This article evaluates the status of community health assessment in Kansas. It describes community characteristics associated with community health assessment completion, factors contributing to success, as well as barriers and limitations that prevented Kansas communities from initiating a community health assessment or completing the process. Survey findings show that certain community characteristics such as interagency cooperation, history of success at problem solving, and shared decision-making power are strongly associated with completion of a community health assessment. Results also indicate that factors such as lack of leadership, money, and time as well as poor functioning coalitions may hinder the completion of community health assessment.

Key words: coalition, community capacity, community health assessment

Background

Community health assessment processes are tools developed to guide communities in identification of health concerns, recognition of multiple factors which affect people's health, development of collaborative ways of working, identification of resources, and generation of ideas for community involvement and action.1,2 By encouraging citizen involvement and participation, community assessment empowers people to have an active voice in decisions influencing their health.3 Community health assessment is usually a joint effort of local government, business, health organizations, and community groups.4

There is no single method for conducting a comprehensive community health assessment. However, most community health assessment shares common steps such as:

1. definition and identification of the community
2. identification of key players
3. review and/or collection of data
4. setting of priorities
5. development of a community health plan
6. implementation of a community health plan
7. evaluation of the process5

In its report, The Future of Public Health, the Institute of Medicine identified assessment as one of the core functions of public health and recommended that there should be a systematic and periodic collection, aggregation, and analysis of information on the health of communities. The Institute of Medicine

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also recommended that state and local public health agencies be responsible for assessing the needs of the communities, analyzing the cause of the problems, collecting and interpreting data, monitoring trends and evaluating outcomes.6

In 1995, the Kansas Department of Health and Environment, Kansas Association of Local Health Departments, and Kansas Hospital Association published the Community Health Assessment Process (CHAP) workbook and provided technical assistance to Kansas communities involved in assessment whether or not they were interested in using this model. The CHAP was divided into six phases:

1. involving and educating the community (coalition building)
2. reviewing community data
3. collecting community data
4. understanding community data
5. developing the community plan
6. implementing and evaluating the community plan

The first five phases were expected to be completed in approximately six months. To support the development of phases 2, 3, and 4, a data chapter was included that contained the county health profile, county profile map, Kansas BRFSS data, and Hospital Discharge data reports. Instructions on how to use these reports and additional data collection techniques were also provided in the workbook.7

Between February 1999 and July 1999 two surveys were conducted by the Office of Local and Rural Health of the Kansas Department of Health and Environment to answer questions about the progress of community health assessment and to help state personnel involved in providing technical assistance to understand the state role in assisting specific communities. This article evaluates community capacity, defined as the characteristics of a community that determine how a community identifies and addresses a social or health problem, and assesses whether community capacity was a determinant in the completion of the community health assessment. Some of the dimensions of community capacity identified by the literature include: participation and leadership, people skills, community resources and ability to access to them, community network, sense of community, understanding of community history, community power, community values and critical reflection5. This article also describes factors contributing to success, as well as barriers and limitations that prevented communities from initiating a community health assessment or completing the process.

Methodology

Between February 1999 and May 1999, a telephone survey was conducted by the Kansas Department of Health and Environment to collect information about the status of community assessment in each county. Interview questions were developed reviewing the literature and trying to incorporate the dimensions of community capacity. A contact person in each of the 105 counties was interviewed by phone. In most cases, the person contacted was a staff member of the local health department who was selected by the regional public health nurse working for the state health agency, on the basis of his or her knowledge about the community and about the process itself. When necessary, an alternative community leader was selected if no such person existed or was no longer in the community. Health departments were selected as the source of information, due partly to the fact that the local health department was a lead agency in nearly all the communities. Furthermore, local health departments are key organizations that help to establish a link between the state public health agency and the communities. Communities which had initiated a community health assessment process were also asked to complete a more extensive questionnaire. The response rate for the mailed survey was 78 percent.

Community assessment was classified as complete if the community had initiated a health assessment process during the preceding 10 years and reported that the process was finished; incomplete if the community had initiated a health assessment process after August 30, 1997, but had not finished it by the time of the survey; not done if a community reported not having initiated a health assessment within the preceding 10 years; and stalled if the CHAP had been initiated before September 1, 1997 and remained incomplete at the time of the survey, a minimum of 17 months after initiation (the average number of months for community health assessment completion was 17 months, range 1–41).

Community capacity, such as community assets, involvement and participation, was measured using Likert-like scales. Each participant was asked to
evaluate their community by rating the following community characteristics between one (lowest) and five (highest):

- willingness of citizens to become involved in community issues
- availability of effective leadership for solving community problems
- interagency cooperation and communication
- shared sense of community among citizens
- past history of success at problem solving
- shared decision-making power
- financial resources and community investment
- people resources (skills, capabilities)
- shared values and vision
- self-honesty and ability to learn from mistakes

Chi-Square and Fisher’s exact tests were used to identify the existence of an association between community characteristics and completion or not of the community health assessment.

Results

Of the 105 counties in Kansas, 64 counties (61%) had initiated a community health assessment (Figure 1). Fifty-seven percent of the assessments were initiated between 1996 and 1998, although ten health assessments had been initiated prior to the CHAP release. At the time of the survey (Spring 1999), 64 percent of the counties which had initiated a community health assessment had completed the process. The county was the geographic entity selected for the community health assessment according to 91 percent of the respondents. Local health departments were the lead agency for 48 percent of the communities; hospitals were the lead agency for 21 percent of the communities; 16 percent of the communities reported other lead agencies; and 16 percent reported that the coalition had no single lead agency.

Communities that had not initiated a health assessment perceived lack of community interest (51%), lack of time (51%), and lack of money (40%) as the most important barriers which prevented them from initiating a community assessment. Other limitations included lack of leadership (23%), lack of understanding about the process (20%), and lack of value or benefit in conducting a health assessment (9%). Seventeen communities reported not having plans to start a community assessment in the future.

Communities with incomplete CHAP reported having less representation of community leaders in their coalitions than communities with completed community assessments (Figure 2). Categories of community leaders that were assessed included: local health departments, business, religious or faith communities, other health provider organizations, physicians, community members (e.g., citizens, consumers), youth, local government agencies, media,
nongovernmental organizations, civic clubs or fraternal organizations, and elected officials. Although the majority of the communities which had initiated a community assessment rated the functioning of the coalition as good or excellent (71%), communities with an incomplete or stalled process appeared less likely to rate their coalition functioning as good or excellent (54%) than their counterparts which had completed the process (77%).

Communities with incomplete health assessment reported having several problems with their coalitions. Some of the limitations included: (1) getting people to complete their tasks (40%), (2) finding people to serve in the coalition (45%), (3) locating financial resources in the community, and (4) loss of interest in the process over time (50%). In addition, communities with incomplete health assessment described feeling overwhelmed by the process (39%) and felt that there was a lack of community and political buy-in to health assessment (46%).

The percentage of respondents who rated their community high (a 4 or 5 on the 5-point scale) for a series of community characteristics is shown in Figure 3. Community characteristics were scored higher by communities with a complete CHAP as compared to those with an incomplete CHAP (see Figure 4). Interagency cooperation, history of success at problem solving, and shared decision making power were found to be statistically significant factors associated with completion of a health assessment.

Communities with a completed community assessment reported that prioritization of health problems (100%), improved communication among community groups (89%), problem understanding (79%), and improved skills in accessing and interpreting data (75%) were among the most positive outcomes derived from the process.

Some accomplishments and constraints were identified by communities which conducted a community assessment. Important elements that contributed to a successful outcome included: (1) prepared data provided in advance (97%), (2) written materials [i.e., CHAP workbook (94%)], (3) grant funding (87%), (4) technical assistance (77%), (5) coalition strength (70%), and (6) effective media communication (69%). The most common limitations identified were: (1) large commitment of time (57%), (2) difficulty getting buy-in to the process within the community (50%), (3) exhausting data collection process (44%), (4) lack of dedicated staff (44%), (5) lack of political buy-in (42%), and (6) overwhelming responsibility (40%).

Communities were asked to select three to six health problems and prioritize them using three criteria: (1) magnitude, (2) seriousness of the conse-
quences, and (3) feasibility of improving the problem. Tobacco use, alcohol and drug use, and teen pregnancy were the health problems most commonly identified by communities. Other commonly selected health problems included: (1) physical activity, (2) access to health care, (3) nutrition, (4) lung cancer, (5) hypertension, (6) breast cancer, and (7) prenatal care. Fifty percent of the communities which finished the priority-setting process selected more than three health problems (range 1–22).

Seventy-two percent of communities which completed an assessment reported having initiated an intervention process; however, only 25 out of the 41 communities which completed an assessment responded to this question.

Discussion

The purpose of this study was to quantify the contribution of factors both intrinsic to the community as well as related to implementation of assessment. It was expected that this study would provide an opportunity to explore factors which may have contributed to community outcomes for the purpose of sharing lessons learned with other communities. Using completion of a community assessment compared to initiated but incomplete assessment as the outcome, this evaluation found significant associations between three intrinsic community characteristics (interagency cooperation and communication, past history of success at problem solving, and shared decision making power). Other observed associations were not significant, but the sample size was small. If successful community actions are dependent on certain intrinsic characteristics, and if these “community risk factors” are alterable, then finding tools and methods for measuring these characteristics is likely to be worthwhile.

While the literature provides an indication of community characteristics that are likely to be associated with successful community outcomes, the methods used in this study were not derived from a validated instrument. Furthermore, the measurement of community characteristics used in this analysis was derived retrospectively from a single community member whose subjective ratings may have been influenced by the success or failure of assessment in his or her community or by the understanding or not of the underlying factors that make up each community characteristic. Unfortunately, lack of state resources and time did not permit use of other type of data collection instruments (e.g., focus groups) which would have allowed to increase the number of respondents. Nonetheless, the results of this study suggest a possible method for evaluating community characteristics in future research. Kansas is now attempting to measure these same factors using the Behavioral Risk Factor Surveillance System, but the identification of persons in the general public who are likely to be able to provide valid answers to questions about community characteristics may prove to be difficult.

Respondents identified several factors such as coalition breadth, community leadership, and technical assistance associated with implementation of community assessment which they believed to be important to a successful community outcome. Coalition building was the first activity undertaken by the communities. As in the subsequent phases of the process, the state health agency acted only as an advisor on coalition development leaving up to the community the task of identifying key leaders, developing task forces, holding town meetings, and planning for resources. Literature has consistently reported that the process of coalition development itself (i.e., working with a wide range of people from the community) and the identification of key community leaders as process facilitators, visionaries and data experts, have been some of the most significant outcomes of community assessments. Technical assistance provided by the state health agency and manner of delivery was considered appropriate and not perceived as interference by the community respondent.

Some of the community limitations identified by the respondents could have easily been addressed by providing better state assistance and a more streamlined process. For example, communities spent much longer than the initially anticipated six months to complete the process. Conducting activities which lacked a good payoff, (e.g., community opinion surveys) or created community friction (e.g., health care provider interviews) may have contributed to the feeling of exhaustion and overwhelming responsibility that some respondents expressed. Although state provided community data was perceived as critical to conducting the assessment by the majority of the respondents, supplying more exten-
sive data and tools for data interpretation could have helped to streamline the process. Kansas is now distributing to the communities new and more complete county health profiles which have also been published on the Internet.

Another common limitation stated by the respondents was lack of political and community buy-in to the process. CHAP was an opportunity to engage community members in a dialogue on serious public health issues, to inform them of their health status and health risks, and to gain their support for implementing solutions. However, whether due to lack of know-how, lack of perceived value, lack of resources (e.g., lack of dedicated staff), feelings of unequal distribution of the workload and varied levels of commitments and interests, this activity was largely unfulfilled. Encouraging a team-building approach during the coalition development, emphasizing key exercises for coalition cohesion and distributing tasks according to the level of time, commitment, work style and interests of the participants may have helped to address some of the limitations reported by the communities.

Although 72 percent of communities which completed an assessment, reported having initiated an intervention process as a result of community assessment, we have no data quantifying the extent or nature of these interventions. Assessment has value independent of action taken to correct community health problems. However, motivating communities to take responsibility for their own health problems is very much the point of community assessment, and may represent a more important outcome than the community benefit derived from an assessment process alone.

REFERENCES