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KANSAS HEALTH INSTITUTE

ISSUE BRIEF

DECEMBER

2013

COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLANNING IN KANSAS

Introduction

Public health is defined by three core functions: assessment, policy development and assurance. Information gleaned through assessment activities is used to guide policy development and to measure how well the public health system is fulfilling its health assurance functions.

Community health assessment (CHA) is a process of systematically collecting and analyzing data about health and health care status, issues and needs in a defined population. CHA approaches health from a broad-based perspective, taking into consideration the multiple individual, community and environmental factors that influence population health. Community health improvement planning (CHIP) utilizes results from the CHA to systematically identify and implement strategies for improving health within a community.

This brief summarizes the results of a study conducted by the Kansas Health Institute and the University of Kansas School of Medicine-Wichita in collaboration with public health practitioners across the state. The study used a mix of focus groups and surveys to gather information about CHA/CHIP experiences and outcomes in Kansas between 2012 and 2013, and finds that significant gains in practitioner confidence and progress through the CHA/CHIP process have been achieved during that period of time.

Background

In recent years, federal and state policymakers and public health organizations have placed increasing emphasis on the importance of community health assessment as a key component of effective public health. In 2010, the Public Health Accreditation Board (PHAB) issued the first set of criteria to be used in accrediting state and local health departments. Those criteria included requirements for health departments to complete community health assessments and community health improvement plans at least once every five years. The Patient Protection and Affordable Care Act of 2010 (ACA) included new requirements that tax-exempt, nonprofit hospitals conduct community health assessments at least once every three years and adopt strategies to meet the needs identified by those assessments.

KEY POINTS

- Between 2012 and 2013, many Kansas communities initiated community health assessment (CHA) and community health improvement planning (CHIP) activities, and made progress through the stages of the CHA/CHIP process.
- During the same timeframe, public health practitioners have gained confidence in their abilities to successfully complete a CHA/CHIP.
- Although most communities are still working on their CHA/CHIPs and have not yet completed implementation of health improvement strategies, positive benefits have been realized in terms of increased community awareness of health issues and strengthened community partnerships.

Motivated by the PHAB accreditation standards and the new assessment mandate included in the ACA, many hospitals and local health departments across Kansas have embarked upon the CHA/CHIP process in recent months. For many, this was their first experience with community health assessment. Their efforts have encountered both opportunities and challenges.

Focus Group Findings

Focus groups were conducted in 2012 and 2013 with local public health/hospital representatives and stakeholders to assess opinions about inputs, processes and outcomes of CHA/CHIP activities. A brief questionnaire was administered that collected demographic information and explored participants' confidence in their abilities to perform CHA/CHIP activities.

Focus group participants reported a number of factors that helped to facilitate CHA/CHIP progress, as well as a number of barriers. The PHAB accreditation standards and the ACA requirement were identified as motivating factors. In addition, having a history of community collaboration, strong leadership, and parallel community health initiatives were identified as factors that facilitated the process. Lack of time, competing priorities, and a need for training and technical assistance were identified as barriers that impeded CHA/CHIP progress.

At the beginning of this study, many public health practitioners were uncertain that they had the skills needed to carry out a CHA/CHIP. Rural practitioners reported lower confidence levels than those in urban areas. Between 2012 and 2013, statistically significant gains in practitioner confidence with CHA/CHIP activities were observed (Figure 1).

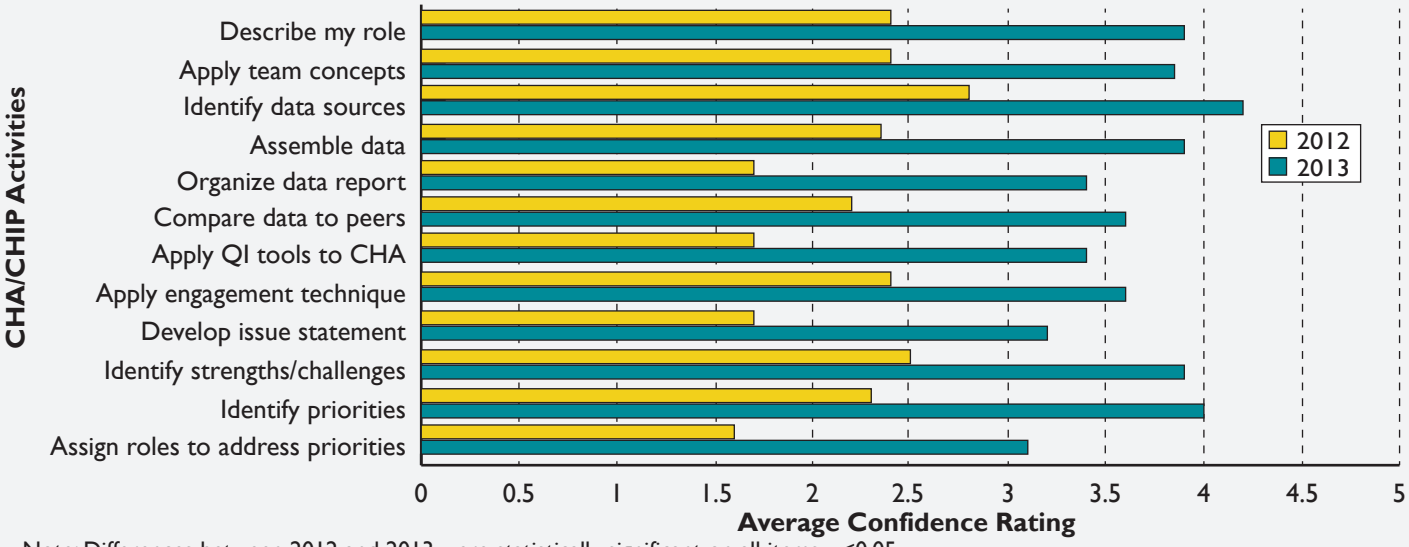
Other differences were also noted in CHA/CHIP experiences reported by rural and urban participants. Rural counties more frequently reported using external consultants (hired in large part by the local hospital) to compile the CHA report and facilitate the prioritization process. It was their perception that the consultant's support made the CHA/CHIP process easier and more efficient. Rural participants frequently reported feeling overwhelmed by the CHA/CHIP process.

Survey Findings

In addition to information gathered through focus group discussions, online surveys were distributed to all local health departments in September 2012 and July 2013. Participants were asked about the tools and resources used in conducting their CHA/CHIPs; the extent of their collaboration with hospitals and other community partners, dates when milestones in the CHA/CHIP process were achieved; content of the completed CHA and CHIP; and the perceived impact of the CHA/CHIP effort.

At the time of the 2012 survey, a significant number of health departments had not yet begun to work on a CHA,

Figure 1. **Change in Perceived Confidence to Perform CHA/CHIP Activities, 2012 versus 2013**



Note: Differences between 2012 and 2013 were statistically significant on all items, $p<0.05$.
Source: KHI analysis of focus group findings.

and many more were in early stages. During the ten-month interval between surveys, progress through the CHA/CHIP process was observed (Figure 2).

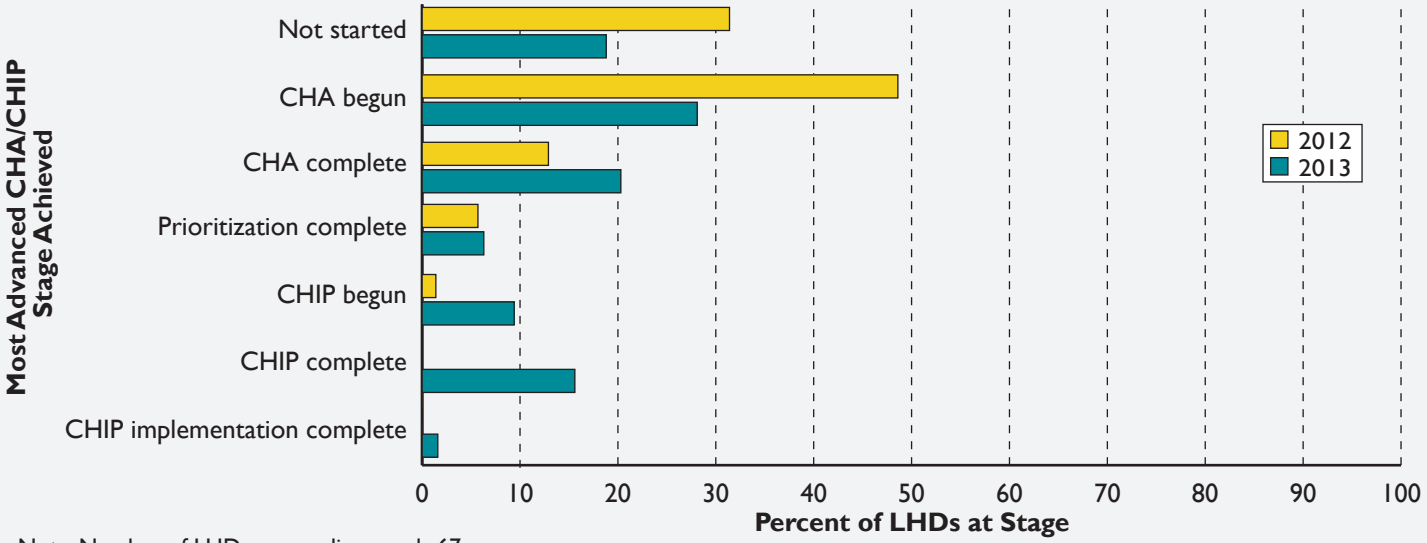
Quality

Quality of the completed community health assessment was measured by comparing the content reported by survey respondents to the specific requirements defined in the PHAB accreditation standards. Among the responding health departments that had completed their CHAs, most incorporated the characteristics described in the PHAB accreditation standards (Figure 3).

Timeliness

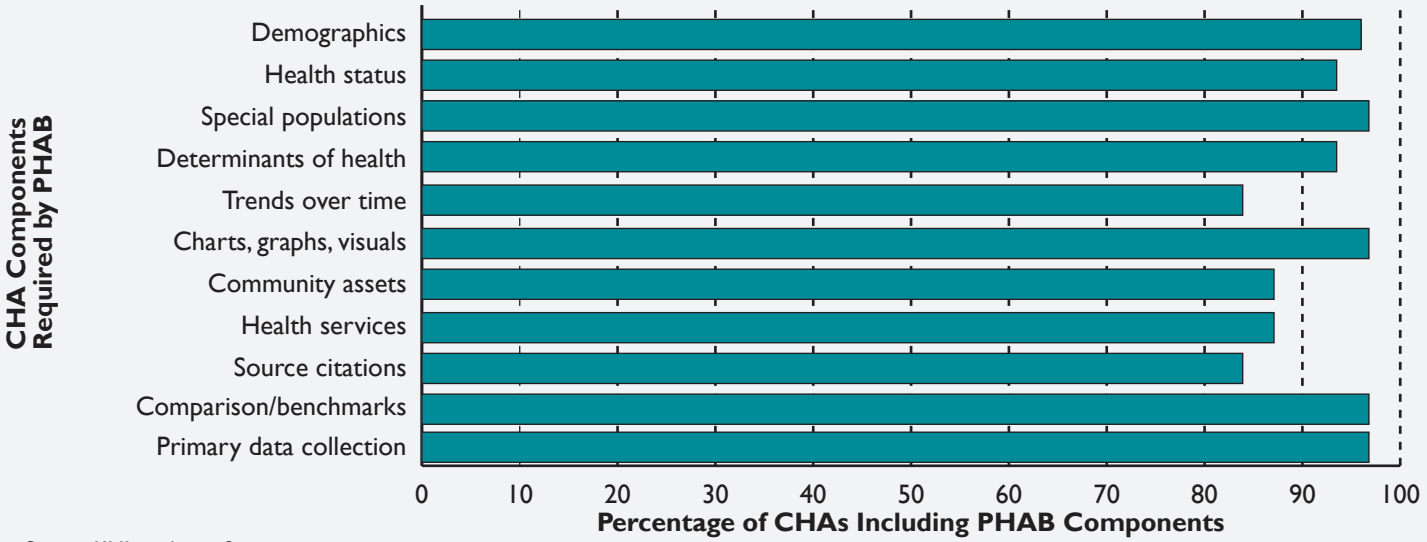
Timeliness was examined from two perspectives — how quickly communities moved forward to begin their CHA, and how much time elapsed between the start and completion of the CHA. Urban or semi-urban health departments, those with prior CHA experience, and those that had participated in the MLC-3 project (a multiyear learning opportunity for building skills in quality improvement) were more likely to be among the "early adopters" group that began their CHAs more quickly. Early adopters were more likely to conduct their CHA under internal leadership; those that began later were

Figure 2. **Progress in CHA/CHIP activities, 2012–2013**



Note: Number of LHDs responding equals 67.
Source: KHI analysis of survey responses.

Figure 3. **Components Included in CHAs**



Source: KHI analysis of survey responses.

more likely to rely upon the leadership of an outside consultant. The amount of time required to complete the CHA was highly variable, averaging 302 days. Urban/semi-urban health departments and early adopters took more time to complete the CHA than their rural peers and those who began the process later, while those where the process was led by an external consultant completed the process more quickly than those who relied upon internal staff resources.

Rural-Urban Differences

Throughout this study, differences were observed between larger health departments located in urban communities, and those smaller health departments in rural areas. Rural health departments faced challenges of limited internal staff capacity and the lack of sufficient local data to accurately describe their community health status. Additionally, staff from rural health departments consistently reported lower confidence levels in their abilities to successfully complete a CHA/CHIP. Rural communities were slower to start their CHAs, and were more likely to rely heavily upon the guidance and expertise of an external consultant to guide them through the CHA/CHIP process.

Short-Term Impact of the CHA/CHIP Process

Survey participants were asked a series of questions about the perceived impact of the completed CHA/CHIP work on organizational operations and in the community. Although most were still working in the initial phases of the CHA/CHIP continuum (Figure 2) and few had yet progressed to implementation of health improvement strategies, most respondents identified some benefit from their early CHA/CHIP efforts. To date, the greatest reported impacts included increased community awareness of health issues, formation of new community partnerships and use of the CHA/CHIP as a resource for prioritization and planning.

Study participants spoke positively about the community collaborations that had developed as a result of their CHA/CHIP work. One survey respondent summarized by saying *"This committee is so positive and they work together to accomplish our goals. It is so nice to see people working together to improve the health of our community. Public health can't do it alone."* Another echoed that sentiment, saying *"Community partners have been our biggest assets."*

Conclusions

Between 2012 and 2013, public health practitioners in Kansas have gained confidence in their CHA/CHIP skills, and have made significant progress toward completing community health assessments and improvement plans. Some have been faced with the challenges of limited internal capacity and a lack of local data, but have pushed forward through partnerships with local hospitals and the guidance of external consultants. Although many communities are still in early stages and have not yet begun to implement health improvement plans, positive impacts have been identified in terms of increased community awareness of health issues, and strengthened community collaborations and partnerships.

About the Issue Brief

This brief is based on work done by Barbara J. LaClair, M.H.A., Gianfranco Pezzino, M.D., M.P.H., Ruth Wetta, R.N., Ph.D., M.P.H., M.S.N. (University of Kansas School of Medicine-Wichita), Frank Dong, Ph.D. (University of Kansas School of Medicine-Wichita). This study was conducted through support from the Robert Wood Johnson Foundation (Grant ID# 69682) and the Kansas Health Foundation. It would not have been possible without the collaboration and support of public health practitioners throughout Kansas. It is available online at www.khi.org.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is a nonprofit, nonpartisan, independent health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

212 SW Eighth Avenue, Suite 300 Topeka, Kansas 66603-3936 Telephone (785) 233-5443 Fax (785) 233-1168 www.khi.org