Community Needs Assessment: Lessons Learned from AccessHealth SC

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Guiding Principles for CNA

- Identify your scope/focus/purpose.
  - Never engage in ‘open-ended’ needs assessments. They take you nowhere fast!

- Have a framework that addresses your scope.
  - Doesn’t have to be ‘theoretical’ but should keep you from drifting into tangential, unactionable areas.
  - Most are rooted in public health and may need modifying for your purpose

- Document indicators and objectives a health service delivery organization can affect.
  - All others (e.g. obesity rates) should reflect strategic processes or partnerships (e.g. public health) whereby you are a support organization

- Be prepared for a multi-methods approach.
  - Rarely can you get what you need from secondary data sources alone.
Purpose of Health System Profile

- To assess community ‘readiness’ and need for improving access to care for uninsured residents through data triangulation.

- Addresses three primary purposes:
  - CAPACITY/BUILT ENVIRONMENT - To provide an ecological description of the local healthcare infrastructure, specifically those resources available to uninsured populations.
  - POLITICAL WILL - To describe ‘readiness’ of the community to develop a network for uninsured populations.
  - EPIDEMIOLOGY - To describe health service utilization issues of the uninsured documenting the degree of unmet need and the underlying predisposing, enabling, and reinforcing factors that influence utilization behaviors.
Data Triangulation

- Secondary data analysis
  - ER and IP data analysis
  - FQHC data analysis
  - Integrated the two sources to compute an ‘uninsured service area’

- Key informant interviews
  - Structured interviews with health and human services community
  - Structured interviews with community leaders

- Focus groups with uninsured patients
Benefits of the Health System Profile

- Explain findings from secondary data sources such as the hospital discharge data
- Provide contextual insights that ground subsequent strategies.
- Inadvertently served as a ‘synergy catalyst’ for communities focusing on the needs of their uninsured residents.
Examples of How HSP Facilitated Awardee Priorities – More than numbers!

- Why the Tricounty area (Charleston, Dorchester, and Berkeley) had among the lowest ER visit rates and highest inpatient hospitalization rates for ambulatory care sensitive conditions.

- How Chesterfield County residents’ define community geographically, culturally, and economically and how that influences where they seek hospital care.
Commonalities Across Awardees in Secondary Data

Primary Care

- Theme 1: Marked deficiencies in availability of primary care physicians for low-income populations Ambulatory care sensitive conditions
- Theme 2: Multiple portals of entry for the uninsured impact ambulatory care sensitive conditions (ACSC) in the ER

Ambulatory Care Sensitive Conditions

- Theme 3: Diabetes, bacterial pneumonia, and congestive heart failure are among the most prevalent reasons for potentially avoidable inpatient hospitalizations.
- Theme 4: Severe ENT infections, dental conditions, and kidney/urinary tract infections are among the most prevalent reasons for potentially avoidable ER visits.
**Commonalities Across Awardees in Secondary Data**

**Specialty Care**
- Theme 5: There is a geographic maldistribution of specialty providers.

**Mental Health**
- Theme 6: Limited access for mild to moderate depression, anxiety, bipolar disorder, mood disorders, and other similar conditions.

**Dental Health**
- Theme 7: Dental is the most prevalent reason for ACSC ER visits by rural uninsured and ranked third statewide.
Community Leadership Perspective: Commonalities from Qualitative Data Collection

Geography Matters!
- Theme 8: The topography of our state appears to influence how, when, and where uninsured residents seek care.

Misconceptions About Place of Care
- Theme 9: Even professionals are unclear about the role FQHCs and free clinics play in the safety net system for the uninsured.

Unmet Needs and Demands for Care
- Theme 10: The uninsured have ‘checked out’ of certain types of care.
Uninsured Residents’ Perspective: Commonalities from Qualitative Data Collection

Deferring Care
- Theme 11: The uninsured defers care out of fear and competing priorities.
- Theme 12: A high degree of fatalism exists.

Availability and Quality of Care
- Theme 13: The uninsured equate quality with payment.

Disparities
- Theme 14: Poverty as the great equalizer?

Education and Empowerment
- Theme 15: Demand for empowerment tools.

Faith Partnerships Expected But Inconsistent
- Theme 16: Having faith-based partners are not always the magic bullet.
## Conclusion

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>FACES</th>
<th>FACTS</th>
<th>FAITH &amp; PHILANTHROPY</th>
<th>FREE CLINICS &amp; FQHCs</th>
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</thead>
<tbody>
<tr>
<td>CAPACITY</td>
<td>Uninsured equate quality with payment</td>
<td>Deferred care translates into expensive avoidable hospital care</td>
<td>Most involved in enabling services or direct care</td>
<td>Variance in scope &amp; availability</td>
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<tr>
<td>POLITICAL WILL</td>
<td>Dichotomy of fatalism &amp; gratitude</td>
<td>Unresolved conflict translates into fractured system</td>
<td>Variance in ‘friendliness’ of support</td>
<td>‘Ownership’ predicts mission</td>
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<tr>
<td>EPIDEMIOLOGY</td>
<td>Numbers grow!</td>
<td>Dental &amp; Diabetes are biggest unmet needs</td>
<td>Soup kitchens serve hundreds</td>
<td>Acute care vs. chronic disease management</td>
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_South Carolina_  
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Results

- Informed decision making about AccessHealth SC network funding requests
- Baseline measures for improving access to care by uninsured adults in South Carolina
- Catalyst for awareness and change in community-based healthcare systems
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