Using Needs Assessment and Improvement Planning to Build Healthy Communities

Harnessing Local Data: How Needs Assessment and Improvement Planning Can Build a Healthy Community

Sandra Melstad, MPH
Public Health Consultant
SLM Consulting, LLC

Sarah Quail
SE Region Tobacco Prevention Coordinator
Volunteers of America, Dakotas

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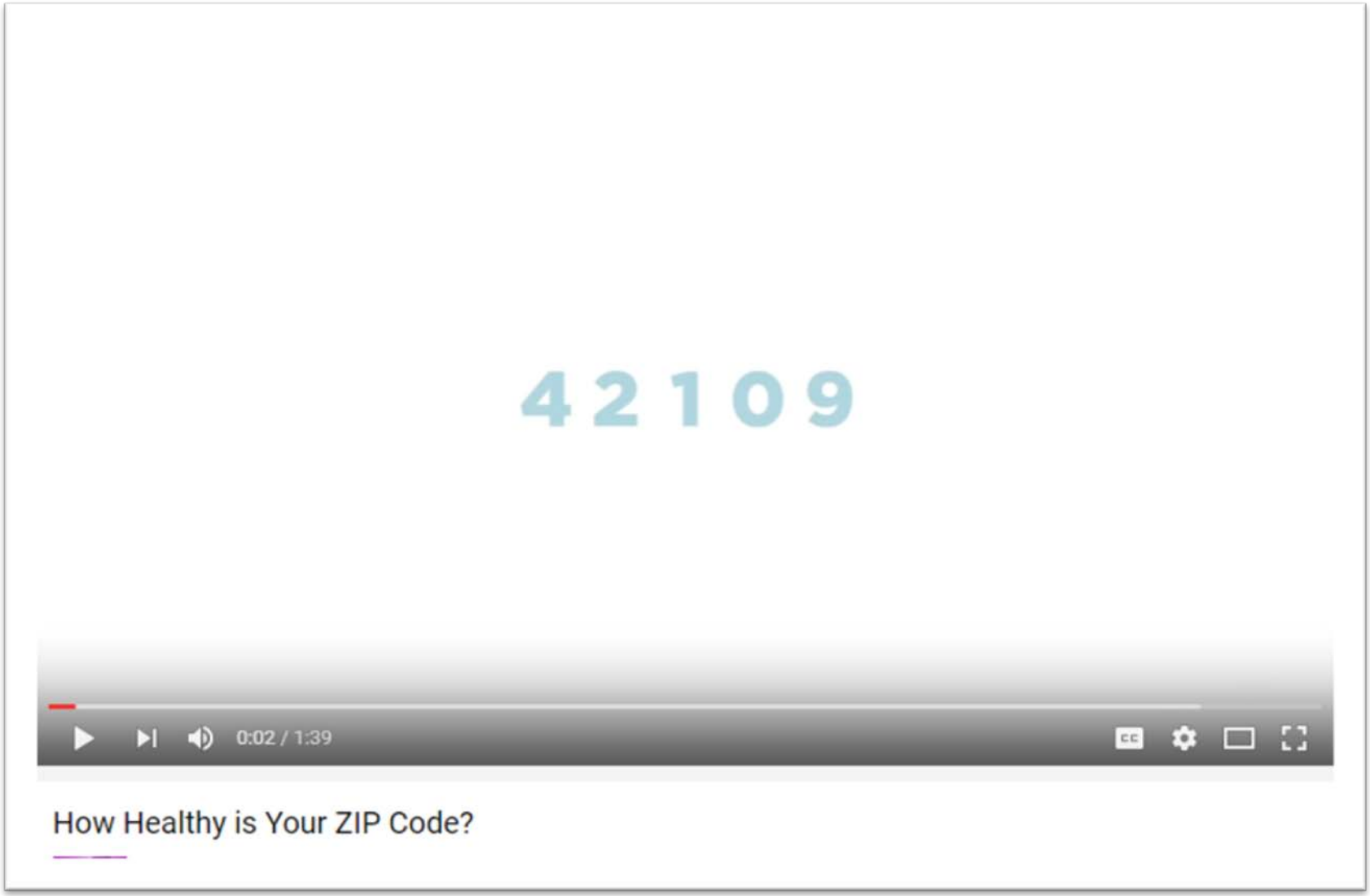

Source: Robert Wood Johnson Foundation

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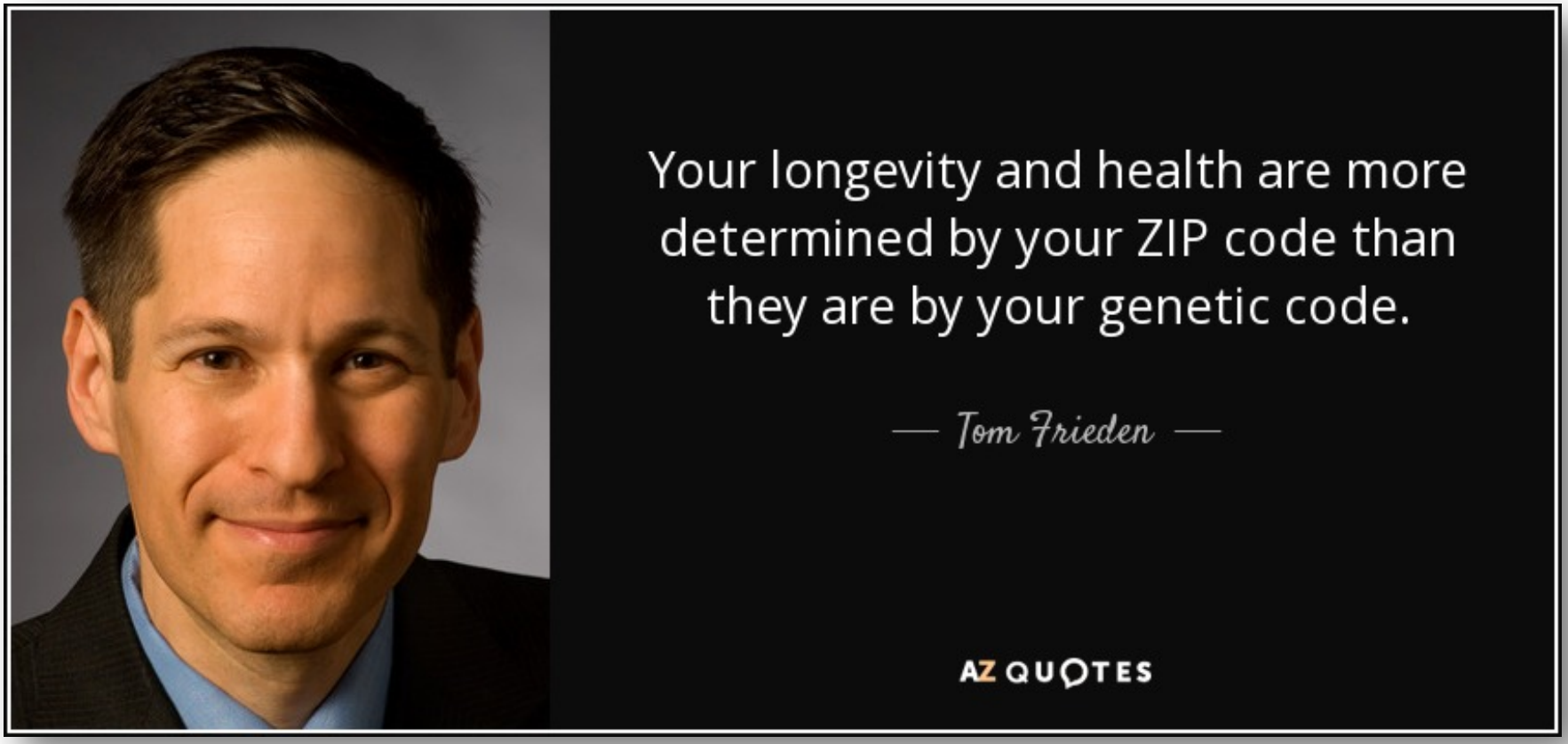

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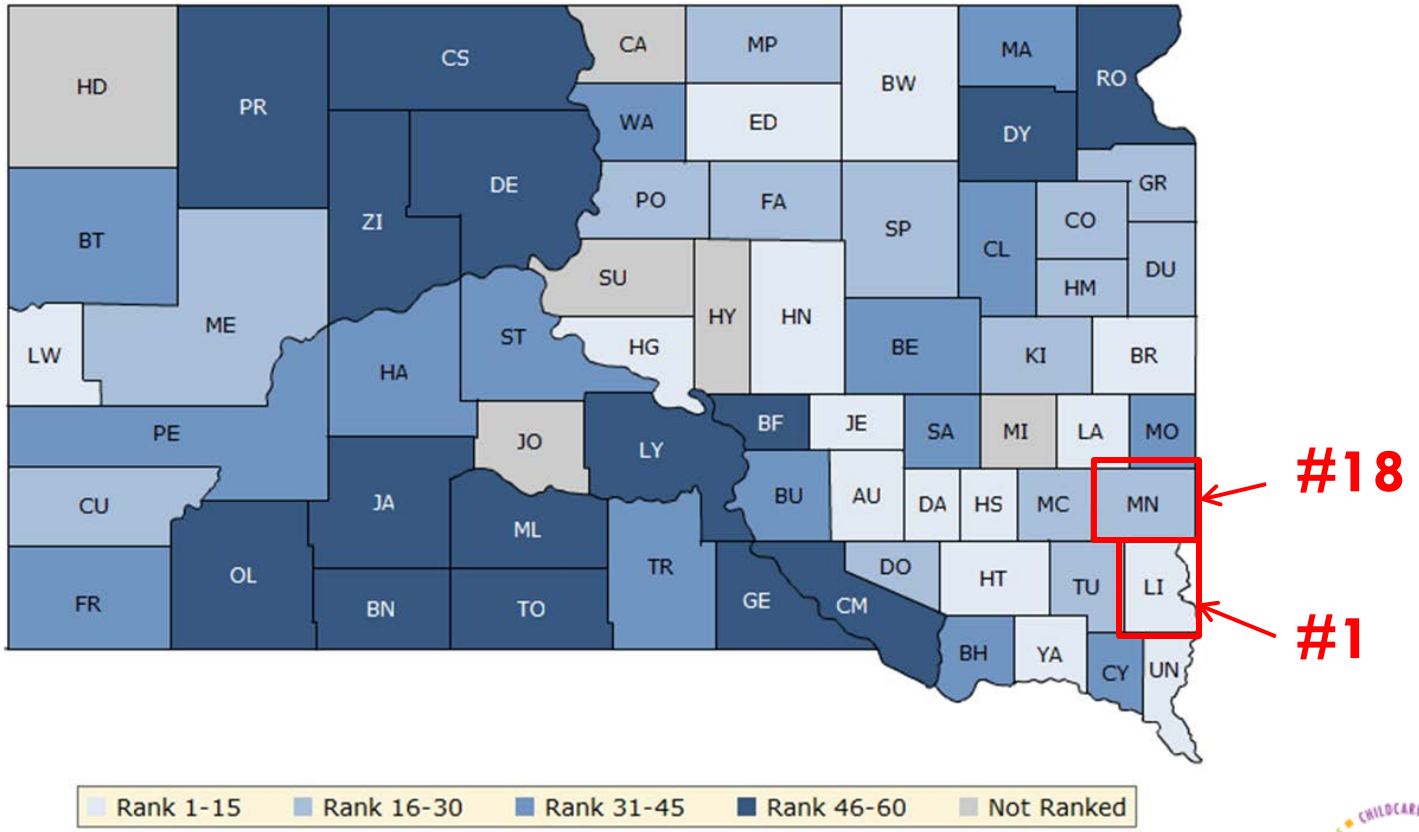
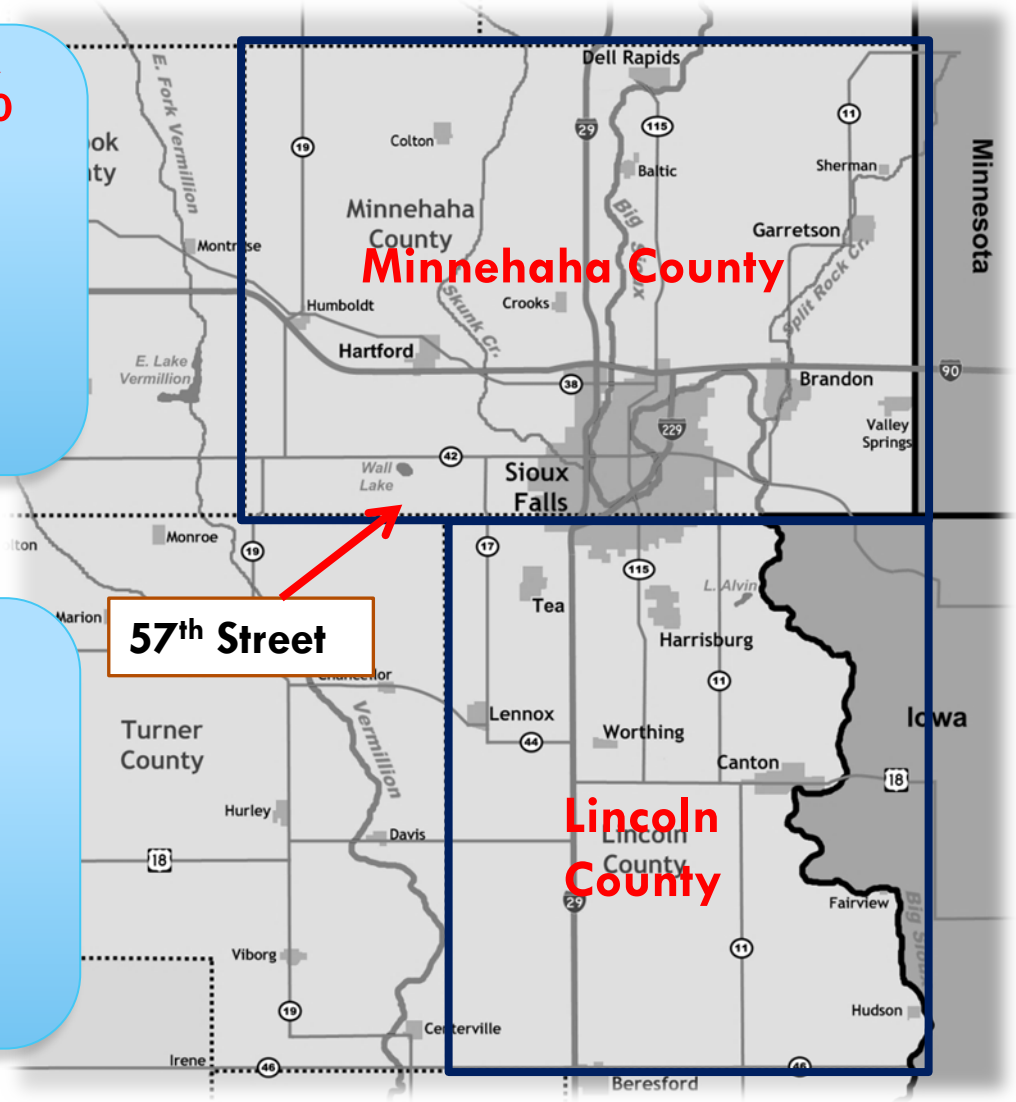
South Dakota Health Factors Rankings



Source: County Health Rankings, 2016

Bachelor's Degree: 29.3%
Income: $68,663
Poverty: 11.5%
Food Insecurity: 11.81
Food Desert: 39%



Bachelor's Degree: 41.%
Income: $87,129
Poverty: 4.3%
Food Insecurity: 8.59
Food Desert: 25.42%

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Data Sources: ACS 2010-2014, 5 year Estimates; Feeding America, Map the Meal Gap; US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.

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What makes a community HEALTHY?

FACT: Over **40%** of deaths in South Dakota are attributable to the chronic diseases of **Heart Disease** and **Cancer**.[1]

FACT: Approximately **30%** of South Dakota adults are **obese**, **20% smoke**, and **54%** get the recommended amount of **aerobic** physical activity; risk factors for chronic disease.[2]

FACT: **1 out of 3** South Dakotans live with an income at or below **200%** Federal Poverty Level which creates **barriers** to health care services and healthy eating choices.[3]

GOOD HEALTH BEGINS where we live, learn, work and play.

- Community-based **prevention** and health **promotion can change behaviors** that contribute to chronic disease.
- **Social** and **environmental** factors contribute to influencing healthy behaviors and exposure to risk factors.
- Changing the environment people live in can **improve** the health of the **entire community.**
- **Understanding your community's needs** is the first step to building a healthy community.

Learn how a Community Health Needs Assessment and Improvement Planning Process can help, at goodandhealthysd.org/communitytoolkit.

AND WHAT'S THE COST OF DOING NOTHING?

$3.8 BILLION

Is the estimated annual **COST** of lost productivity and medical treatment due to chronic disease in South Dakota

That's **$4,559** for every person in every SD community.[4]

Sources:
1 - South Dakota 2012 Vital Statistics Report; 2 - South Dakota BRFSS 2013; 3 - US Census Bureau, American Community Survey: 2008-12
4 - The Economic Burden of Chronic Disease on South Dakota From: DeVol, Ross, and Armen Bedroussian, An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007. Report available at www.milkeninstitute.org

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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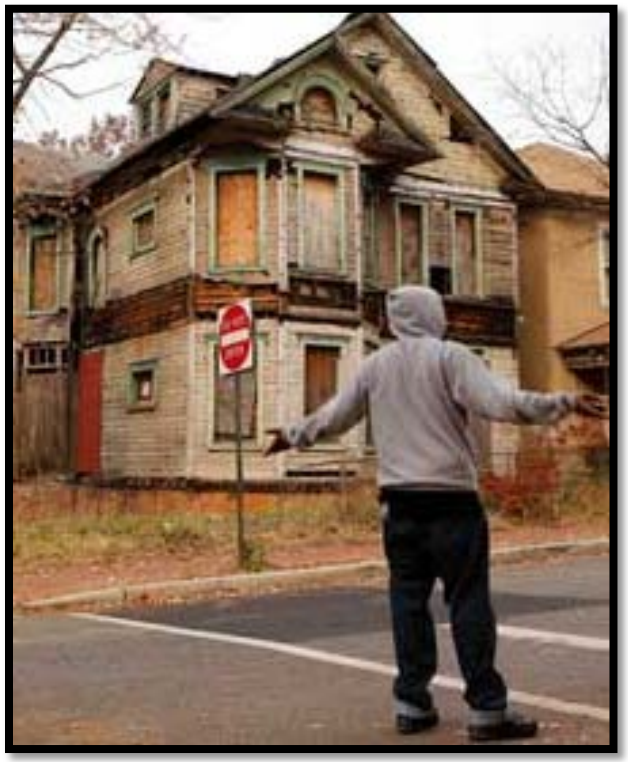
"IT IS UNREASONABLE TO EXPECT THAT PEOPLE WILL CHANGE THEIR BEHAVIOR EASILY WHEN SO MANY FORCES IN THE SOCIAL, CULTURAL, AND PHYSICAL ENVIRONMENT CONSPIRE AGAINST SUCH CHANGE"

SMEDLY & SYME, 2000

Policy, Systems, Environment Change



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CHNA and Improvement Planning Process

- **Community Health Needs Assessment**
  - A structured process, usually conducted in collaboration with other community groups and organizations for determining the health status and needs of community members and identifying community health improvement programs and services on which to focus.

- **Improvement Plan**
  - A long-term, systematic effort to address public health problems in a community. The plan is based on the results of the Community Health Needs Assessment activities, and is part of a community health improvement process.
  - Developed through a collaborative process, and defines a vision for the health of the community.

Source: Public Health Accreditation Board (PHAB) Acronyms and Glossary of Terms, Version 1.0 (PDF: 512KB / 38 pages), Minnesota Department of Health

South Dakota Good & Healthy Community Health Needs Assessment and Improvement Planning Toolkit

http://goodandhealthysd.org/communitytoolkit/

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7 Core Process Steps

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HEALTHY COMMUNITY GRANT

Project Goal

- For a community to assess its health status and develop health promotion and disease prevention strategies for future implementation.

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Project Outcomes

- **Outcome 1:** Increase number of South Dakota communities who have conducted community health needs assessment and improvement planning to understand their health status regarding chronic diseases and associated risk factors.

- **Outcome 2:** Increased number of community coalitions or task forces working on chronic disease prevention and control and associated risk factors.

- **Long-Term Outcome:** Improved prevention and control of chronic diseases and associated risk factors.

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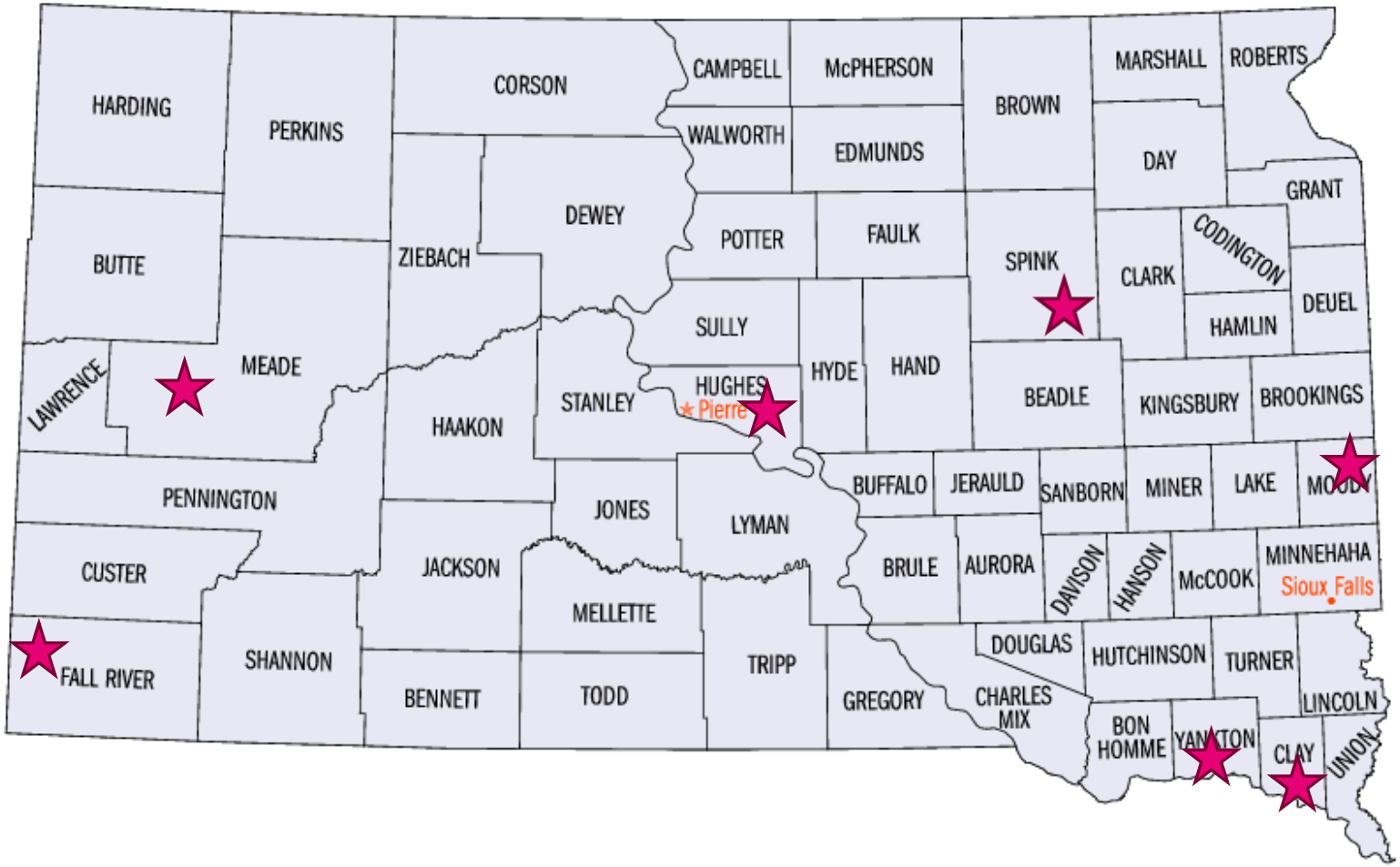
Completed CHNA



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DELIVERABLES

- Training and monthly technical assistance
- Webinars
- Healthy Community Checklist
- Good & Healthy Community Indicator Template
- CHNA Summary Report
- Community Health Action Plan

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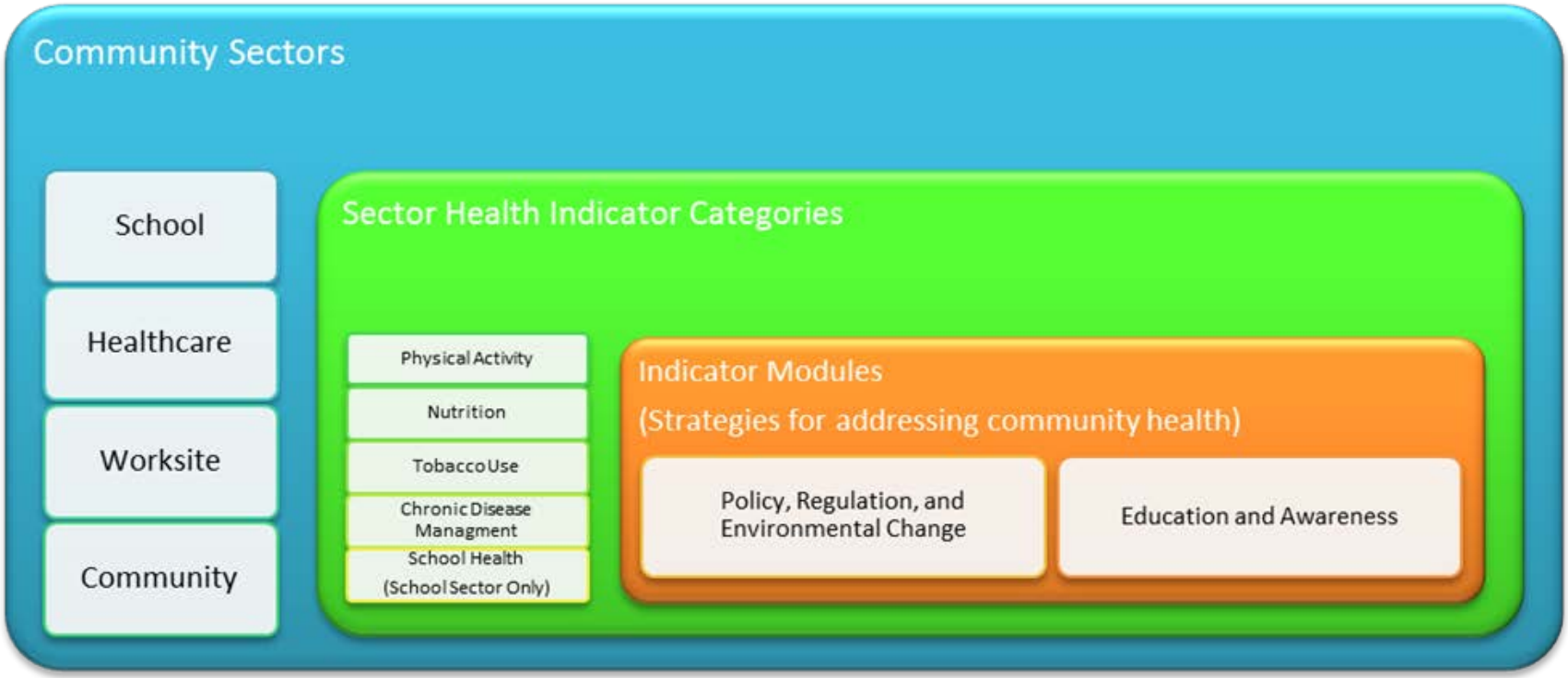
BUILD THE FOUNDATION

Information Gathering & Data Collection to Support Coalition – WHY?

- Guide efforts to improve health of communities
- Identify local needs
- **Supports community stakeholders and partners**
- Determines health priorities
- Identify and activates local and state resources
- **Develop an action plan to implement strategies to promote local public health.**

Methods to Gathering Local Data

South Dakota Good & Healthy Community Checklist



SOUTH DAKOTA GOOD & HEALTHY COMMUNITY PRIMARY INDICATORS

Health Determinant	Focus Area	Indicator	Data Source	Data Accessibility	Year (Group of Years)
LONGTERM OUTCOMES	Chronic Health Indicators & Morbidity	% of adults that report having been diagnosed as having Diabetes**	BRFSS	HIW	2006-2012
		Age-adjusted cancer incidence rate**	SD Cancer Registry	SD CANCER REGISTRY	2007-2011
		% of adults with Heart Disease**	BRFSS	CC	2011-2012
		% of adults that report having been diagnosed with high blood pressure**	BRFSS	HIW	2006-2012
		% of adults that report fair or poor health**	BRFSS	CHR, HIW	2006-2012
		Average number of reported physically unhealthy days per month among adults 18 years of age and over**	BRFSS	HIW	2006-2012
		Average number of reported mentally unhealthy days per month among adults 18 years and over**	BRFSS	HIW	2006-2012
COMMUNITY & CLINICAL CARE	Preventive Services	% of adult women respondents age 50+ who report having mammogram in past 2 years**	BRFSS	HIW	2006-2012
		% of adults age 50+ who have had a Sigmoidoscopy/ Colonoscopy within the past 10 years**	BRFSS	HIW, CC	2006-2012
		% of women age 18+ who report having a pap smear test in the past 3 years**	BRFSS, WISEWOMAN	HIW, CC	2006-2012
	Access to Care	% of adults under 65 years (18-64) of age without health insurance**	SAHIE	SAHIE	2012
HEALTH BEHAVIOR	Diet & Exercise	% of adults who are Obese based on BMI of >30**	BRFSS	HIW, CC	2011
		% of K-12 students who are obese based on BMI by Region**	SD School Height/ Weight Report	SD DATA SPECIFIC TO LOCAL SCHOOL(S)	2012-2013
		% of children 2-4 years of age who are obese in households who received at least one WIC Program food instrument or food during the report month or were breastfed by a participating mother**	WIC	WIC	2014+ Data collected from WIC staff
		% of adults that report fewer than 5 servings of fruits/vegetables per day**	BRFFS	CC	2005-2009
		% of adults who report no leisure-time physical activity in the past month**	BRFSS	HIW, CC	2011
	Tobacco Use	% of adults 18 years and over that report currently smoking cigarettes**	BRFSS	CHR, CC, HIW	2006-2012

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SOUTH DAKOTA GOOD & HEALTHY COMMUNITY SECONDARY DATA SOURCES

Data Set	Description	Focus Areas	Source	Time Period	Level of Specificity						Links
					State	County	City	Zip Code	Census	Other	
LONGTERM OUTCOMES											
South Dakota Vital Statistics	State and county leading health indicators for vital statistics.	• Mortality • Morbidity • Women & Children	South Dakota Vital Statistics	Annual	X	X					http://doh.sd.gov/Statistics
Cancer in South Dakota: South Dakota Cancer Registry Report	A statewide population-based cancer registry that collects data on cancer incidence and reports on cancer incidence and mortality.	• Chronic Health Indicators	Centers for Disease Control & Prevention (CDC) & South Dakota Department of Health	Bi-Annual, 5-year estimates	X	X					http://getscreened.sd.gov/registry/data
Behavior Risk Factor Surveillance System (BRFSS)	State-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.	• Morbidity • Chronic Health Indicators	Centers for Disease Control & Prevention (CDC) & South Dakota Department of Health	Annual	X						http://apps.nccd.cdc.gov/brfss/index.asp
SMART: BRFSS City and County	The Selected Metropolitan/Micropolitan Area Risk Trends (SMART) project uses the Behavioral Risk Factor Surveillance System (BRFSS) to analyze the data of selected metropolitan and micropolitan statistical areas (MMSAs) with 500 or more respondents.	• Morbidity • Chronic Health Indicators	Centers for Disease Control & Prevention (CDC) & South Dakota Department of Health	Annual		X	X	X			http://apps.nccd.cdc.gov/BRFSS-SMART/SelMMSAPrevData.asp *(Sioux Falls and Rapid City MMSAs only)*
Health Indicator Warehouse	Data hub for that provides a single source for national, state, and community health indicators (i.e. BRFSS data).	• Chronic Health Indicators	Department of Health and Human Services	Varies	X	X					http://www.healthindicators.gov

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"Prioritizing issues allows the health department and community to direct resources, time, and energy to those issues that are deem most critical and practical to address."

APEXPH process, Centers for Disease Control and Prevention

EVALUATION APPROACHES

Focus Group

Knowledge, Attitudes, and Practices Survey regarding Community Health

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Objective

Evaluate experience and knowledge gained from participating in a community health needs assessment and improvement planning process in community

Themes

- Community Engagement & Collaboration
- Community Resources
- Value Added Data Collection Process
- Technical Assistance & Resources
- Take-Aways

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Focus Group Themes

Community Engagement & Collaboration

- *"Good opportunity to bring good group together to work on this can expand further into the community…never took time to do it before"*
- *"Cool to bring large section of community that you know but don't know well, most part fun to bring everyone together and get everyone's opinions on where needs lie. ….This was a real eye opener at macro level versus my own micro focus."*

Community Resources

- *"The other thing is that we knew everyone was out there but we didn't think to tap into resources. The fact that we could strictly put 40 different representatives in the same room, to think that they're all in this community and to think why don't we sit down and work together more often?"*
- *"One of the things I got out of the process was how many services are available within community, but community isn't aware of them."*

Focus Group Themes

Value Added Data Collection Process

"We needed all the parts, Checklist as well as primary and secondary data, needed focus groups, wouldn't have understood how much we needed that until I wrote the report."

"One thing the Checklist did was provide an observation, where do you think we have problems and where do you think we are limited on resources…Confirmed what focus group was saying that we still see this happening."

"I appreciated when we came together and talked about the focus group and how many people participated…But it really expanded viewpoints of what is needed, so that was really good."

"Provided a lot evidence-based models, there are different ways to get from point A to B, but we could look at each model and choose from different ways of doing it and even mix and match different pieces."

Focus Group Themes

Technical Assistance & Resources

- *"The toolkit created a framework for us to go from. The CHNA process and aftermath can be very intimidating, but the toolkit made it very manageable."*
- *"Beneficial to have 3rd party (consultants) to lead meetings – unbiased answers and direction rather than someone specifically from hospital leading."*

Take Away's

- *"Finding a way to make sure the community is aware of resources."*
- *"We have the expertise to carry this out especially with tools you provided to do that."*
- *"Even being as small as we are there are still under-represented and under-served groups in a community. That would be really important things, to be mindful of that.'*

Data Source: County Health Rankings & Roadmaps

Utilizing Your Coalition

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"The *only* reason to spend time building a coalition is to amass the power necessary to accomplish something that can only be done by organizations working together."

Midwest Academy Organizing Manual

Funding Opportunity

- Support the assessment of community health and develop health promotion and disease prevention strategies for future implementation
- Letters of Interest will be accepted through an ongoing basis and reviewed monthly
- http://goodandhealthysd.org/communitytoolkit/

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Thank you!

Sandra Melstad, MPH
slmelstad.consulting@gmail.com