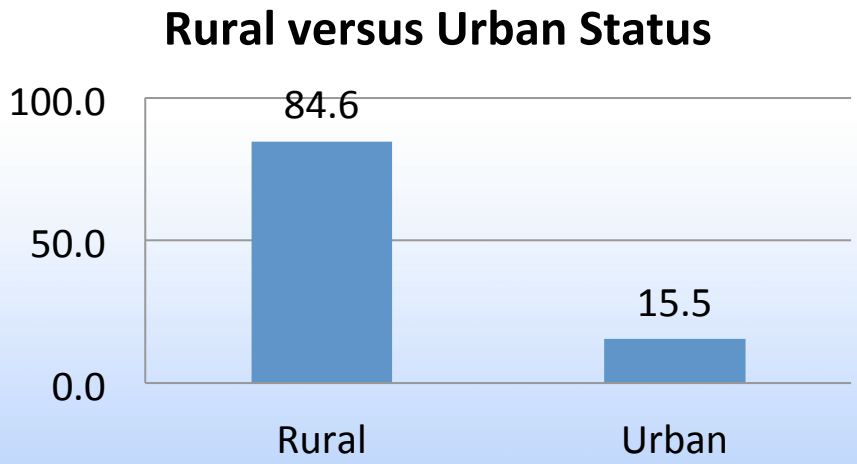


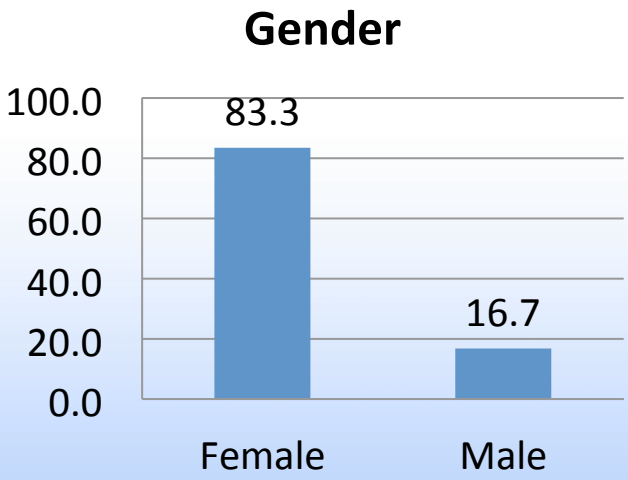
Year	N	%
2012	57	44.5
2013	71	55.5

Regional Representation

2012 = 11 of 15 (73%)

2013 = 14 of 15 (93%)





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Common CHA-CHIP Themes

Community Health Assessment	Community Health Improvement Planning
• Multiple perspectives and stakeholders • Include community-at-large with input from general population • Use current information from a broad spectrum of sources • Organized and ongoing initiative • Communication among members and with community	• Identify gaps • Prioritize critical issues • Ascertain the number of issues to address • Identify resources • Identify best approach to derive change • Outline timeframe for accomplishing tasks

CHA Findings

- CHA phase completed in 6-12 months
- Overall, positive community engagement reported

  "Strengthened us. We take great pride in our action plan, our implementation plan . . . going to take it year by year, step by step. Plan to find a responsible person or agency to take care of a particular piece and work it through."

- Varying levels of participation with hospital partners
- CHA consisted of web-based information, secondary data, town hall meetings, surveys and focus groups.

  "I think it is Public Health's responsibility to look at the data carefully and make sure for our strategic plan that we identify the appropriate things for our agency."

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CHA Findings

- Many participants voiced concern about reaching all segments of the community

  "We had good participation at our town hall meeting. I will tell you that our town hall meeting was made up of people who have. They weren't any have nots."

- On average 3 priorities identified (range 3-10)
- External support made process (assessment and prioritization) easier and more efficient
- Dissemination methods included web-based reports, social media, presentations, handouts and posters distributed to library, town hall meetings and frequently visited community locations

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CHIP Findings

- CHIP beginning or in early stages in most counties

  "We've had six months now and haven't gotten very far. We can't go at this pace and need to step it up. I don't think three years is going to be enough to see big improvement."

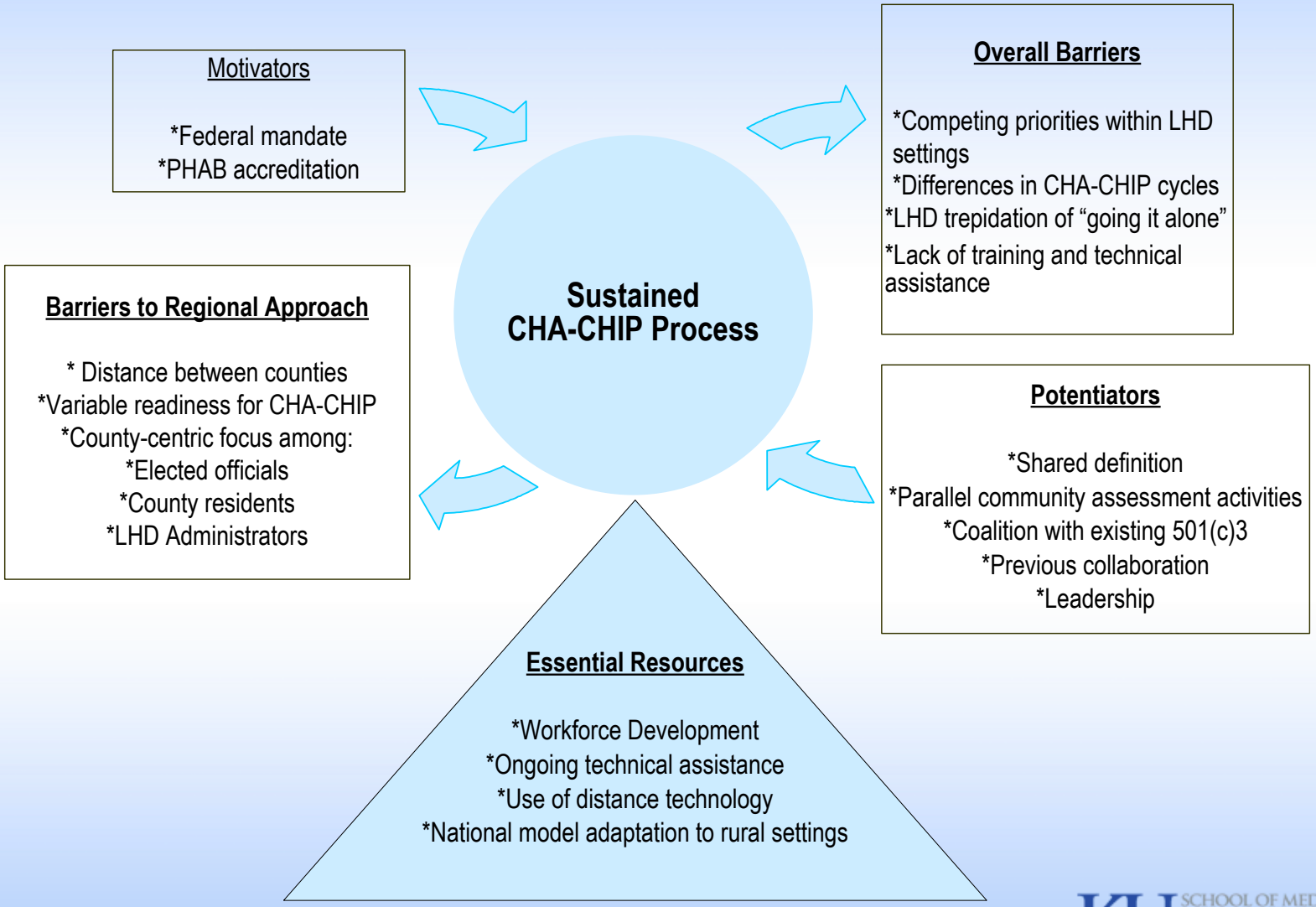
- Those reporting CHIP progress indicated that interventions were aligned with current activities

  "Honestly our priorities are in line with things we are already doing. Our commissioners asked if moving on this plan would involve a lot of additional funding, and I told them I didn't think so at this point."

Perceived Essential Resources

- Year 1 included additional funding, staff and time, and external technical assistance to support
  - data compilation and interpretation,
  - community meeting facilitation,
  - national model adaptation to rural settings and
  - distance technology use for training and guidance.
- By year 2 participants reported that CHA-CHIP was aided by data on Kansas Health Matters, grant funding, hospital funding, volunteers, parallel community health assessment activities and leveraging resources within organizations

Focus Group Principal Findings and Implications



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Was it worth it?

Yes

"It put a face on the health department that hadn't been there in a while. There was a gal at the hospital . . . She and I worked really well together and continue to work together. We have pulled off many things together. Good things came out of it."

AND

No

"I would say no. We have people in the county that wanted to be part of the group but the health department calls the meeting together, and all of the work is ours at the end of the meeting. The coalition members don't feel a lot of ownership to make changes."

Confidence Survey Items

Item #	Item Explanation
Q01	I can describe my role in development of a CHA
Q02	I can apply team concepts w/ LHD employees
Q03	I can identify data from multiple sources
Q04	I can assemble data from multiple sources
Q05	I can organize/assemble data sources into a report
Q06	I can compare my data to peer community or region
Q07	I can apply QI tools appropriate for CHA
Q08	I can apply at least one community engagement technique
Q09	I can develop a public health issue statement
Q10	I can identify community strengths and challenges
Q11	I can identify community priorities
Q12	I can assign roles to address community health priorities

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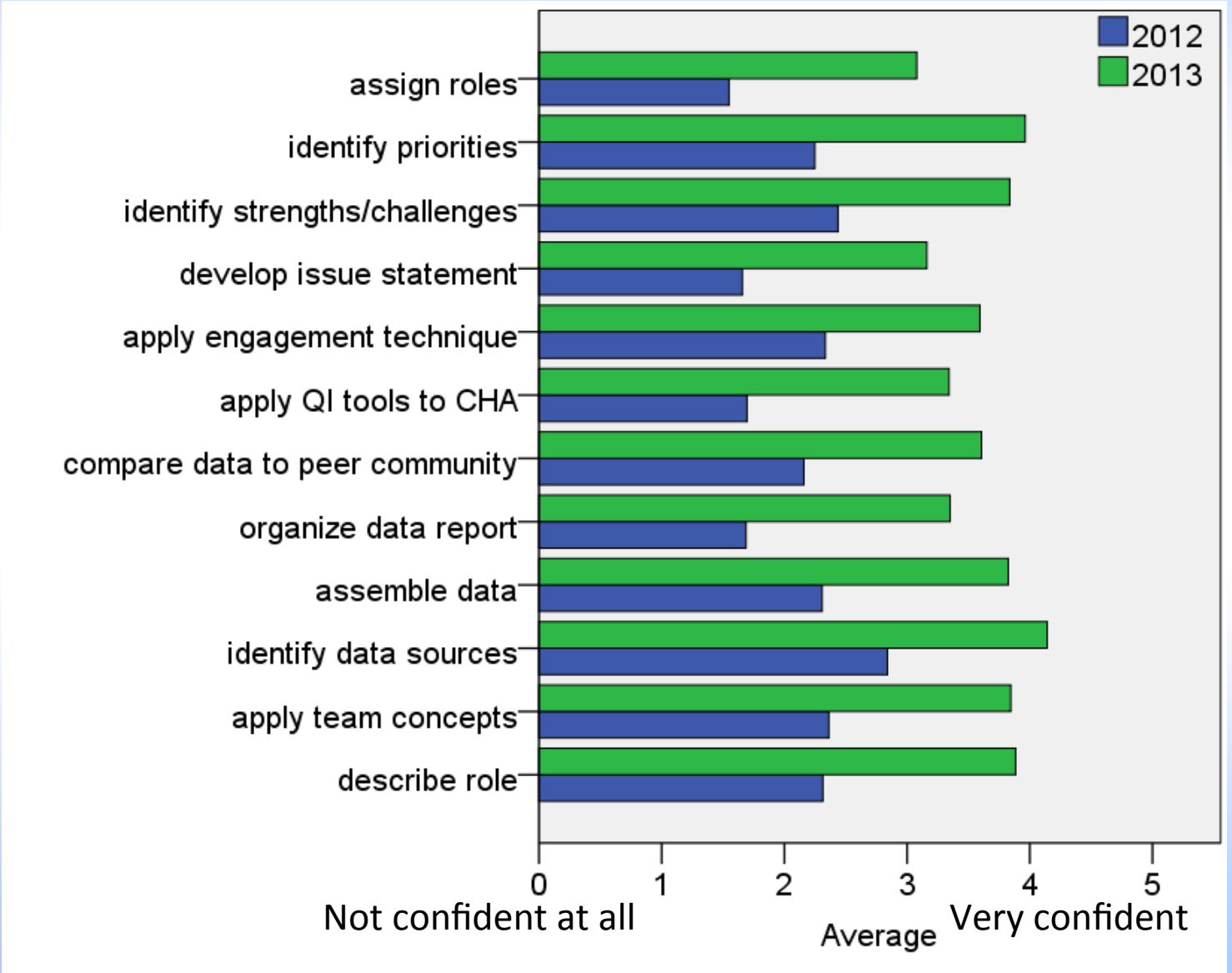
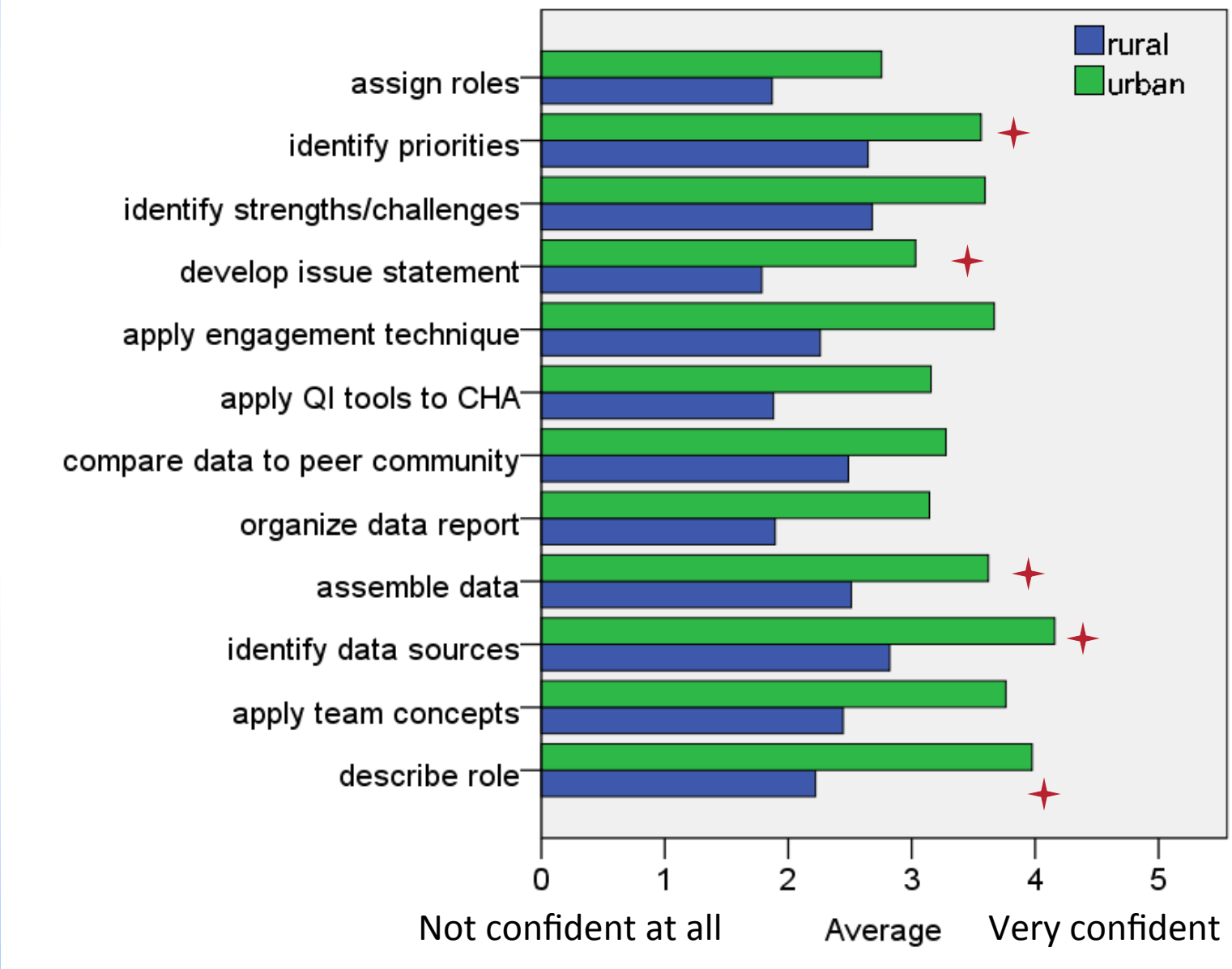
Change in Perceived Confidence to Perform CHA-CHIP Activities, Year 1 versus Year 2



Change in Perceived Confidence to Perform CHA-CHIP Activities, Rural versus Urban



Quantitative Survey Results

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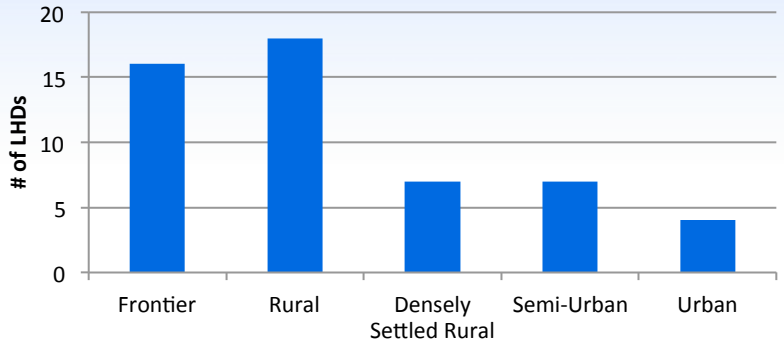
Quantitative Methods

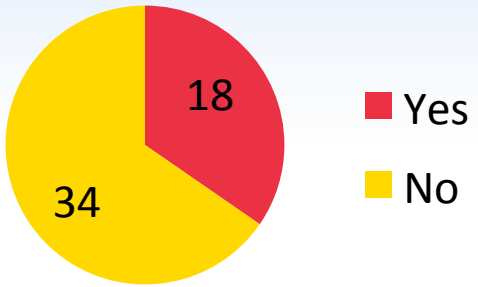
- 2 online surveys (Sept 2012, Jul 2013)
- Questions about:
  - LHD characteristics
  - Dates when milestones reached
  - CHA-CHIP partnership with hospital
  - Resources available and used
  - Community collaboration
  - Content of final products
  - Perceived impact of the process
- 67/100 LHDs completed 2nd survey

LHD Respondent Characteristics

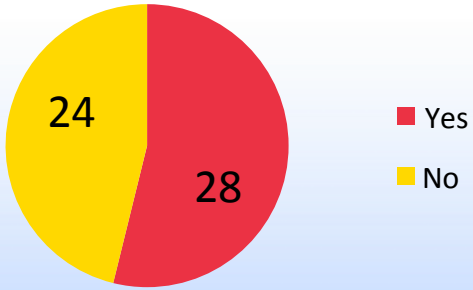
Population Density



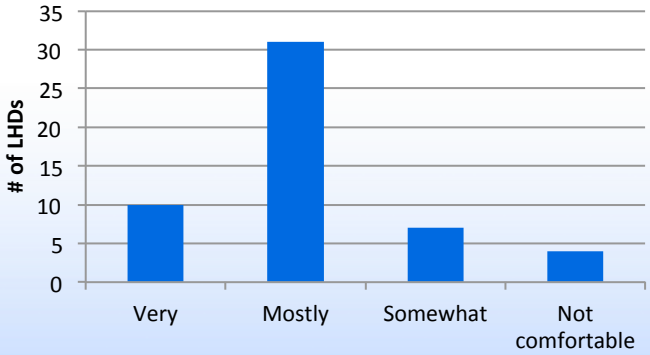
Prior CHA



MLC-3 Participation



QI Comfort



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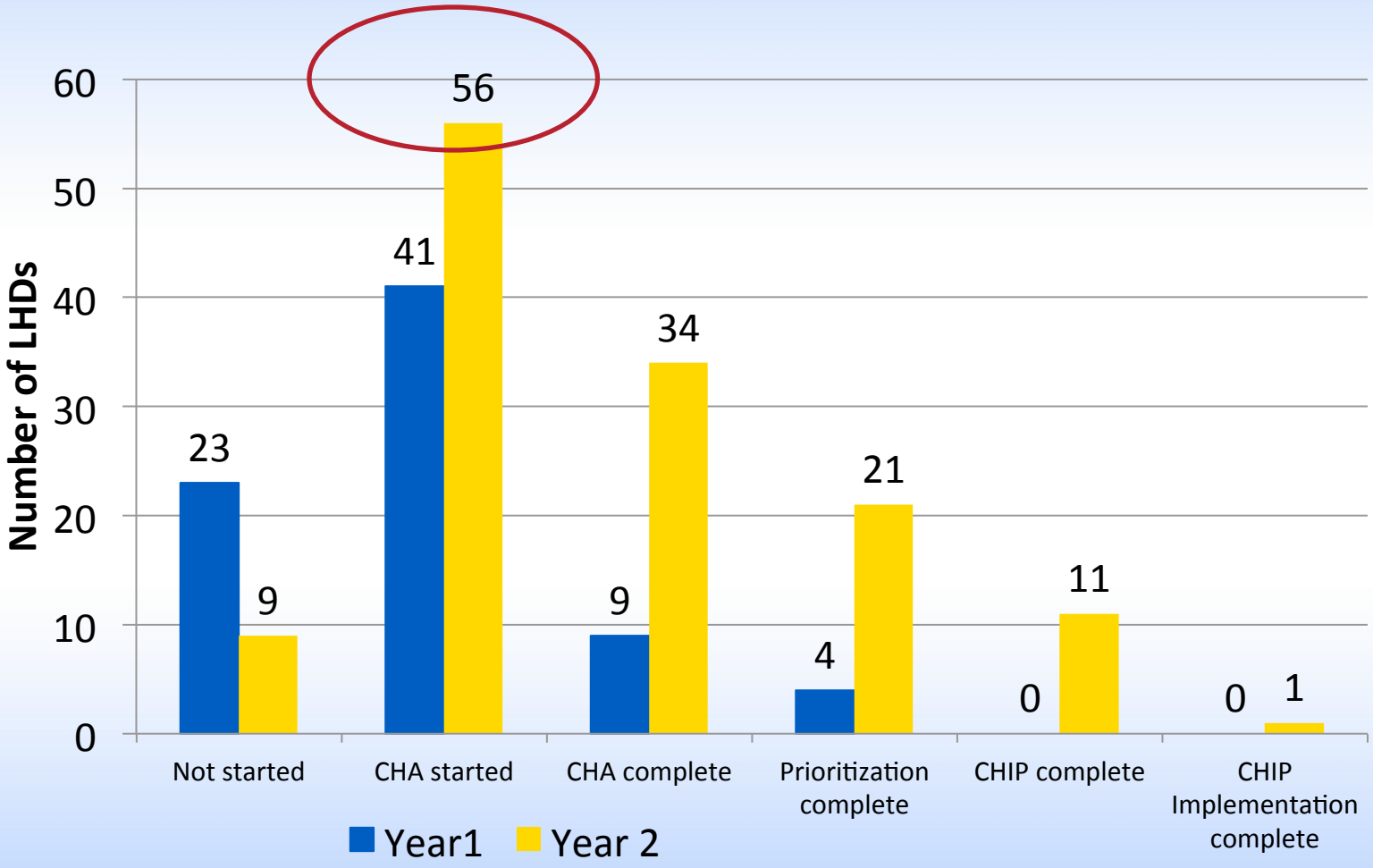
LHD Progress with CHA/CHIPs



N=67 in Year1, 67 in Year2

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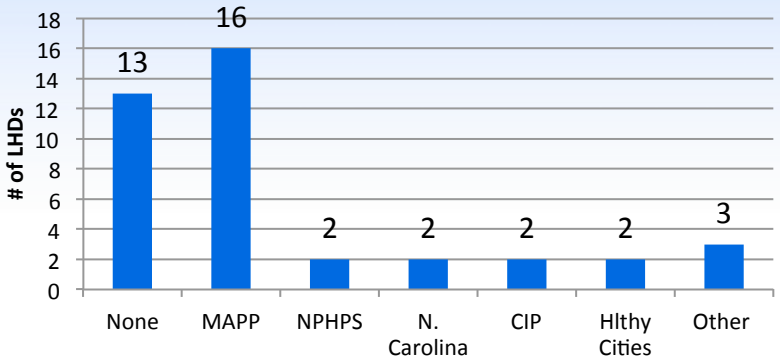
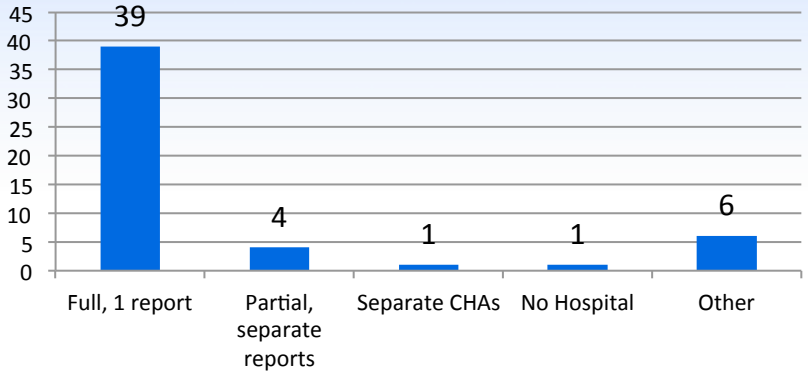
CHA Inputs

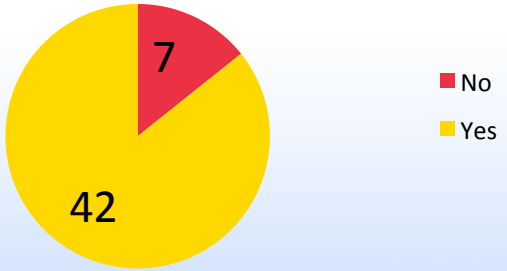
Model Used



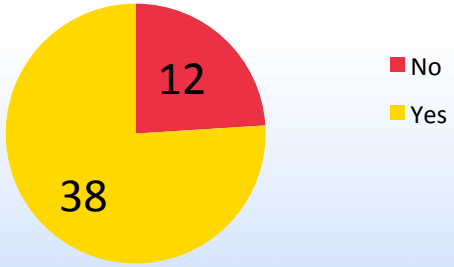
Hospital Collaboration



Technical Assistance



Dedicated Funding



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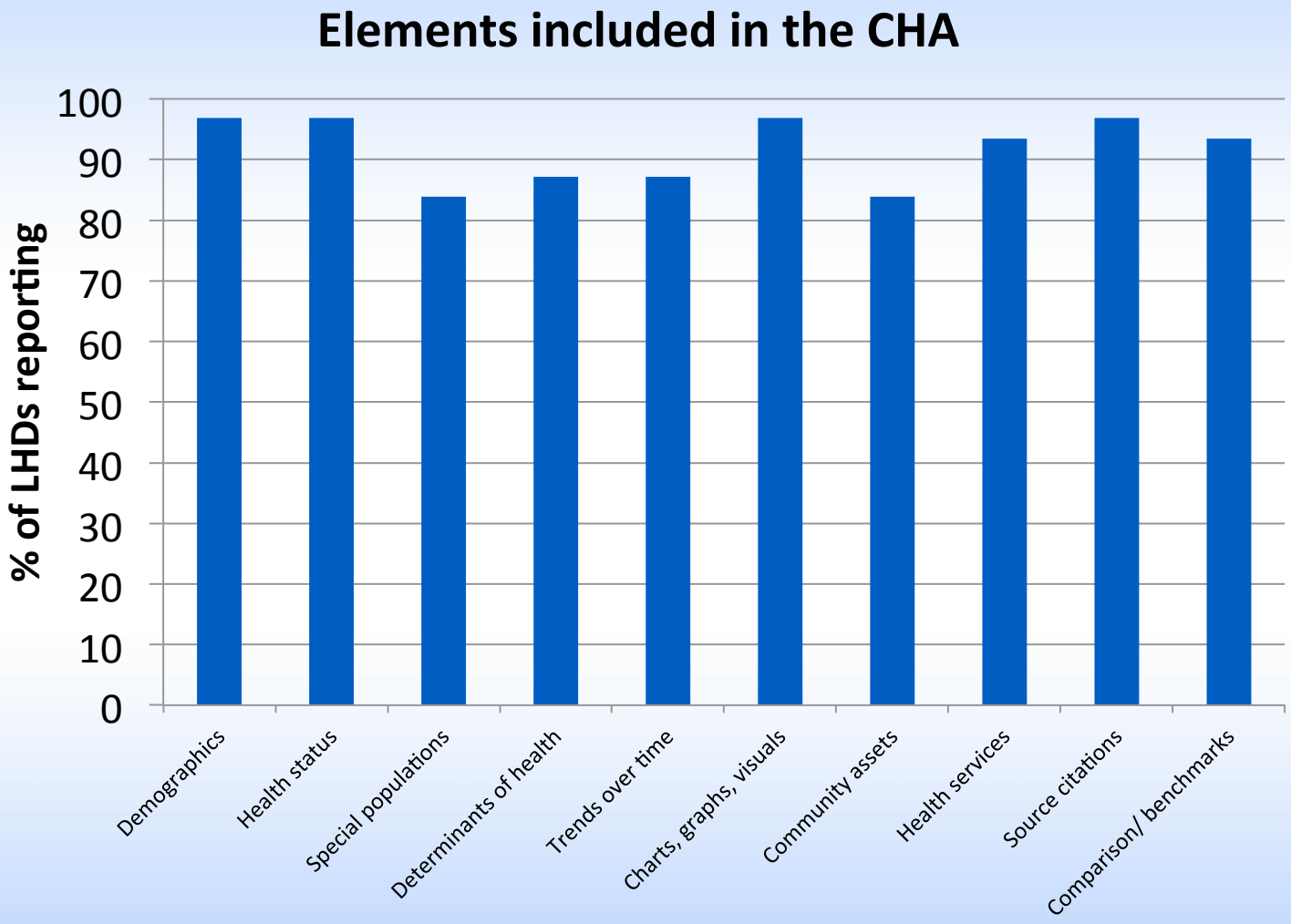
CHA Content



n = 31

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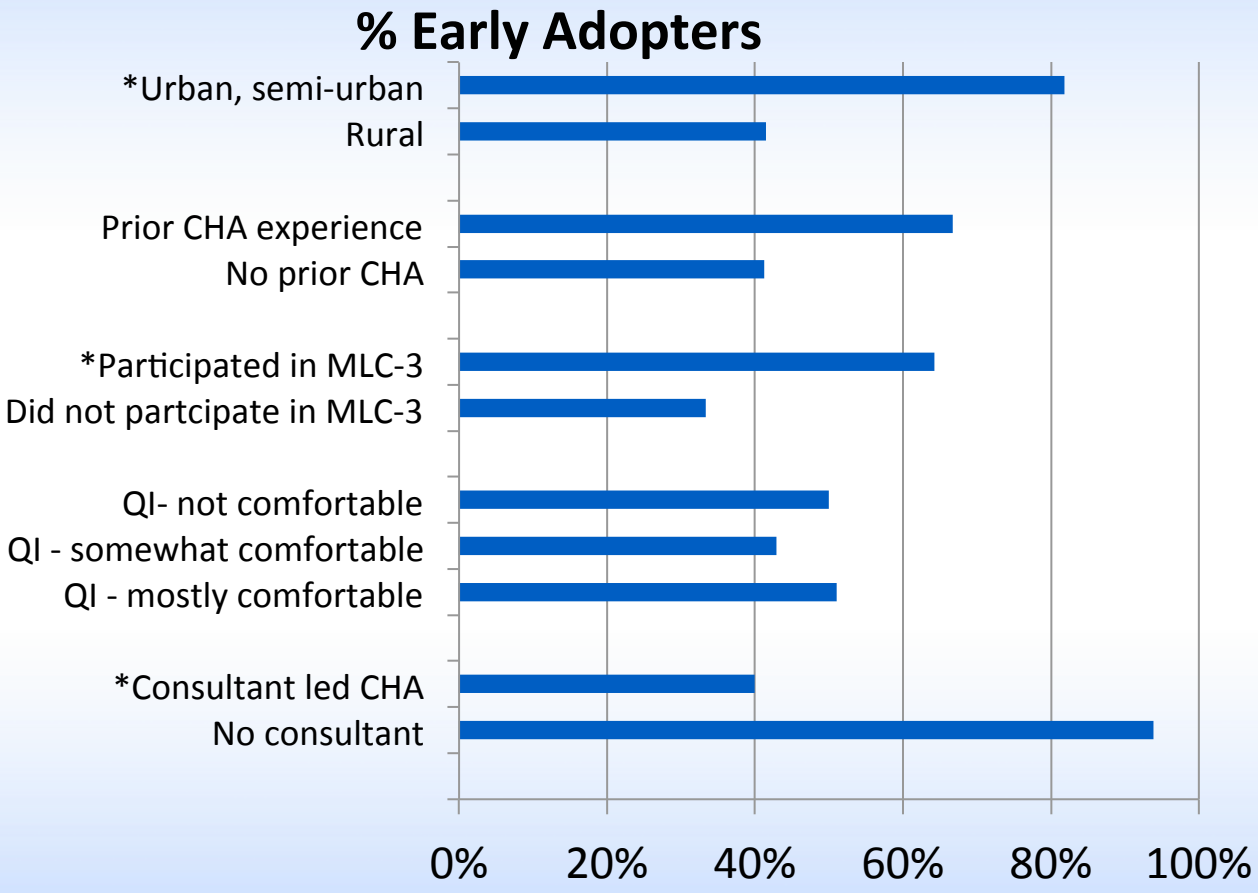
“Early Adopters”



N = 52, 26 “Early Adopters”, began prior to May 1, 2012
*Differences are statistically significant, $p < .05$

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Perceived Impact of CHA-CHIP Activities

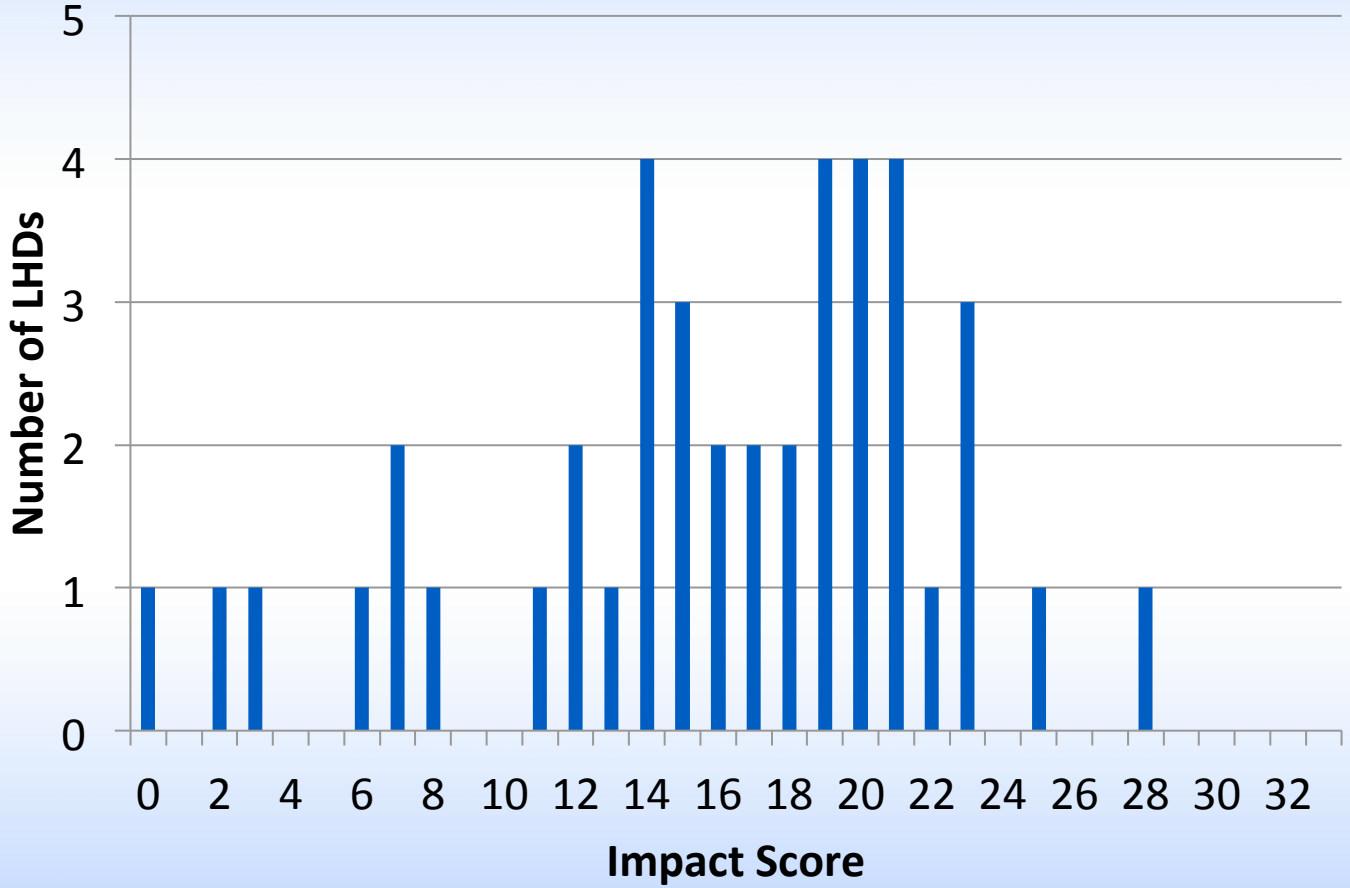
To what extent do you think that your CHA/CHIP process has resulted in each of the following:

Has your CHA/CHIP……	A lot (3)	Somewhat (2)	Only a little (1)	Not at all (0)	Mean Score
Raised community awareness of health issue(s)?					2.1
Resulted in formation of new community partnerships?					2.0
Served as a resource to prioritize and plan services?					2.0
Served as a resource for writing grant applications?					1.4
Resulted in the initiation of a strategic planning process for your organization?					1.3
Served as a resource to guide a comprehensive health promotion strategy?					1.3
Resulted in development or modification of a health strategy or program?					1.3
Resulting in obtaining new resource(s) to address an identified priority?					1.2
Influenced budgeting decisions within your organization?					0.9
Resulted in development or modification of health policy in your community?					1.1
Resulted in alteration or development of new strategic direction for your organization?					1.2
Been implemented as planned, according to the plan timeline?					1.1

Impact Score

- Index of indicators collected to measure perceived impact of CHA-CHIP activities related to
  - Community awareness
  - Partnerships
  - Strategic Planning
  - Health promotion strategies
  - Leveraging new resources
  - Budgeting decisions

Distribution of Impact Scores



N=42
Mean = 15.9

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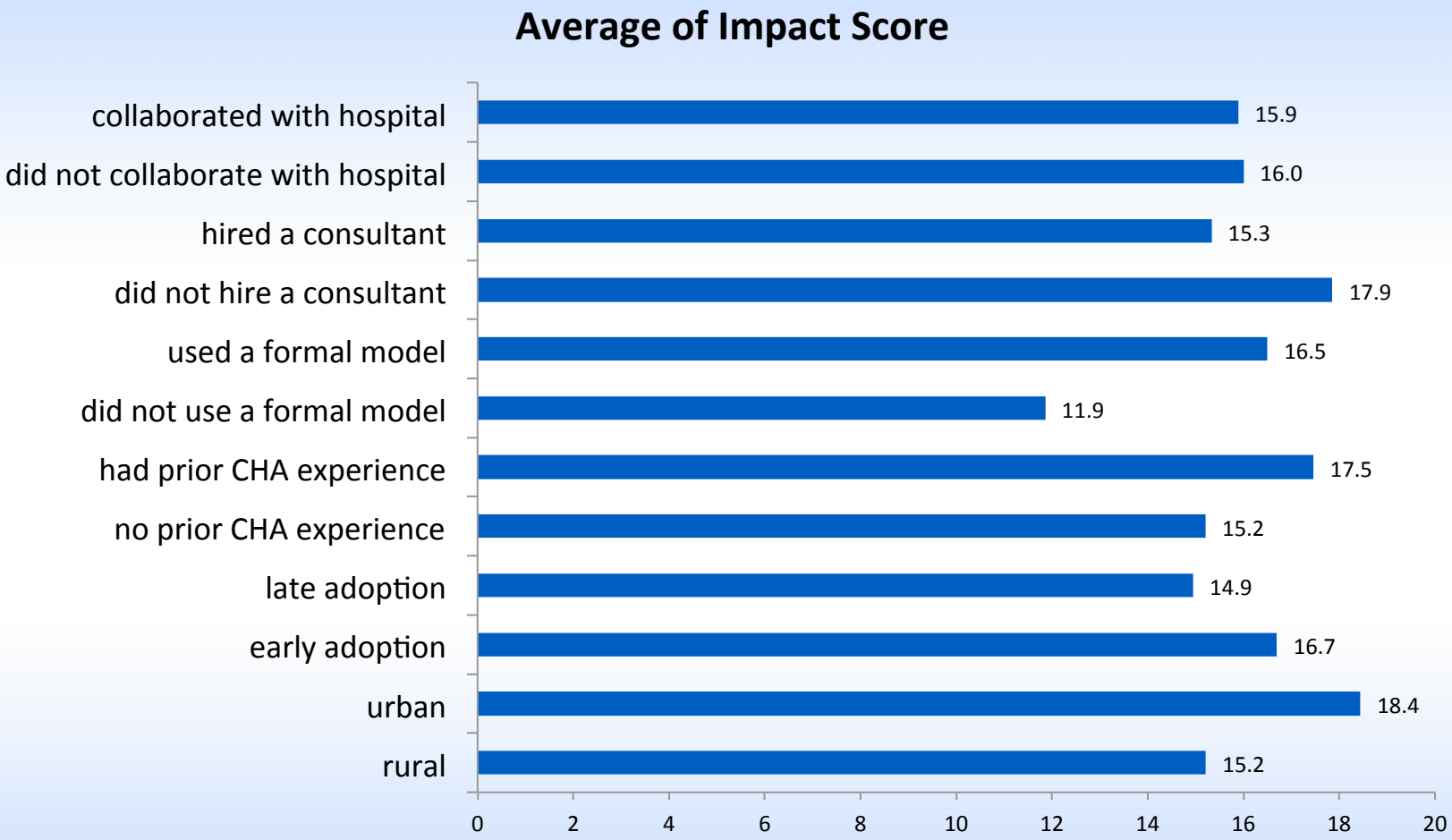
Perceived Impact



Range of possible scores from 0 – 33. Differences not statistically significant
N=42

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Key Findings

- LHDS at varying stages of CHA/CHIP process
- Most CHAs include key characteristics defined by PHAB
- Significant urban/rural differences identified
- Potentiating factors (parallel community assessments, 501(c)3 status) identified
- Barriers (funding, staff, time, training and technical assistance) exist
- Methods for monitoring CHIP results needed

Key Findings

- Urban LHDs, MLC-3 participants more likely to begin CHA earlier
- Early adopters less likely to employ consultants
- Time to CHA completion widely variable
- Consultant-led CHAs completed more quickly
- Highest impact: community awareness, new partnerships, resource for prioritization & planning services

Discussion

Findings parallel previous publications

- Variable completion time [8]
- Community partner participation necessary [7, 8] and lead to new partnerships [9]
- CHA procedures consistent with guidelines [7, 8, 10, 11, 12] but efforts needed to reach all constituents [7, 9)
- Barriers, such as funding, staff, time, training and technical assistance), previously reported, [6, 12] remain as system level issues
- Urban/rural differences documented [13]
- Confidence increase consistent with adult learning principles [14]

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Conclusions and Implications

- Uniform interpretation of CHA-CHIP requirements in both rural and urban regions
- Rural counties lack the capacity to perform many CHA-CHIP activities
- Critical need for workforce development for CHIP-related activities
- Supportive frameworks and technical assistance should be individualized to meet rural/urban needs
- Leverage potentiating factors when possible
- Previous training and applied experience important to CHA-CHIP progress

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Conclusions and Implications

- Big opportunity loss is lack of community engagement in overall process
- Further research needed to quantify the contribution of collaboration to the progress of CHA-CHIP completion
- Public health system development issues are at the center of concerns
- Long-term maintenance of CHA-CHIP activities by LHDs are questionable without action to address public health system issues

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