Community Health Assessment and Health Improvement Planning in Kansas
Early Experiences and Factors that Influence Timeliness and Quality

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Community Health Assessment
and Health Improvement
Planning in Kansas:
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that Influence Timeliness and Quality

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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.

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EXECUTIVE SUMMARY

Assessment is a core function of public health. Community health assessment provides a data-driven basis for understanding community health needs and priorities, and for the development of services, programs and policies to address those needs and improve community health.

In recent years, policymakers and public health affiliate organizations have placed increasing emphasis on the importance of community health assessment as a key component of effective public health function. 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 include requirements for health departments to complete community health assessments (CHAs) and community health improvement plans (CHIPs) 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.

As a result, community hospitals and local health departments in many Kansas communities have embarked upon the processes of community health assessment and community health improvement planning. For many, this has been their first experience with community health assessment. They have encountered barriers and have, at times, sought and secured resources to help them overcome the roadblocks and hurdles. Progress has been made, and many lessons have been learned along the way. Their approaches to community health assessment have been diverse and their experiences varied.

The purpose of this study was to examine the CHA/CHIP experiences that were taking place in Kansas communities, and to identify factors that either contribute to or serve as barriers to timely completion of high-quality community health assessments and community health improvement plans. In partnership with public health practitioners and other key community stakeholders, focus groups and surveys were conducted to gather information about CHA/CHIP activities in Kansas.
During the study period, significant progress was seen as communities worked their way through the CHA/CHIP continuum. Increases in practitioners’ levels of confidence with the CHA/CHIP process were also observed. Many new community partnerships were forged as community stakeholders were convened to participate in the assessment and improvement planning processes. Competing priorities, limitations of staff time and financial resources, and lack of technical expertise were frequently cited as barriers to successful completion, but most communities have continued to push forward. Although few communities had completed their community health improvement plans and moved into implementation stages by the conclusion of this study, nearly all reported some level of immediate impact from their early CHA/CHIP efforts.

Throughout this study, differences were observed between larger health departments located in urban communities, and smaller health departments in rural areas. Rural health departments faced challenges of limited internal staff capacity and a lack of local data to describe their community health issues. Additionally, representatives of rural health departments were less confident in their ability to successfully complete a CHA/CHIP than their urban counterparts. Rural health departments were slower to begin their CHAs, and were more likely to rely heavily upon the guidance of an external consultant in completing their CHA/CHIP.

CONCLUSION

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. Many practitioners in rural communities have faced challenges of limited internal capacity and a lack of local data, but have overcome those challenges through partnerships with local hospitals and the guidance of external consultants. Although many communities are still in early stages of their CHA/CHIPs and have not yet begun to implement health improvement strategies, positive impacts have been identified including increased community awareness of health issues and strengthened community collaborations and partnerships.
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.

In recent years, policymakers and public health affiliate organizations have placed an increasing emphasis on the importance of community health assessment as a key component of effective public health function. In 2010, the Public Health Accreditation Board (PHAB) issued the first set of criteria to be used in accrediting state and local health departments (Public Health Accreditation Board, 2011). The criteria included requirements for health departments to complete community health assessments and community health improvement plans (CHIPs) 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 (Patient Protection and Affordable Care Act of 2010).

Motivated by the PHAB accreditation standards and the new ACA mandate, 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. Kansas is a predominantly rural state. While it is geographically the 15th largest state, covering nearly 82,000 square miles, the population of about 2.8 million people ranks Kansas 40th among states on the basis of population density (O’Brien & Holmes, 2008). Within the state there are 100 local health departments (LHDs) serving 105 counties. Many of those local health departments are located in sparsely populated rural and frontier counties and operate with small staffs and limited budgets. With the exception of a few larger health departments serving more populated regions, most have limited experience with conducting community health assessments and limited internal capacity for data collection and analysis. In recent years, there has been growing recognition of
the challenges that small, rural health departments face in fulfilling the essential functions of public health and meeting emerging performance or accreditation standards (Meit, Harris, Bushar, Piya, Molfino, 2008). Although there has been some movement toward the formation of regional agreements between local health departments in Kansas, there has been no formal consolidation of operations and most continue to function and operate at the single county level. These small, rural health departments face unique challenges of limited internal staff capacity, limited resources and limited availability of local health-related data that make successful completion of community health assessment and health improvement planning more difficult. Similarly, 127 community hospitals serve patients in Kansas, with 84 of those being small, rural facilities with no more than 25 licensed beds. There are 83 designated Critical Access Hospitals currently operating in Kansas (Kansas Hospital Association, 2010).

At the onset of this study, many of the smaller health departments had not yet begun to conduct a community health assessment, and some indicated that they had no definite plans to do so. Others were beginning to plan with an eye toward eventual accreditation, and had embarked upon the CHA/CHIP process. A few were well into the process and nearing completion. At the same time, nonprofit hospitals had been mandated under provisions of the Affordable Care Act (Patient Protection and Affordable Care Act of 2010) to conduct and complete community health assessments and were preparing to begin.

The objective of this observational study was to identify factors that contribute to or detract from the timeliness and quality of completed CHA/CHIPs, using a mix of quantitative and qualitative methods. As we proposed this study, we anticipated that many local health departments would partner with their community hospitals to complete community health assessments, and that some would work within their regional alliances to conduct and develop joint community health assessments and health improvement plans for the region. We believed that the existing variability in terms of health department capacity, implementation of regional alliances, and health departments’ previous experiences in conducting community health assessments could provide a natural setting for a prospective observational study to learn more about the factors associated with timely completion of high-quality CHA/CHIPs.
BACKGROUND

Published reports have suggested that LHDs and hospitals face a variety of issues as they attempt to complete their CHAs/CHIPs, but little is known about factors that can facilitate or impede the successful implementation of this process. A number of models and approaches to community health assessment have been promulgated, including Community Health Report Cards, Mobilizing for Action through Planning and Partnerships (MAPP), Planned Approach to Community Health (PATCH), and the Assessment Protocol for Excellence in Public Health (APEXPH) (Novick, Morrow & Mays, 2008). Association and professional groups such as the Institute of Medicine, the Association for Community Health Improvement (ACHI), the National Association of County and City Health Officials (NACCHO), the Catholic Hospital Association, PHAB, and others have proposed their own version of CHA/CHIP. However, no widely accepted descriptions of characteristics that denote a quality CHA/CHIP currently exist.

BARRIERS AND FACILITATING FACTORS IDENTIFIED IN PUBLISHED STUDIES

Obstacles to performing a quality CHA have been reported and continue to pose a challenge for public health practitioners (Kanaraek, Tsai & Stanley, 2011). In Kansas, a 1999 study (Curtis, 2002) found that community characteristics such as interagency cooperation, history of success at problem-solving, and shared decision-making power were strongly associated with CHA completion, while communities with incomplete CHAs reported having less representation of community leaders in their coalitions. Those communities that did not initiate a CHA reported lack of community interest, lack of time, and lack of money as the most important barriers. In Florida, researchers found that while 96 percent of LHDs had begun assessment and planning activities by 2007, completion of the CHIP was relatively low, suggesting that barriers to completion existed (Abarca, Grigg, Steele, Osgood and Keating, 2009). An assessment in New York State (Byrne et al., 2002) reported that LHDs showed the greatest strengths in explaining the demographics and health status of their local population and identifying priority health issues and at-risk populations, but displayed difficulty in using CHAs to assess and describe the local health care environment and the roles of key stakeholder organizations in addressing identified priorities.

A number of published studies have examined the importance of community participation and collaboration in community health assessment and improvement planning activities. Williams,
Bray, Shapiro-Mendoza, Reisz & Peranteau (2009) reported that the use of community-based participatory research (CBPR) principles as part of the CHA process provided better information and greater insight into the community’s perspective of health status as compared to more traditional non-participatory CHA methods, but acknowledged that CBPR was also more time intensive and costly to conduct.

Collaboration between public health and health care organizations for the purposes of community health assessment has long been advocated (Stanley & Stein, 1998; Byrne et al., 2002; Spice & Snyder, 2009). In an effort to fully describe the local health care environment and resources, Byrne et al., (2002) suggested that the CHA and CHIP should include not only public health practitioners, but health care providers, hospitals and other local organizations and partnerships.

GUIDELINES FOR EVALUATING QUALITY

Prior to March 2013, no formal guidelines existed for evaluation of CHA/CHIP quality (National Association of County and City Health Officials, 2013). Researchers have suggested that community health assessment reports should state their goals and purpose; include the most important aspects of the community's health; allow comparisons with other communities, external benchmarks, and trends across time; present data in meaningful subgroups of population; provide sufficient focus on positive characteristics; and document the process and methods that are used to create the CHA (Stoto, Straus, Bohn, & Irani, 2009). Curtis (2002) suggested that the following factors should be used to assess the quality of CHA: (1) utility — useful to individuals and communities, (2) feasibility — realistic, prudent, diplomatic, frugal, and uses existing resources and expertise, and (3) propriety — ethical and legal activities that conform to community standards and are acceptable to the community. Byrne et al., (2002) suggested that accuracy, usability, readability and completeness are factors that should be used to judge the quality of a CHA.

MEASURING CHA/CHIP OUTCOMES

Friedman and Parrish (2009) have suggested that a CHA should be evaluated in terms of the quality of information produced and its usefulness to the overall process of improving the health of a community. In their 2009 study, Solet et al. inferred that effective CHAs (1) led to
documentation of new, locally pertinent problems; (2) used local data and rigorous examination; (3) included appropriate analyses (e.g., quantitative and/or qualitative approaches); (4) attracted media attention; (5) engaged and motivated policymakers and stakeholders; (6) led to the development of new partnerships; (7) influenced resource allocation; (8) led to policy development; and (9) led to program development. They suggested four outcome indicators for the evaluation of CHAs:

- description of changed policies and the number of people affected by policy change;
- the number of new partnerships and the size of population represented by partners;
- dollars allocated to new programs and/or committed to sustaining existing programs; and
- importance of data in understanding the CHA issue and supporting community advocacy (from qualitative textual analysis).

To date, no published studies have examined the relationships between possible barriers or facilitating factors to the CHA/CHIP process and the outcomes of CHA/CHIP quality or timeliness. In addition to documenting current CHA/CHIP experiences in Kansas, this study provides new insights into the factors that contribute to quality and timely completion.

**METHODS**

**STUDY POPULATION AND SUBJECT RECRUITMENT**

The purpose of this mixed-methods observational study was to identify factors that contribute to or detract from the timeliness of CHA/CHIP completion and to assess the quality of the completed CHA/CHIP. Data were collected through focus group discussions and surveys of study participants.

The sampling frame for the study was all 105 counties in Kansas. Representatives of local health departments in each county were the primary target of recruitment efforts. Representatives of community hospitals and key CHA/CHNA stakeholders were also invited to participate. Coordinators of the state’s 15 public health preparedness regions and staff from the Kansas Association of Local Health Departments assisted with recruitment of participants.
Study participation was anonymous and voluntary. No incentive for participation was provided. Human subjects approval was secured through the University of Kansas School of Medicine-Wichita, HSC # 220121476.

FOCUS GROUP DATA COLLECTION

Qualitative focus groups and structured interviews were conducted with local public health practitioners and key community partners to elicit information about their CHA/CHIP experiences. Two sets of focus groups were conducted, at baseline (2012) and the beginning of year two (2013). Purposive sampling to ensure representation of each public health region in Kansas was pursued. Focus group recruitment, facilitation and analysis followed the standards of Berg (2004). Interviews were conducted primarily by telephone or webinar sessions. Topics discussed in the focus groups included the effect of the presence or absence of local partnerships and the role of the Kansas Health Matters information system for the various stages of CHA/CHIP development. The interview script is included in Appendix A. Specific questions included:

1. What characteristics of the CHA process influenced its adoption within the county or region?
2. How were decisions made about the expected inputs, process, outputs and outcomes of the CHA?
3. What individual or groups influenced the adoption and implementation of the CHA/CHIP?
4. What products and interventions resulted as a consequence of the CHA/CHIP process?
5. What communication channels were useful in the CHA/CHIP process?
6. What are the pros and cons of performing a regional versus a single-county CHA/CHIP?

Prior to the beginning of each focus group, participants completed a brief demographic and attitudinal survey. To describe the characteristics of the focus group participants, demographic data were collected that included age, gender, and public health region affiliation. In addition, a 12-item attitudinal survey was administered. Using a Likert scale that ranged from -5 (not

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1 Kansas Health Matters is a Kansas-specific web-based public health information system designed for the purpose of supporting public health assessments in the state. The customized system operates on the platform developed and maintained by the Healthy Communities Institute.
confident at all) to +5 (very confident), participants’ confidence to perform CHA/CHIP activities was explored (Table 1). The complete questionnaire is included in Appendix B.

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

**QUANTITATIVE DATA COLLECTION**

Surveys were utilized to collect more detailed quantitative data about communities’ CHA/CHIP experiences. Online surveys were distributed to all local health departments in Kansas in September 2012 and again in July 2013. Participants were asked about the tools and resources they were using 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. Invitations to participate in the survey were distributed through email, with automated reminder messages generated at one and two weeks following the initial distribution. At three weeks post distribution, non-respondents were contacted by their regional coordinators and urged to complete the surveys.
VARIABLE DEFINITION

The key outcomes of interest in this study were timeliness and quality of the CHA/CHIP. Timeliness was assessed from two perspectives: (1) innovation or rate of adoption, defined as the relative speed with which communities embarked upon the CHA/CHIP process (Rogers, 1995), and (2) the amount of time (in days) required to complete each phase of the CHA/CHIP process. CHA/CHIP phases were defined as shown in Table 2, and participants were asked to provide the dates when they began and completed each phase.

<table>
<thead>
<tr>
<th>Table 2: Phases of the CHA/CHIP process</th>
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<tbody>
<tr>
<td><strong>Planning Phase</strong>: Project team and other major stakeholders are in the process of defining project scope, methods, schedule, and preparations for next phase. Planning phase ends when data collection related to the CHA begins.</td>
</tr>
<tr>
<td><strong>Conducting Community Health Assessment</strong>: Project team is actively involved in collecting, compiling or analyzing data related to community health, or the write-up of preliminary findings. This phase ends when the priority setting process with community partners begins.</td>
</tr>
<tr>
<td><strong>Priority Setting</strong>: Preliminary Community Health Assessment report has been completed, and stakeholder and community feedback is being or has been sought. With input from stakeholders, community health priorities are being identified. This phase ends when priorities have been identified.</td>
</tr>
<tr>
<td><strong>Community Health Improvement Planning</strong>: Priorities have been identified, and planning process is underway to identify interventions and strategies to address the priorities. This phase ends when strategies have been identified, responsible parties and timelines assigned, and the CHIP document is ready for public release and dissemination.</td>
</tr>
<tr>
<td><strong>Dissemination of the Community Health Improvement Plan</strong>: The CHIP has been finalized and is being released and disseminated. Community discussion and presentation of the material, and efforts to build community support for the CHA/CHIP strategies may be taking place. This phase ends when partners have adopted sections of the CHIP and begun working toward implementation of the strategies.</td>
</tr>
<tr>
<td><strong>Implementation</strong>: Implementation of strategies outlined in the CHIP has begun. Partners have officially adopted sections of the CHIP, have developed agency-specific strategic plans, and are working toward implementation of the strategies. This phase does not end until beginning of a new CHA or partner agencies no longer reference or follow strategies outlined in the plan.</td>
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Published studies, reports and standards were reviewed to generate an initial list of possible factors for inclusion in the evaluation of CHA/CHIP quality. The resulting list of items was subjected to an interactive voting process with a group of public health practitioners at a project kick-off meeting held in January 2012. Real-time polling technology was utilized to allow participants to provide input on what factors/activities they felt were important and appropriate indicators of a successful Community Health Assessment (CHA) and Community Healthy Improvement Plan (CHIP) process. Results from this polling were analyzed to determine which
indicators the audience of those involved in public health in Kansas felt were most important. Items assigned the highest ratings of importance from the polling process were combined with CHA/CHIP specifications included in the PHAB Accreditation Standards (PHAB, 2011) to produce a final list of survey questions that would be used to assess CHA quality (Table 3).

<table>
<thead>
<tr>
<th>Table 3. Indicators of CHA quality</th>
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<tbody>
<tr>
<td>Variety of data sources used</td>
</tr>
<tr>
<td>Demographic data are described</td>
</tr>
<tr>
<td>Data describe key health issues in community</td>
</tr>
<tr>
<td>Data describe health issues of special populations</td>
</tr>
<tr>
<td>Data include determinants of health/contributory factors</td>
</tr>
<tr>
<td>Community assets and resources are identified</td>
</tr>
<tr>
<td>Data describe health-related services available or needed in community</td>
</tr>
<tr>
<td>Data compare trends and changes in measures over time</td>
</tr>
<tr>
<td>Data profile includes visual aids such as charts, graphs, tables or maps</td>
</tr>
<tr>
<td>Citations for data sources are included</td>
</tr>
<tr>
<td>Primary data were collected</td>
</tr>
<tr>
<td>Local data are compared to other counties, regions, state or national data</td>
</tr>
</tbody>
</table>

Self-reported responses to each item were scored and then summed across the entire set of questions to produce a composite score of CHA quality (see Appendix D for scoring details).

As an alternative approach to measuring quality, survey respondents were asked to rate the extent to which they thought that their CHA/CHIP process had resulted in a set of described actions or impacts. For each question on the list, respondents were asked to quantify the degree to which the CHA/CHIP had achieved that result as “a lot,” “somewhat,” “a little,” or “not at all.” Responses were assigned scores and then totaled across the eleven items to produce an overall impact score. Possible impact scores ranged from 0 to 33 points (refer to Appendix D for detail).

Based on published reports and anecdotal experiences, several factors were hypothesized as potential predictors of either timeliness or quality of the CHA/CHIP and included in the quantitative data collection process. Two factors were of primary interest. The first was the
extent of adoption and use of a new statewide public health information system (known as Kansas Health Matters) developed to support CHA/CHIP. The second was the degree of collaboration between LHDs (or public health regions), their area hospitals, and other community stakeholders. Community collaboration was assessed through a panel of survey questions asking the extent of involvement that each of several categories of community stakeholders had participated in the CHA/CHIP process. Survey responses to each item were assigned scores based upon degree of stakeholder involvement and summed across the panel of questions to create a composite score for community collaboration (See Appendix C for survey questions).

Other possible explanatory factors that were examined included the availability and use of technical assistance for the CHA/CHIP process, the availability of dedicated local funding for the CHA/CHIP process, the availability and use of other local information systems to support the CHA/CHIP, and the degree of comfort with the use of quality improvement tools and techniques.

Additional descriptive data elements such as agency size and scope of services, and demographic characteristics of the population served were available from public use data sources, and were abstracted and merged with survey response data to minimize respondent burden.

**ANALYSIS**

Focus group and interview sessions were audiotaped and transcribed. Transcripts were studied for themes across responses to questions, following procedures defined by Berg (2004). Comparison with survey results was performed to triangulate the epidemiology of focus group findings. Survey responses were summarized using frequencies and percentages for categorical variables, and means and standard deviations for continuous variables. Chi square and t-test statistics were used to test for differences between sub-groups of respondents. A multilevel regression analysis was conducted to explore the effect of period and rural-urban differences related to confidence. All statistical analyses were two-sided with an alpha set at <0.05 to denote statistical significance. Statistical analyses were conducted using the SAS software for Windows (version 9.3, Cary, North Carolina).
RESULTS

FOCUS GROUP RESULTS

There were a total of 57 focus group participants in 2012, and 71 in 2013. Eighty-three (83.0) percent of participants were female and 35.4 percent reported being between 51 and 60 years of age. The vast majority (84.6 percent) of participants reported being from rural areas. Additionally, a majority of Kansas public health regions were represented in both years with 73 percent in 2012 and 93 percent in 2013. Year one results have been reported elsewhere (Wetta, Pezzino, LaClair, Orr and Brown, 2013).

CHA Inputs, Processes and Outcomes

Most year two focus group participants indicated that their CHA had been accomplished within six to twelve months; however, a few reported exceeding one year. Many respondents reported a positive experience with engaging their community stakeholders and groups, but hospital participation in partnering was variable.

There were consistent descriptions of the CHA process and elements of the CHA report that contained information found via the Internet, including Kansas Health Matters, County Health Rankings and other data sources, such as the U.S. Census data, vital statistics, economic data, and other local agency reports. In addition, many participants described community-based information sources, such as listening sessions, town hall meetings, focus groups, and community surveys. Many stated that public health practitioners had a responsibility to assess data sources carefully and ensure applicability to their setting. A few participants indicated that they were not able to connect to all community subgroups, particularly vulnerable populations and minorities. Methods employed in communication of CHA results were varied, and included the Internet, social media applications, presentations in community settings, and handouts and/or posters in frequently visited local venues such as the public library or local stores and town hall meetings. Stakeholders participating in the CHA/CHIP process did not change between 2012 and 2013.

As compared to year one results, most counties reported being in the early stages of the CHIP in 2013 and had identified, on average, three community health priorities. Among those counties
reporting progress, interventions were associated with planned activities within the community. A handful reported a plan to track the outcomes of activities associated with the CHIP.

**Influential CHA/CHIP Factors**

The pursuit of public health accreditation and the federal mandate for nonprofit hospitals were identified as motivating factors to pursue CHA/CHIP activities. In year two, additional factors were reported: parallel assessment activities occurring in the community and the presence of an existing 501(c)3 organization associated with a community coalition. When other community health assessment activities such as a social or childhood needs assessments had been conducted within a close timeframe to the CHA, CHIP progress appeared to be accelerated. Additionally, advanced CHIP progress was reported in two rural communities in which a community coalition was functional and had established 501(c)3 status. Participants in these two communities indicated that a functioning 501(c)3 coalition facilitated ongoing collaboration and served as the fiscal agent for grant applications and receipt of funding that supported community initiatives. As in year one, the need for partnership and leadership in the CHA/CHIP was echoed in year two.

**Barriers to the CHA/CHIP Process**

Participants described a number of barriers that impeded progress on their CHA/CHIPs. Among those most frequently mentioned were lack of staff time and competing priorities, lack of funding to support CHA/CHIP efforts, and lack of internal staff technical expertise in areas such as survey design, focus group facilitation, data analysis and interpretation, and facilitation of community stakeholder discussions.

**Urban and Rural Differences**

In year two, urban counties reported being engaged in CHIP activities while most rural counties had recently completed the CHA and prioritization process. Another reported difference between rural and urban counties was the use of external consultants, hired in large part by the local hospital, to compile the CHA report and facilitate the prioritization process. Rural participants perceived the consultant’s support as making the CHA/CHIP process easier and more efficient. Rural participants reported feeling beset by the CHA/CHIP process more often than urban participants.
Regional Versus County-Level CHA/CHIP Perceptions

Reported barriers to pursuing a regional CHA/CHIP in year two were similar to those reported in year one, and included:

- geographic distance between counties too great,
- varying levels of readiness to initiate CHA/CHIP activities among counties in a region,
- most elected officials were focused on their own county versus counties in the region,
- county residents feared the loss of local resources, and
- greater potential for success with a county-level versus regional-level focus.

During the study timeframe, only one region pursued a regional approach to their community health assessment. That eight-county region received funding through the National Association of County and City Health Officials (NACCHO) to perform the Centers for Disease Control and Prevention Public Health Performance system process at a county and regional level. With support from an external consultant to prepare the data for the report, this region reported successful completion of the CHA process at both the local county level and as a region and had implemented interventions and initiated a monitoring system to track results. Participants from this region reported that having the entire region involved was helpful, stating, “We will use the regional level when needed [but] will not apply for funding as a region. We will come together as a region when we need to.”

The majority of participants perceived the CHA/CHIP work as valuable and “worth it,” indicating that it provided greater visibility for the health department. A minority of participants suggested that the CHA/CHIP had minimal value, alluding to the perceived burden of work associated with not only CHA activities, but also the ongoing nature of CHIP processes.

CHA/CHIP Confidence Survey Findings

Results of the attitudinal surveys about confidence to perform CHA/CHIP activities showed significant changes between 2012 and 2013. The mean scores of the 12 self-efficacy items showed significant increases in confidence to perform CHA/CHIP activities, and are displayed in Figure 1 (page 14). Additionally, a summary of the 12 self-efficacy items by urban versus rural
designation are presented in Figure 2 (page 15). Urban participants reported higher confidence in their ability to perform activities associated with the CHA/CHIP process.

The results of a multilevel regression analysis revealed a significant time effect and rural-urban differences in perceived self-efficacy. Between 2012 and 2013, statistically significant improvement in all 12 self-efficacy items was observed. Only six skill areas showed statistically significant rural-urban disparities (Figures 1 and 2).

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

Differences between 2012 and 2013 were statistically significant on all items, p<0.05.
SURVEY RESULTS

In both the baseline and follow-up surveys, responses were received from 67 of the 100 local health departments in the state, although the lists of health departments responding in each cohort were not identical. Except for the comparison of results of the two surveys to assess movement through the CHA/CHIP process, analysis of study questions used only data from the second survey. Due to the limited numbers of health departments that had completed CHIP activities, analysis of timeliness and quality was restricted to the CHA phase only.

At the time of the first survey, a significant number of health departments had not yet begun to work on a CHA, and many more were in early stages. During the ten-month interval between surveys, significant progress through CHA/CHIP process was achieved (Figure 3, page 16). At the time of the baseline survey in 2012, nearly one-third of responding health departments had not begun a community health assessment, and only one had completed their CHA and started to work on a community health improvement plan. Ten months later, one health department had completed implementation of the health improvement strategies outlined in their CHIP, 12 had completed their CHIPs and were working on implementation of improvement strategies, and an additional seven were developing their community health improvement plans.
Quality of the CHA

Quality of the CHA 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 as essential. There was little variability in the composite quality scores, which ranged from five to 13 of a possible zero to 13 points, with a mean score of 12.0. The percent of CHAs meeting each of the measured quality criteria are shown in Figure 4 (page 17).
Figure 4. Quality of Community Health Assessments

<table>
<thead>
<tr>
<th>CHA Components Included</th>
<th>Percent of LHDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>96.8</td>
</tr>
<tr>
<td>Health status</td>
<td>96.8</td>
</tr>
<tr>
<td>Special populations</td>
<td>83.9</td>
</tr>
<tr>
<td>Determinants of health</td>
<td>87.1</td>
</tr>
<tr>
<td>Trends over time</td>
<td>87.1</td>
</tr>
<tr>
<td>Charts, graphs, visuals</td>
<td>96.8</td>
</tr>
<tr>
<td>Community assets</td>
<td>83.9</td>
</tr>
<tr>
<td>Health services</td>
<td>93.5</td>
</tr>
<tr>
<td>Source citations</td>
<td>96.8</td>
</tr>
<tr>
<td>Comparison/benchmarks</td>
<td>93.5</td>
</tr>
<tr>
<td>Primary data collection</td>
<td>96.0</td>
</tr>
</tbody>
</table>

Timeliness of the CHA

Timeliness was examined from two perspectives — how quickly communities moved forward to begin the CHA, and how much time elapsed between the start and completion of the CHA. Because of the small number of subjects that had completed a CHA, “early adopters” was defined as those counties that were among the first half of the respondent group to begin their CHAs. Urban or semi-urban health departments were significantly more likely than rural LHDs to be among the early adopter group (p<0.05). Health departments that had previously participated in the MLC-3 project (a multi-year learning opportunity for the purpose of building skills with quality improvement tools and techniques) were significantly more likely to be early adopters than those that had not participated (p<0.05). Early adopters were more likely than later starters to conduct their CHA under internal leadership; those that started later were more likely to rely upon the leadership of an external consultant (p<0.001).
The amount of time required to complete the CHA was highly variable, averaging 302 days. Urban/semi-urban health departments took longer to complete their CHAs than rural LHDs (p<0.001). Early adopters took longer to complete their CHAs than those that began later, while health departments where the CHA was led by an external consultant completed the process more quickly than those who self-directed their CHAs. Health departments that reported following a specific model for conducting the CHA required longer to complete their CHAs than those that did not follow a model.
Short-Term Impact of the CHA/CHIP Process

Although most communities were still working in the initial phases of the CHA/CHIP continuum and few had yet progressed to implementation of health improvement strategies, the majority of respondents identified some impact from their early CHA/CHIP efforts. At the time of the second survey, the largest perceived impacts had been in terms of raising community awareness of health issues, the formation of new community partnerships and the CHA/CHIP serving as a resource for prioritizing and planning services. Lower impact scores were given in response to questions about CHA/CHIP influence on health department budgeting decisions and development of or changes to health policies at the community level. Overall impact scores ranged from zero to 28 of a possible 33 points, with an average score of 15.9. Distribution of the overall impact scores are shown in Figure 7, page 20.
When impact score results were broken out by characteristics of the health departments and their approaches to community health assessment, some small but non-significant differences were observed. Urban health departments, health departments with previous CHA experience, and health departments that led their CHA internally rather than relying on an external consultant tended to have somewhat higher perceived impact from their CHA/CHIP efforts than their counterparts (rural, no previous CHA experience, consultant-led).

**Factors that Helped to Facilitate the CHA/CHIP Process**

In both the focus groups and surveys, study participants were asked to describe factors or resources that had been helpful to them as they worked on their CHA/CHIPS. Collaboration and strengthened relationships with community partners were mentioned most often as positive factors. In addition, a number of participants cited grant support as helpful, both in providing financial support for the work and in establishing firm timelines that had to be met. The use of external facilitators and technical assistance services were also mentioned by several as being helpful.
Among the comments received from survey participants:

- “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.”
- “Collaboration between the hospital and health department has been very beneficial.”
- “Community partners have been our biggest assets.”
- “It has been helpful to get to know other partners in the county.”

**Barriers to Completing the CHA/CHIP**

Participants were also asked to identify challenges or barriers that had impeded or slowed their progress in completing the CHA/CHIP process. Time constraints and competing priorities were cited most frequently, with numerous comments about the amount of time involved in meetings while still maintaining the daily workload. Lack of sufficient financial support for the CHA/CHIP process was also a recurrent theme. Staff turnover and other unexpected emergencies were mentioned as disruptions in some jurisdictions. Some respondents expressed a lack of satisfaction with the services provided by a contracting consultant, and frustration with the compressed CHA timelines that partnering hospitals faced to meet their IRS nonprofit requirements.

Selected comments by survey participants:

- “Time is our biggest challenge in getting meetings arranged as well as getting the survey out there.”
- “Things come up in everyday life to slow things down.”
- “Lack of funding to carry out plans to address identified needs.”
- “Time, money and staffing.”
- “Assessment was rushed and did not have a true representation of the community.”
Lessons Learned

When asked to identify what, if anything, they would do differently in their next CHA/CHIP, participants shared many insights. Several mentioned that they would invest more time in the planning phase and in developing relationships with community partners. Others expressed a desire to have broader inclusion of community members, and particularly of representatives of vulnerable populations, in the next CHA/CHIP cycle. Some indicated that they would attempt to use different tools or methods to aid in data collection and analysis, or to seek out external technical assistance with specific aspects such as analysis and interpretation of data. Several indicated that they would not hire the same consultant the next time.

Comments from survey participants:

- “Take more time in recruiting and engaging community partners. A L-O-T more time! Really work at developing those relationships.”
- “When you decide what process you are going to utilize, have someone who can get some training and really dig into the process and know what the next steps should be. We were so ‘in the moment’ trying to learn the process and teaching others about it that I felt we didn’t do as good a job.”
- “Attempt to have more diverse voices or representatives at the table. We had little faith-based input or Hispanic community voices.”
- “Have a ‘community-minded, what is in it for the good of the community, how can we improve our community’ attitude and be sure the focus stays on the community and not on the interests of a single organization or two.”

DISCUSSION

During the time period examined by this study, public health and health care practitioners in most Kansas counties have at least begun a process of community health assessment and improvement planning, and have faced both opportunities and challenges. Many have undertaken the CHA/CHIP process for the first time. Most have struggled to carve out sufficient time to complete their CHAs while continuing to meet demanding day-to-day workloads. Smaller, rural health departments have struggled with lack of internal capacity and skill to collect, analyze and interpret data, as well as facing the data limitations of handling small sample sizes related to
sparse populations. Despite these challenges, many health departments have found benefit in the new community partnerships and collaborations forged during the CHA/CHIP process, and have gained knowledge, skills and confidence that will make their future community health assessment efforts both easier and more successful. Significant growth in practitioner confidence with the CHA/CHIP process was observed and documented in this study, and substantial progression through the CHA/CHIP sequence has occurred.

In this study, the challenges of carrying out successful community health assessments in sparsely populated rural jurisdictions were revealed through both qualitative and quantitative methods. Larger health departments located in urban areas were able to move ahead with their CHAs more quickly, without reliance upon external consultants. Practitioners located in smaller, more rural communities were less confident in their own abilities, waited longer before beginning a CHA, and were more likely to rely heavily upon the guidance of a consultant to lead them through the process. Many of the more rural health departments worked in close collaboration with their community hospitals, and the consultants that were hired by the hospitals to complete the required community health assessments. Although the consultant-led CHAs were completed more quickly, comments from study participants and early assessment of CHA/CHIP impact suggest that there may have been some tradeoffs of inclusiveness for the sake of expediency, and that communities that took longer to work through the process on their own may be realizing more impact as a result of their efforts.

Results from this study indicate that the majority of health departments that have engaged in community health assessment and community health improvement planning have found the process to yield short-term impact even though most have not yet completed the CHIP or begun implementation of health improvement strategies. Areas where the CHA/CHIP processes were rated as having the greatest impact were in raising community awareness of health issues, formation of new community partnerships, and serving as a resource for prioritization and planning of services. The lowest average impact ratings were given to CHA/CHIP influence on health department budgeting decisions and development of or changes to health policies at the community level. These findings suggest that health departments are realizing some immediate benefit of their CHA/CHIP efforts in terms of building and strengthening community partnerships and increased awareness of community health issues, but may not yet have fully
realized potential benefits in terms of using the CHA/CHIP as a basis for strategic planning, resource allocation and policy development. It is still too early to assess the longer-term impact in terms of improvements in the health of their communities.

**STUDY LIMITATIONS**

This study had several limitations. First, the small number of counties that had completed at least the CHA phase of the CHA/CHIP process limited our ability to fully explore and analyze relationships between predictor variables and study outcomes. Second, because many study participants were still working on completing community health assessments and developing community health improvement plans at the close of the study, it is likely that our results understate the full impact that will be realized by the completed CHA/CHIPs. Our approach to quality assessment of the CHA, while reassuring that almost all study participants reported high levels of conformance with widely accepted desired characteristics, failed to identify sufficient variability to be useful in assessing factors associated with higher levels of quality. This may be due, in part, to our reliance upon self-reported descriptions of CHA content. A different approach employing independent review of completed CHA/CHIP documentation could possibly have yielded different results.

**CONCLUSIONS**

By late summer of 2013, the majority of local health departments in Kansas had at least begun work on a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). For most, the work was still in process at the conclusion of this study. Few had completed their CHIPs and moved on to the implementation phase. They have met challenges and barriers along the way, and have also forged new community partnerships and identified opportunities. Despite the challenges and barriers that have been faced, local health departments and hospitals in Kansas are responding to the call for assessment to be viewed as an essential part of their service to their communities, are gaining confidence and developing their capacities to conduct community health assessments, and are beginning to see returns on that investment in terms of new community partners who can share in the work of improving community health.
APPENDIX A: FOCUS GROUP INTERVIEW SCRIPT

Title: Factors that Influence the Timeliness and Quality of Community Health Assessments and Community Health Improvement Plan Activities in Kansas

INTRODUCTION

Good morning/afternoon and welcome to our session. Thank you for taking the time to join our discussion. My name is _______________ and I am with the KU School of Medicine-Wichita. Assisting me is ______________.

You have been invited to share your thoughts and opinions about how Community Health Assessments (CHA) and Community Health Improvement Plan (CHIP) activities are accomplished in your community. Specifically, we would like to know your opinions on factors that may influence the timeliness of CHA and CHIP progression and what factors might influence the quality of a CHA/CHIP in your area. We will ask a series of questions and would like for you to respond openly. This session will last approximately _____ hours. We will be tape recording our discussion and taking notes on a laptop computer. Your name will not be used in any reports related to this session.

Now, let me share a few ground rules. Please use first name only (this applies specifically during the focus group interview). There are no right or wrong answers and your participation is completely voluntary. You do not have to answer any questions that make you uncomfortable. If you become uncomfortable, you can stop participating at any time. Please respect the privacy of other members in the group by not disclosing any personal information that might be shared during the focus group discussions. Also, please maintain complete privacy of the conversation taking place and do not repeat anything that may be said to anyone outside of this group. You may quit at any time without any problem.
Please remember that there are no wrong answers, only different points of view. We want to make sure that everyone feels comfortable expressing his or her own opinion. So, all we ask is that you are respectful of everyone by listening to one another and waiting until the person speaking has finished before you begin. Because everything everyone says is important, we also ask that you try not to have a side conversation with anyone else during the discussion. What you are saying may be something that everyone could comment on and could provide us with useful information as well. In addition, it can be very hard to make out what is being said on the tapes if more than one person is talking at once. Let’s begin.

I. Definition of CHA/CHIP

CHA

1. Please tell us, in your own words, what a community health assessment is?
   a. How would you define a Community Health Assessment (CHA)?

CHIP

1. Now, let’s talk a little bit about what you think a Community Health Improvement Planning (CHIP) process is? How would you define a CHIP?

Why do communities adopt the CHA/CHIP process?

II. CHA/CHIP INPUTS — LHD Capacity and Capability

In the past three years, has a health needs assessment that included the use of morbidity, mortality, and vital statistics data been conducted? (needs; Richards, 1995)

In the past three years, has a population survey on health behaviors been conducted in your community? (behaviors; Kanarek, 2006)

In the past three years, has your population been surveyed for behavioral risk factors? (high-risk behaviors; Richards, 1995; Kanarek, 2006)

In the past three years, has your population been surveyed for priority health needs and/or health resources? (priority; Richards, 1995; Kanarek, 2006)
In the past three years, has your population been surveyed by age to assess participation in preventive and screening services? (age-specific behaviors; Richards, 1995; Kanarek, 2006)

Tell us about your experiences with this process:

Can you describe how they were conducted?

In your community what groups or persons were involved?

Next we’d like to you tell us about what resources you think are needed to perform a CHA/CHIP?

As you consider activities that will be needed to conduct a CHA/CHIP, what skills do you think will be needed to perform these activities? From your perspective, what expertise is required?

What sources of data would you use to formulate a health assessment in your community?

What sources of data are not available?

Community Partners

1. How will you develop partnerships within the community to support assessment efforts? To support planning efforts? To support implementation efforts?

2. What organizations do you plan to invite to participate?

3. What criteria would you plan to use to choose your partnering organizations? What are characteristics you think are important?

4. What are the motivators for your community to pursue a CHA/CHIP process? For your organization?

5. What are reasons to participate? To not participate?

6. How will you work with the community? How do you plan to involve community groups? Will the process be open (to the public comment or driven primarily by the CHA/CHIP leadership group)?

What barriers, from your perspective, may prevent or impede progress toward conducting a CHA . . . from completing the CHIP plan?
Communication Plan

1. Would you tell us about how you intend to communicate information about the CHA/CHIP in your community?
   
   a. Will the communication strategy change for different target groups?
   
   b. What methods are planned? (internet, newspaper, radio, presentations, newsletters, flyers, reports)?
   
   c. What group will be responsible for communicating information?
   
   d. What communication channels were useful in the CHA/CHIP process?

Performance management tools assist in ongoing monitoring of progress

1. LHD Capacity — QI Principles
   
   a. What (if any) QI principles and/or tools have you and your staff used when conducting a CHA/CHIP?
   
   b. What IT (Information Technology) tools have you used? How helpful were these IT tools in relation to the QI principles/tools?
   
   c. How have you and your staff used these QI principles and tools when conducting a CHA/CHIP? *(Have participants provide examples of how they have used these tools/principles or how they plan to use these tools/principles.)*

Decision-making methods

1. What methods will your community use to identify community priorities? Discussion, matrix, small group identifies the priorities and makes recommendations, consensus?

2. How were decisions made about how priorities will be addressed (responsibility, resource allocation)

3. What individual or groups influenced the adoption and implementation of the CHA/CHIP?
III. CHA/CHIP PROCESS — Community Partner Involvement

1. Community partners, stakeholders and health care providers (Byrne et al., 2002)
   a. Who did you involve as community partners in your CHA/CHIP activities? 
      (Respondents do not have to identify a person by name, but they do need 
      to state what position they hold and what organization they are associated 
      with.)
   
   b. What roles did your community partners play in CHA/CHIP activities? Explain.

   i. How involved are elected officials in your community in public health?
      (Richards, 1995)

   How effective are local partnerships between hospitals and LHDs in promoting 
   the completion of high-quality CHAs/CHIPs? Is there any trade-off resulting from 
   these partnerships that should be taken into account?

IV. CHA/CHIP OUTPUTS/OUTCOMES

How are the results of your CHA/CHIP activities used?
   a. How are they used in prioritizing community health problems?
   b. How are they used in local health planning?
   c. How are they used in developing local health policies?

Regional versus county-based CHA/CHIP

What do you perceive as the advantages and disadvantages of conducting a CHA/CHIP 
on a regional versus single-country basis?

Are some portions of a CHA/CHIP process more suitable than others for a regional 
approach versus a county approach? What portion of the CHA would be best suited to 
the regional approach? To the county level approach?

What characteristics of the CHA process influenced its adoption within the 
region/county?
APPENDIX B: FOCUS GROUP QUESTIONNAIRE

1. What is your GENDER?
   1. Female
   2. Male

2. What category best represents your AGE?
   1. 20 years or younger
   2. 21-30 years
   3. 31-40 years
   4. 41-50 years
   5. 51-60 years
   6. 61 years or older

3. In what preparedness REGION of the state do you work? _____________

   1. Northwest BT Region
   2. West Central Public Health Initiative
   3. Western Pyramid
   4. Southwest Kansas Health Surveillance
   5. North Central Kansas Public Health Initiative
   6. Central Kansas
   7. South Central Coalition
   8. Kansas South Central Metro
   9. Northeast Corner
   10. Wildcat
   11. East Central Coalition
   12. Lower 8 of Southeast Kansas
   13. Kansas City Metro
   14. Southeast Kansas
4. In the following list, please place an “X” next to the groups you plan to include in your CHA/CHIP process?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Schools</td>
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<tr>
<td>2</td>
<td>Academics</td>
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<tr>
<td>3</td>
<td>Businesses</td>
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<tr>
<td>4</td>
<td>Director of local health department</td>
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<tr>
<td>5</td>
<td>Elected officials</td>
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<td>6</td>
<td>Emergency Management Services</td>
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<tr>
<td>7</td>
<td>Employers</td>
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<td>8</td>
<td>Environmental health agency/organization</td>
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<tr>
<td>9</td>
<td>Epidemiology staff</td>
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<tr>
<td>10</td>
<td>Faith-based organizations</td>
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<td>11</td>
<td>Fire department</td>
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<td>12</td>
<td>Health officer/medical consultant</td>
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<td>13</td>
<td>Health insurance companies</td>
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<td>14</td>
<td>Home health</td>
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<td>15</td>
<td>Law enforcement</td>
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<td>16</td>
<td>Hospitals</td>
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<td>17</td>
<td>Long-term care</td>
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<td>18</td>
<td>Laboratories</td>
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<td>19</td>
<td>Mental health</td>
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<td>20</td>
<td>Media</td>
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<tr>
<td>21</td>
<td>Nonprofit organizations</td>
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<tr>
<td>22</td>
<td>Neighborhood organizations</td>
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<tr>
<td>23</td>
<td>Other health care delivery organizations</td>
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<tr>
<td>24</td>
<td>Physicians</td>
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<tr>
<td>25</td>
<td>Program supervisor or coordinator</td>
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<td>26</td>
<td>Program director(s)</td>
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<tr>
<td>27</td>
<td>Regional coordinator</td>
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<tr>
<td>28</td>
<td>Social service agency/organization</td>
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<td>29</td>
<td>State agencies</td>
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<tr>
<td>30</td>
<td>Substance abuse treatment facilities</td>
</tr>
</tbody>
</table>

Other community partner (please list)____________________________________
5. In the following list, please place an “X” next to information sources your community has used for CHA activities?

<table>
<thead>
<tr>
<th></th>
<th>Information Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>State data sets</td>
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<tr>
<td>2</td>
<td>County health rankings</td>
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<td>3</td>
<td>State vital records</td>
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<td>4</td>
<td>Healthy People 2020</td>
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<td>5</td>
<td>Previous CHAs or reports</td>
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<td>6</td>
<td>United Way reports</td>
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<td>7</td>
<td>Hospital CHNA information</td>
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<td>8</td>
<td>Federally qualified community health centers assessment</td>
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<td>9</td>
<td>Local partners who have access to their data through their organizations</td>
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<tr>
<td>10</td>
<td>County government agencies (courts, police, schools, libraries, parks, city planners)</td>
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<td>11</td>
<td>Nonprofit organizations</td>
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<tr>
<td>12</td>
<td>Managed care organizations, insurance companies</td>
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<tr>
<td>13</td>
<td>Universities and colleges</td>
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<tr>
<td>14</td>
<td>Chambers of Commerce</td>
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</tbody>
</table>
7. In the following data sources, please place an “X” next to those information sources you plan to use in your community health assessment process?

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<table>
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<tbody>
<tr>
<td><strong>1. Maternal/Child health data</strong></td>
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<td>2. Pregnancy Risk Assessment Monitoring System (PRAMS)</td>
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<td>3. Youth Risk Behavioral Surveillance (YRBS)</td>
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<td>4. Behavioral Risk Factor Surveillance System (BRFSS)</td>
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<td>5. Injury data</td>
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<td>6. Chronic diseases</td>
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<td>7. Vital records</td>
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<td>8. Community Health Status Indicators (CHSI)</td>
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<td>9. Disease outbreak data</td>
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<td>10. Environmental hazards</td>
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<td>11. Community surveys</td>
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<td>12. Population health status</td>
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<td>13. Outbreak investigations</td>
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<td>14. Cluster investigation reports</td>
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<td>15. Epidemiologic reports</td>
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<td>16. CDC National Public Health Performance Standards Program State Public Health System (NPHPSP SPHS)</td>
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<td>17. Demographics via U.S. Census Data</td>
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<td>18. Access to health care</td>
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<td>19. Local health care environment</td>
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<td>20. High risk groups</td>
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<td>21. Unmet service needs</td>
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<td>22. Community assets (resources)</td>
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</tbody>
</table>

What additional data sources might you use?
SECTION TWO INSTRUCTIONS: Using the ruler below, please rate your confidence in your ability to perform each of the following activities by placing an “X” on the ruler as a result of the MLC experience/process:

For example:

![Ruler with X mark]

1. I can describe my role in the development of a community health assessment specific to my setting (e.g., state health department, local health department, region).

2. I can apply team concepts to my work with health department employees in my setting.

3. I can identify data from multiple sources.

4. I can assemble data from multiple sources.

5. I can organize/synthesize data sources into a report.

6. I can compare the data from my region to data from “peer community” or “peer region”.

Place an “X” at the point that represents your confidence level.
7. I can apply quality improvement tools/techniques appropriate for community health assessment.

-5 0 5
Not confident at all Extremely confident

8. I can apply at least one community engagement technique.

-5 0 5
Not confident at all Extremely confident

9. I can develop a public health issue statement.

-5 0 5
Not confident at all Extremely confident

10. I can identify community strengths and challenges

-5 0 5
Not confident at all Extremely confident

11. I can identify community health priorities.

-5 0 5
Not confident at all Extremely confident

12. I can assign roles to address community health priorities.

-5 0 5
Not confident at all Extremely confident
APPENDIX C: SURVEY INSTRUMENT

Kansas Health Institute

PBRN CHA/CHIP Study — Follow-up Survey Instrument

Introduction:

Thank you for your participation in this study of Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes in Kansas. This study is being conducted by the Kansas Health Institute and the University of Kansas School of Medicine-Wichita, for the purpose of increasing understanding of the factors that are either helpful or serve as barriers to health departments’ timely completion of high-quality CHAs and CHIPs. We are asking that you or a representative of your organization complete this survey to help us learn about CHA/CHIP progress has been made in Kansas during the past year. Results of this study will be shared with participants at a Learning Congress that will be held in the fall of 2013.

A representative from your organization may have completed a baseline survey in August of 2012. If so, a copy of your organization's responses to the baseline survey has been sent to you by separate email; it may be helpful to refer to that document as you complete this survey.

We estimate that this survey should take about 15–20 minutes to complete, and your participation is completely voluntary. The information you provide will be kept in strict confidence. Your responses will be aggregated with those from other organizations, and will not be identified by your name or organization. If you begin the survey, you may discontinue at any time. You may choose not to answer any question which makes you uncomfortable. If you have any questions regarding this study, please contact Barbara LaClair (blaclair@khi.org) at the Kansas Health Institute, (785) 233-5443.

Do you agree to participate in this survey?

☐ Yes, I agree to participate.
☐ No, I decline to participate. (SKIP TO END)

SECTION 1: ORGANIZATIONAL DESCRIPTION

A. About your Organization:

Organization Name:____________________________

Name of person completing this survey: ______________________

Position within your organization:__________________________

Email address:_________________________________________

Telephone number:______________________________________
B. Quality Improvement Concepts, Tools and Methods

1. To what degree are leaders (executive managers, directors or supervisors) in your organization comfortable with employing Quality Improvement tools and techniques? (select one response)

   □ Not comfortable
   □ Somewhat comfortable
   □ Mostly comfortable
   □ Very comfortable
   □ Don’t know

2. Prior to January 2011, had your organization ever completed a Community Health Assessment?

   □ Yes □ No

SECTION 2. CHA/CHIP PROGRESSION

1. Please describe in your own words where you are in the CHA/CHIP process, and your major accomplishments to date: (open-ended)

2. Which of the following best describes where your organization is currently in the CHA/CHIP process? (select only one)

   □ No plans - At this time, we have no plans to conduct a Community Health Assessment or Community Health Improvement Plan. (If selected, SKIP to end of survey).
   □ Planning phase - Project team and other major stakeholders are in the process of defining project scope, methods, schedule, and preparations for next phase. Planning phase ends when data collection related to the CHA begins.
   □ Conducting Community Health Assessment - Project team is actively involved in collecting, compiling and analyzing data related to community health, or the write-up of preliminary findings. This phase ends when the priority setting process with community partners begins.
   □ Priority setting with partners - Preliminary Community Health Assessment report has been completed, and stakeholder and community feedback is being or has been sought. With input from stakeholders, community health priorities are being identified. This phase ends when priorities have been identified.
   □ Working on Community Health Improvement Plan - Community health priorities have been identified, and planning process is underway to identify interventions and strategies to address the priorities. This phase ends when strategies and interventions have been
identified, responsible parties and timelines have been assigned, and the CHIP document is ready for public release and dissemination.

☐ Dissemination of the Community Health Improvement Plan — The CHIP has been finalized and is being released and disseminated. Community discussion and presentation of the material, and efforts to build community support for the CHA/CHIP strategies may be taking place. This phase ends when partners have adopted sections of the CHIP and start working toward implementation of the strategies.

☐ Implementation of CHA/CHIP-identified strategies - Implementation of strategies outlined in the CHIP has begun. Partners have officially adopted sections of the CHIP, have developed an agency-specific strategic plan, and are working toward implementation of the strategies. This phase does not end until beginning of new CHA or partner agencies no longer reference or follow strategies outlined in the plan.

3. Have your plans for conducting a CHA/CHIP changed in any way in the past year? (Yes/No)

If YES, in what way have your plans changed?

SECTION 3. THE COMMUNITY HEALTH ASSESSMENT

Community Health Assessment (CHA): A Community Health Assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a CHA is to develop strategies to address the community’s health needs and identified issues. Essential ingredients are community engagement and collaborative participation. (Modified from definition from Public Health Accreditation Board, Acronyms and Glossary of Terms, Version 1.0, September 2011)

Since January of 2011, has your organization either begun work on or completed a Community Health Assessment?

☐ Yes ☐ No (If YES, continue; IF NO, SKIP to END)

When did you begin work on your CHA? (mm/dd/yyyy)________________
A. CHA COLLABORATION:

1. Is/was your Community Health Assessment conducted at the county or regional level? (The term “regional” in this survey refers to the public health preparedness regions.) *(check only one)*
   - Single County (assessment covers only your county)
   - Partially Regional (some portions include full region, or portions of your region)
   - Fully Regional (entire assessment includes full region, or portions of your region)

2. To what extent did the local health department and the local hospital collaborate on your Community Health Assessment? (Other partners may have also contributed to the process, but we are primarily interested here in the degree of collaboration between the health department and hospital.) *(check only one)*
   - The health department and hospital worked together to conduct one CHA, with one report (which may contain specific sub-sections only applicable to the health department or hospital)
   - The health department and hospital developed portions of the CHA together, but produced separate reports
   - The health departments and hospital worked separately on their CHAs and produced separate reports (either or both completed a CHA)
   - The health department developed a CHA without a hospital because there is no local hospital
   - Other (specify) ____________________________________________________________

B. MODEL: Was a formal model used to guide development of your CHA? *(check all that apply)*

- Mobilizing for Action through Planning and Partnership (MAPP)
- Healthy Cities/Communities
- Community Indicators Project
- National Public Health Performance Standards Program (NPHPS)
- Assessment Protocol for Excellence in Public Health (APEX/PH)
- Protocol for Assessing Excellence in Environmental Health (PACE-EH)
- Institute of Medicine CHA/CHIP model
- Other (specify) ____________________________________________________________
- No formal model used
C. CHA DATA SOURCES:

1. What data sources or information systems have you utilized in obtaining data for your Community Health Assessment?

<table>
<thead>
<tr>
<th>I used this resource........</th>
<th>To a large extent</th>
<th>Somewhat</th>
<th>Only a little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census.gov, American FactFinder</td>
<td></td>
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</tr>
<tr>
<td>KDHE Vital Statistics summary reports (printed or online)</td>
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<tr>
<td>KDHE BRFSS summary reports or online data</td>
<td></td>
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<tr>
<td>KS Department of Education statistics</td>
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<tr>
<td>U.S. Bureau of Labor Statistics online data</td>
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<tr>
<td>Kansas County Health Rankings</td>
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<tr>
<td>Kansas Information for Communities (KIC) online system</td>
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<tr>
<td>Kansas Health Matters online system</td>
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<tr>
<td>Local information systems</td>
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<tr>
<td>Community input (surveys, focus groups, town hall meetings)</td>
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<tr>
<td>Secondary reports from partner organizations</td>
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<tr>
<td>Other:___________________________</td>
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<td>Other:___________________________</td>
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<td>Other:___________________________</td>
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<tr>
<td>Other:___________________________</td>
<td></td>
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</tbody>
</table>

2. Have you completed your CHA?

☐ Yes ☐ No (If YES, continue; IF No, SKIP to Section 8. Strategic Plan)

When did you complete your CHA? (mm/dd/yyyy) ______________________________

D. CHA CONTENT

<table>
<thead>
<tr>
<th>Does your Community Health Assessment....</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the demographic characteristics of your community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe key measures of health status in your community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe key measures of health issues in your community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe the health issues of special populations such as uninsured, low-income or minorities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe key measures of contributory factors influencing health in your community? (Behaviors, injuries, environmental factors, built environment, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compare trends and changes in performance indicators over recent years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorporate visual aids, such as charts, graphs, tables or maps?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe community assets and resources?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe health-related services available or needed in your community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include source citations for all data included in the CHA?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E. CHA COMPARISONS:

1. Does your Community Health Assessment include comparisons of local performance to that of any of the following other locations or benchmarks? (check all that apply)

   - Other Kansas counties
   - Your public health region
   - Other public health regions
   - Kansas state-level values
   - National values
   - Healthy People 2020 goals
   - Other benchmarks (specify): ____________________________
   - No comparisons are used

SECTION 4: DISSEMINATION AND PRIORITY SETTING

A. DISSEMINATION OF COMMUNITY HEALTH ASSESSMENT:

1. Have you begun to share, or completed sharing, preliminary findings from your Community Health Assessment with community members and invited their feedback?

   - Yes  □ No  □ (If NO, SKIP to 4.B.1 Prioritization)

   Date dissemination of the CHA findings began (mm/dd/yyyy)______________________.

2. Through what means have you disseminated preliminary findings of your CHA to members of your community, and sought community input? (check all that apply)

   - Dissemination of the report to partner organizations
   - Dissemination to public, without mechanism(s) for comment or feedback
   - Distribution to public, with a mechanism to invite public comment
   - Publication of the report on your organization’s website, without web-based comment form
   - Publication of the report on your organization’s website, with web-based comment form
   - Publication of findings in local newspaper
   - Distribution through local library
   - Presentation and discussion at meetings of local groups/organizations
   - Public forums or events, such as town hall meeting(s)
   - Other (specify) ____________________________________________________________________
3. Have you completed your CHA dissemination and community engagement?

☐ Yes ☐ No (If YES, Continue to next Question; If NO, SKIP TO SECTION 4.B.1, Prioritization)

Date CHA dissemination and community engagement activities were completed (mm/dd/yyyy)______________________.

B. IDENTIFICATION OF PRIORITIES:

1. Have you begun work to identify priority health issues for your community?

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO SECTION 4.C.1. Resources)

Date prioritization activities began (mm/dd/yyyy)______________________.

2. What methods did you use to identify priority issues for your CHIP? (check all that apply)

☐ Consensus-building
☐ Voting
☐ Prioritization matrix
☐ Criterion-based selection
☐ Selected by leadership group
☐ Other (specify)________________________________________________________

3. Partners in Prioritization: Please indicate the extent to which each of the following have participated as partners in identification of health priorities in your community:

<table>
<thead>
<tr>
<th>These partners participated…</th>
<th>To a large extent</th>
<th>Somewhat</th>
<th>Only a little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health department(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local hospital(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governing bodies or elected official(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community physician(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public schools (K-12)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Higher education institution(s)</td>
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</tr>
<tr>
<td>Local businesses</td>
<td></td>
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<tr>
<td>Faith-based organization(s)</td>
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<tr>
<td>Law enforcement</td>
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<tr>
<td>Philanthropic organization(s)</td>
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<tr>
<td>Other nonprofit organization(s)</td>
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<td></td>
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<tr>
<td>Other community-based organization(s)</td>
<td></td>
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</tr>
<tr>
<td>Members of the community</td>
<td></td>
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</tbody>
</table>
C. RESOURCES AND SUPPORT FOR CHA PROCESS:

1. Were any technical assistance resources available within your county or region to assist with development of your CHA? (Examples: facilitators, help with data analysis)

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 4.C.2, non-local TA question)

If yes, were local technical assistance resources utilized in your CHA process?

☐ Yes ☐ No

If yes, please describe___________________________________________________________

2. Were any technical assistance resources from outside of your county or region utilized to assist with development of your CHA?

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 4.C.3, funding question)

If yes, please describe___________________________________________________________

3. Was any dedicated local funding available to support your CHA activities? (Please do not include contributions of staff time in your answer.)

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO non-local 4.C.4, external financial resources question)

IF yes, how much? ___ Less than $1,000 ___ $1-5,000 ___ More than $5,000

Source of funding: ____________________________

4. Have external financial resources (grants, other sources of funding) been obtained for support of CHA activities?

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 4.C.5 Completion of Priorities Question)

If yes, how much? ___ Less than $1,000 ___ $1-5,000 ___ More than $5,000

Source of funding: ____________________________
5. Have you completed identification of health priorities for your community?

☐ Yes ☐ No (If YES, Continue to next Question; If NO, SKIP TO Section 8: Strategic Plan)

Date CHA prioritization activities were completed (mm/dd/yyyy)__________________.

SECTION 5: COMMUNITY HEALTH IMPROVEMENT PLAN

Community Health Improvement Plan (CHIP): A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community. (Public Health Accreditation Board, Acronyms and Glossary of Terms, Version 1.0, September 2011)

Has your organization either begun work on, or completed a Community Health Improvement Plan?

☐ Yes ☐ No (If YES, continue to next questions, If NO, SKIP to Section 8: Strategic Plan)

Date your Community Health Improvement planning process began (mm/dd/yyyy) ______________

A. CHIP COLLABORATION

1. Is/was your Community Health Improvement Plan developed at the county or regional level? (Check only one)

☐ Single County (Plan covers only your county)
☐ Partially Regional ( Portions of the plan include full region, or portions of your region)
☐ Fully Regional (Entire Plan includes full region, or portions of your region)
2. To what extent have the local health department and the local hospital collaborated on your Community Health Improvement Plan? (Other partners may have also contributed to the process, but we are primarily interested here in the degree of collaboration between the health department and hospital.) *(Check only one)*

- The health department and hospital worked together to conduct one CHIP, with one report (Which may contain specific sub-sections only applicable to the health department or hospital.)
- The health department and hospital developed portions of the CHIP together, but produced separate reports
- The health departments and hospital worked separately on their CHIPS and produced separate reports. (Either or both completed a CHIP)
- The health department developed a CHIP without a hospital because there is no local hospital
- Other (specify) ______________________________________________________________

B. CHIP PARTNERSHIPS: Please indicate the extent to which each of the following have participated as partners in identification of interventions or strategies for your CHIP:

<table>
<thead>
<tr>
<th>These partners participated...</th>
<th>To a large extent</th>
<th>Somewhat</th>
<th>Only a little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health department(s)</td>
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<td>Community physician(s)</td>
<td></td>
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<td>Local businesses</td>
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<tr>
<td>Faith-based organization(s)</td>
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<td>Law enforcement</td>
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<tr>
<td>Philanthropic organization(s)</td>
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<td></td>
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<tr>
<td>Other nonprofit organization(s)</td>
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<td></td>
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<tr>
<td>Members of the general community</td>
<td></td>
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</tr>
</tbody>
</table>
C. RESOURCES AND SUPPORT FOR CHIP PROCESS:

1. Were any dedicated local funding sources available to support your CHIP planning activities? (Please do not include contributions of staff time in your answer.)

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 5.D.2 local TA question)

If yes, how much? ___ Less than $1,000 ___ $1-5,000 ___ More than $5,000

2. Were any technical assistance resources from within your county or region utilized to assist with development of your CHIP? (Examples: facilitators, help with data analysis)

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 5.D.3 non-local TA question)

If yes, please describe___________________________________________________________

3. Were any technical assistance resources from outside of your county or region utilized to assist with development of your CHIP?

☐ Yes ☐ No (If YES, continue; If NO, SKIP TO 5.3.4 Completion of CHIP Question)

If yes, please describe___________________________________________________________

4. Have you completed your Community Health Improvement Plan?

☐ Yes ☐ No (If YES, continue to next question, If NO, SKIP TO Section 8: Strategic Plan)

When was your CHIP document completed? (mm/dd/yyyy)__________________________

D. CHIP CONTENT: Does your Community Health Improvement Plan...

<table>
<thead>
<tr>
<th>Does your Community Health Improvement Plan...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe issues and themes identified by stakeholders?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Align with state and national priorities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include plans to measure and monitor health outcomes?</td>
<td></td>
<td></td>
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<tr>
<td>Have measurable objectives and timeframes for completion?</td>
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<tr>
<td>Include action steps for entities beyond the Local Health Department who have agreed to accept responsibility?</td>
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</tr>
<tr>
<td>Identify community assets and resources to be utilized in health improvement activities?</td>
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<td></td>
</tr>
<tr>
<td>Identify stakeholders that have accepted responsibility for implementation of action steps?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 6: DISSEMINATION OF COMMUNITY HEALTH IMPROVEMENT PLAN:

1. Have you either begun, or completed dissemination of your Community Health Improvement Plan to members of your community?

☐ Yes ☐ No (If yes, continue; IF NO, SKIP to SECTION 7: INTERVENTIONS)

Date CHIP dissemination activities began (mm/dd/yyyy) __________________________

2. Through what means have you disseminated your Community Health Improvement Plan? (Check all that apply)

☐ Shared report with partner organizations
☐ Distribution to public, without mechanisms for feedback
☐ Distribution to public, with a mechanisms to invite public comment
☐ Publication of the report on website, without web-based comment form
☐ Publication of the report on website, with web-based comment form
☐ Publication of findings in local newspaper
☐ Distribution to local library
☐ Presentation and discussion at local meeting(s)
☐ Presentation at public forums or events, such as town hall meetings
☐ Other (please describe)

__________________________________________________________________________

3. Have you completed dissemination of your CHIP?

☐ Yes ☐ No (IF YES, continue; IF NO, SKIP TO Section 7: Interventions)

Date CHIP dissemination activities were completed (mm/dd/yyyy) __________________

SECTION 7: IMPLEMENTATION OF CHIP INTERVENTION STRATEGIES

1. Has your organization begun to implement the intervention strategies identified in your Community Health Improvement Plan?

☐ Yes ☐ No ( IF YES, continue; If NO, SKIP TO Section 8: Strategic Plan)

Date you began implementation activities (mm/dd/yyyy) __________________________
2. Have you completed implementation of your CHIP intervention strategies?

☐ Yes ☐ No (If YES, continue; If NO, SKIP to 7.A.1. Funding sources question)

Date implementation activities ended (mm/dd/yyyy) ______________________

A. RESOURCES AND SUPPORT FOR INTERVENTIONS:

1. Are any dedicated local funding sources available to support your CHIP interventions?

☐ Yes ☐ No (If YES, continue; If NO, SKIP to External Funding question)

IF yes, how much? ___ Less than $1,000 ___ $1-5,000 ___ More than $5,000

2. Have external resources (grants, other sources of funding) been actively sought for support of CHIP interventions?

☐ Yes ☐ No (If YES, continue; If NO, SKIP to Section 8: Strategic Plan)

If yes, have external resources been obtained to support CHIP interventions?

☐ Yes ☐ No

SECTION 8: STRATEGIC PLANNING

Strategic Plan - A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Public Health Accreditation Board, Acronyms and Glossary of Terms, Version 1.0, September 2011)

1. Has your organization either developed a new or revised an existing Strategic Plan, based upon findings from your CHA/CHIP process?

☐ Yes ☐ No (If YES, continue; If NO, SKIP to Section 9: Impact)

Date strategic planning activities began (mm/dd/yyyy) ______________________
2. Have strategic planning activities been completed?

☐ Yes ☐ No *(If YES, continue; If NO, SKIP to Section 9: Impact)*

Date strategic planning activities concluded (mm/dd/yyyy) __________________

SECTION 9: IMPACT OF CHA/CHIP PROCESS

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

<table>
<thead>
<tr>
<th>Has your CHA/CHIP...</th>
<th>A lot</th>
<th>Somewhat</th>
<th>Only a little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised community awareness of health issue(s)?</td>
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<tr>
<td>Been implemented as planned, according to the plan timeline?</td>
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</tbody>
</table>

2. What factors or resources have been helpful to you as you have progressed through your CHA/CHIP process? What has helped you to move forward?
3. What challenges or barriers have impeded or slowed your progress in completing your CHA/CHIP?

4. What, if anything, would you do differently the next time you conduct a CHA/CHIP?

This survey is now complete. Thank you for your participation.
## APPENDIX D:
CHA/CHIP QUALITY AND IMPACT SCORING ALGORITHMS

### Quality Scoring: Community Health Assessment

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHAB Reference</th>
<th>Data Source</th>
<th>Scoring</th>
<th>Documentation/Interpretation</th>
<th>Max Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variety of data sources used</td>
<td>1.1.2 T/L</td>
<td>Survey, 3.C.1</td>
<td>4 + sources=2 2–3 sources = 1 0–1 sources = 0</td>
<td>Number of sources identified as being used somewhat or to a large extent</td>
<td>2</td>
</tr>
<tr>
<td>Demographic data are described</td>
<td>1.1.2 T/L</td>
<td>Survey, 3.D.1</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data describe key health issues in community</td>
<td>1.1.2 T/L</td>
<td>Survey, 3.D.3</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data describe health issues of special populations</td>
<td>1.1.2 T/L</td>
<td>Survey 3.D.4</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data include determinants of health/contributory factors</td>
<td>1.1.2 T/L</td>
<td>Survey 3.D.5</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Community assets and resources are identified</td>
<td>1.1.2 T/L &amp; 5.2.1L</td>
<td>Survey 3.D.8</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data describe health-related services available or needed in community</td>
<td>1.1.2 T/L &amp; 5.2.1L</td>
<td>Survey 3.D.9</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data compare trends and changes in measures over time</td>
<td>1.3.1A</td>
<td>Survey, 3.D.6</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Data profile includes visual aids such as charts, graphs, tables or maps</td>
<td>N/A</td>
<td>Survey, 3.D.7</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Citations for data sources are included</td>
<td>1.2.3A</td>
<td>Survey, 3.D.10</td>
<td>Yes = 1</td>
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<td>1</td>
</tr>
<tr>
<td>Primary data were collected</td>
<td>1.2.3A</td>
<td>Survey, C.1.10</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
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<tr>
<td>Local data are compared to other counties, regions, state or national data</td>
<td>1.3.1A</td>
<td>Survey, E.1</td>
<td>Yes = 1</td>
<td></td>
<td>1</td>
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<tr>
<td>TOTAL MAXIMUM SCORE</td>
<td></td>
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<td></td>
<td>13</td>
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</table>
## CHA/CHIP Impact Scoring Algorithm

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**TOTAL SCORE** (Range of possible scores 0 to 33)
APPENDIX E: REFERENCES


