SKILLS, KNOWLEDGE AND VALUES OF COMMUNITY HEALTH NEEDS

ASSESSMENT MANAGERS

A Thesis
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

Karen Michelle Crabtree

In Partial Fulfillment of the Requirements
for the Degree of
MASTER OF SCIENCE

Major Program:
Community Development

November 2018

Fargo, North Dakota

North Dakota State University
Graduate School

Title

SKILLS, KNOWLEDGE AND VALUES OF COMMUNITY HEALTH
NEEDS ASSESSMENT MANAGERS

By

Karen Michelle Crabtree

The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota

State University's regulations and meets the accepted standards for the degree of

MASTER OF SCIENCE

SUPERVISORY COMMITTEE:

Gary A. Goreham, adviser, North Dakota State University

Chair

Jeffrey Bumgarner, North Dakota State University

Mary Emery, South Dakota State University

Mary Ann Reitmeir, ex officio, Bemidji State University

Approved:

November 26, 2018

Date

Gary Goreham

Department Chair

ABSTRACT

Nonprofit hospital systems must complete a community health needs assessment (CHNA).   In healthcare there is a lack of consensus on what skills, knowledge and values are important for the person managing CHNA departments, including educational background appropriate or needed to be successful.

This is an exploratory study of one healthcare system.   The study seeks to identify the perception of what skills, knowledge and values are necessary to be an effective CHNA manager, and how that aligns with the skills, knowledge and values taught in public health, community development and social work.   The study utilizes grounded theory, inductive research and evaluative research methods.

Question: What are the perceived most important skills, values and knowledge for the CHNA manager to be effective in their role by CHNA personnel? How do those skills, knowledge and values align with macro practice social work, public health, and community development education in healthcare?

DEDICATION

This thesis is dedicated in honor of Mary, Becky, Sara and Kim Norstebon.   For the women in

my life who are strong, talented, mindful, and improving the world a little at a time.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF MODELS

LIST OF ABBREVIATIONS

ACA ....Also known as, PPACA or Obamacare- Patient Protection and Affordable Care Act

ACO ....Accountable Care Organization

CHNA ....Community Health Needs Assessment

LICSW ....Licensed Independent Clinical Social Worker

LSW ....Aka generalist social worker- Licensed Social Worker

SDOH...Social Determinants of Health

CHAPTER 1: INTRODUCTION

Healthcare systems for years focus on what happens within the walls of the health center, specific to physical health, and focus on how their services positively impact patients. Technologies expanded, focuses on efficiency improved care and the medical world is continuously evolving to improve care. Simultaneously, the cost of healthcare has become tremendously inflated and is currently 17.9% of the GDP (Health Expenditures, 2016). Comparatively, the US spends double the amount of GDP on healthcare than other industrialized nations, and lags behind in life expectancy, which created a crisis in healthcare. The passing of the Affordable Care Act and the Triple Aim of Healthcare developed in response to the healthcare crisis as ways to decrease spending, improve quality and health of communities.

Science has proven that 80% of a persons' health is non-related to healthcare services, but influenced by factors of social determinants of health, environment and behavior. This understanding has developed opportunities in healthcare to change how we create positive health change and supports innovative thinking. This culture shift is now focusing on social determinants of health, and health systems are trying to identify how they can improve them. Three educational areas of study historically focused on social determinants; including: macro social work practice, community development and public health. Community Development specifically as an academic profession of its own is fairly new in the past 10 years, yet it has been nationally recognized by health related organizations as a way to positively impact social determinants. Even though the areas of study focus on the development of healthy and sustainable communities and systems, historically they are yet to be recognized in health systems as "required education" for CHNA managers. Therefore, it seems there is a disconnect between

what knowledge, skills and values are really needed for a CHNA manager, and what educational programs provide those skills to improve health by addressing the SDOH.

Therefore, this study seeks to examine what administrative and CHNA managers think the most important skills, values and knowledge are for the CHNA manager to be effective in their role. Furthermore, it examines what opportunities might be available for macro social work practice, public health and community development in CHNA management roles.

1.1. Determinants of Health

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of people.

"Why is Jason in the hospital?

Because he has a bad infection in his leg.

But why does he have an infection?

Because he has a cut on his leg and it got infected.

But why does he have a cut on his leg?

Because he was playing in the junk yard next to his apartment building and there was

some sharp, jagged steel there that he fell on.

But why was he playing in a junk yard?

Because his neighborhood is kind of run down. A lot of kids play there and there is no one

to supervise them.

But why does he live in that neighborhood?

Because his parents can't afford a nicer place to live.

But why can't his parents afford a nicer place to live?

Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed?

Because he doesn't have much education and he can't find a job.

But why ...?"

("Toward a Healthy Future: Second Report on the Health of Canadians." n.d.)

http://www.phac-aspc.gc.ca/ph-sp/determinants/

1.2. Definitions and Acronyms

Patient Protection and Affordable Care Act (PPACA)- also known as the Affordable Care Act (ACA) or Obamacare: health reform legislation passed by the 111th Congress and signed into law in March 2010 by President Barack Obama that expands and improves access to care, reduces the number of uninsured citizens, and curbs healthcare spending through regulations and taxes ("Accountable Care Organizations". n.d.)

Accountable Care Organization (ACO): The Center for Medicare and Medicaid Services defines an ACO as, "…groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients" (page). The goal is to improve quality care, avoid duplication of services and reduce medical error, and reduce the cost of care so that the groups can "share in the savings" it achieves for the Medicare program ("Accountable Care Organizations". n.d.).

Case Manager - aka care coordinator: A person who is tasked with processes of assessments, intervention, goal planning, care coordination, evaluation and advocating for individuals so they can access options and services to meet their comprehensive health needs. The goal of a case manager is to improve quality patient care and decrease costly unnecessary medical treatment or crisis ("Case Management Society of America", n.d.).

Community: Community is geographical and also recognizable by attributes. Social, physical, interests, culture, collective entity (Kretzmann and McKnight, 1993).

Community Development Community Development is a term that can be used to describe action to change a community in many different ways as IACD, CDS, NACDEP, GP-IDEA (2017) state it is, "… a practice-based profession and an academic discipline that promotes participative democracy, sustainable development, rights, economic opportunity, equality and social justice, through the organization, education and empowerment of people within their communities, whether these be of locality, identify or interest, in urban and rural settings." For the purpose of this study the term community development is referring to the professional practice and theory of community development.

Community Health Needs Assessment (CHNA): Required as a result of implementation of the ACA, the CHNA is required to be completed and reported by non-profit hospitals to the IRS. It is the examination of health status indicators using systematic methods and analysis for a given population which is utilized to identify opportunities and assets within the community. The CHNA is utilized to develop strategies to address needs or identified opportunities of the community using a strength based approach and requires persons to be involved who represent the broad interests of the community served.

Health: Health has many definitions and is often used as a noun that means to be, "free from illness or injury" or can be a modifier where it is used to describe something such as "a health risk" ("Health", n.d.). In this study the term health is defined holistically as a, "relative state in which one is able to function well physically, mentally, socially, and spiritually to express the full range of one's unique potentialities within the environment in which one is living" ("Health". n.d.).

Healthcare system: A Healthcare system can refer to organizations of people or institutions that deliver health care services and resources to meet the health needs of a population ("healthcare system", n.d.)   In the United States health care systems can be private for profit, not for profit or government owned and operated.   Because of the complexity of government owned & operated health institutions, this research study refers to a health system as a private for profit or not for profit organization that primarily delivers personal health care services for individuals and families to meet the needs of a population.   Furthermore, this research study will examine only the healthcare systems that are required to complete a community health needs assessment. Healthcare systems that require a CHNA are those of which are in a hospital which is owned and operated on the same location as their healthcare system.

Licensed Independent Clinical Social Worker (LICSW): Within Minnesota this is a title for someone who has obtained a Master's degree in social work, has completed required supervision requirements post-graduation, has passed the LICSW Board exam and is licensed by the Minnesota state board of social work. The LICSW works as a therapist to diagnose and treat mental health and behavioral issues, and utilizes the tools and skillsets of a generalist social worker to help patients overcome their own mental/emotional/behavioral challenges or illnesses.

Licensed Social Worker (LSW) aka generalist social worker: A title for someone who has obtained a bachelor's degree in social work, has passed the social work exam, is currently undergoing or has completed required supervision hours and is licensed through the Minnesota state board of social work.   LSW's focus on individuals, groups, systems, communities and policies to help improve problems by empowering people. An LSW career can vary from child and family, child welfare, human services, healthcare, school, gerontological, policy and system, community development corporations, or private practice.

Population health: The term population health has been used to describe concepts or

field of study and an exact definition has been long debated.   Population health, as it applies in

relation to a healthcare system is, "the health outcomes of a group of individuals, including the

distribution of such outcomes within the group" (Kindig and Stoddert. 2003, p380).

Rural: Can be defined by land use, population, distance, density or other and can vary

greatly- rural healthcare may be recognized differently than rural business programs. The most

common agencies that define what rural is: the US Census Bureau, the Office of Management and

Budget, and the Economic Research Service of the US Department of Agriculture (USDA).   For

the purpose of this study the term rural will be defined in concordance with the Centers for

Medicare and Medicaid & the federal Office of Rural Health Policy for rural health clinics

(RHC's) as the focus is on rural health ACO healthcare facilities.   This means the health facility

must be located outside of a US Census Bureau Urbanized Area where an urbanized area has a

population of 50,000 or more people ("Am I Rural", 2017).

Social Determinants of Health (SDOH): According to Ahnquist, Wamalaa and

Lindstrom (2012), "Social structures and socioeconomic patterns are the major determinants of

population health" (p34). The Public Health Agency of Canada (2013) has shown significant

research that explains the determinants of patient health, which include: income and social status,

social support networks, education and literacy, employment/working conditions, social

environments, physical environments, personal health practices and coping skills, health child

development, biology and genetic endowment, health services, gender and culture.   By

addressing the social determinants of health the focus of the community turns to a "population

health approach" which relates to improved physical, mental and social well-being, quality of life,

satisfaction in life and work, and improves financial well-being (Public Health Agency of Canada, 2013).

Social Work: The global definition of social work is a "practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people" ("Global Definition of Social Work". 2014) where the Council on Social Work Education (CSWE), which accredidates undergraduate and graduate social work programs, describes the purpose of social work:

> The purpose of the social work profession is to promote human and community well-being. Guided by a person and environment construct, a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work's purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty and the enhancement of the quality of life for all persons (CSWE, 2008, p. 1)

Social work is focused on systems and strength based theories and applications to support change in levels of intervention. Social work academia includes three levels of intervention:

a) Micro – practice of engagement and interventions of individuals and families to solve problems

b) mezzo – practice of engagement and interventions that affect small to medium sized groups that focus on organizing, management, shared learning, and institutional or culture change

c) Macro- interventions of a large scale that affect entire communities and

   systems that empower and engage citizens by involving them in systemic

   change

Macro social work: addresses social problems in communities, organizations or institutions, and society. Macro social work aims to, "achieve social change through neighborhood organizing, community planning, locality development, public education, policy development and social action" (Miley, O'Melia, DuBois, 2009. p. 12).

Triple Aim of Healthcare- aka Triple Aim: A term utilized in healthcare, developed by the Association for Community Health Improvement, that means pursuit of a single movement involving three dimensions a) improve the patient experience of care b) improve the health of populations and c) reduce the per capita cost of healthcare

1.3. Delineations

This study does not intend to address the cause of the patient's social, economic, bio/psycho/environmental, or cultural issues or the social determinants of health

This study does not intend to address all the roles in healthcare for social workers, public health or community development.

This study will be limited to one non-profit hospital that to include CHNA program managers and administrators or directors over CHNA manager staff.

This study does not intend to measure the impact of social work, public health or community development.

1.4. Assumptions

People will continue to experience social, emotional, psychological, biological, environmental, economic and legal problems.

Community development, public health and social work are three separate, but closely related, areas of academia and professions.

Healthcare systems will continue to treat people for health issues or problems.

Generalist social work requires knowledge and training of three levels of intervention including micro, mezzo and macro. This study will specifically focus on macro social work intervention skills and practice; known as macro social work. Social workers are impactful on patient care as micro, mezzo and macro practitioners. They practice in all three areas generally, with macro being the minority of focus, within the occupation.

In order to examine the disconnect between macro social work practice, public health and community development and the opportunity to impact community health, it's important to know the historical significance and basic teachings of each profession, along with the similarities and differences. Secondly, we need to look at healthcare, the ACA and implications of the triple aim in non-profit hospitals, ACO models of care, and how these systems are rising to meet the challenges and standards set forth in regards to the CHNA. Since health systems are complex in how they function, and every hospital has a different way of doing CHNA work, this study will focus on one health system in which there are multiple CHNA personnel. Finally, once these topics are been explored we will integrate information to frame the research study typology and methods to be used.

This study will utilize inductive research and grounded theory, in addition to evaluative data methods to identify the perceived most important skills, values and knowledge for the CHNA manager to be effective in their role and how the skills, knowledge and values align with macro practice social work, public health, and community development education.

If health organizations want to be effective in CHNA work (as required by the IRS), they should know which professions offer the skills most sought after that align with what they are looking for. Additionally, the study is valuable to the public health, social work and community development academia as it will inform them of what the most valued skills, knowledge and values are.

CHAPTER 2: LITERATURE REVIEW

2.1. Healthcare

Throughout the years advances in the field of health care provide patients in the United States with the most advanced health care available anywhere in the world. Even though these services are available, that does not mean they are accessible. Synonymously, the cost of healthcare services has skyrocketed as providers of care are paid in a fee for service model which does not incentivize them to improve patient health. Cowles (2013) states that people in the U.S. population lack access to health care due to financial barriers, and health care is regarded as a privilege rather than a right, vs. all the other industrial nations (except South Africa) where it is deemed a right. Current trends in the U.S. health care system reflect efforts to control rising health care costs, but do not include a focus on public health, or movement to a single payer health system which is problematic. Even though it is more affordable to fund preventative services by focusing on public and community health initiatives, it means providing funding up front for more programs which is many times unsupported by politicians. The more formal service systems historically are underfunded, leaving many in need without adequate assistance to remain in their residences.

The combination of the low health ratings, the issues that impact health, the lack of services and a constrained budget testify to the fact that a persons' health is a community issue. Keeping people healthy is known to lower the cost of healthcare services, improves patient and provider satisfaction and improves overall quality of life for individuals (Institute for Healthcare Improvement, 2013). Therefore, it is imperative that health care move to a different way of operating. This being said, there are some gains being made towards a movement.

2.2. Affordable Care Act (ACA)

The Affordable Care Act (ACA) passing created a movement for healthcare organizations to meet the triple aim- developed by the Institute for Healthcare Improvement in 2008 as a guide for the development of new approaches to address the appropriate delivery of health care services (Healthcare.gov, 2013).

Federal changes in the Affordable Care Act support greater use of health information technology, community health intervention and care coordination. The Institute for Healthcare Improvement (n.d.) "…calls for developing new designs and initiatives to 1) improve the health of the population 2) enhance the patient experience of care (including quality, access and reliability 3) reduce, or at least control, the per capita cost of care", which is the triple aim of healthcare. The ACA also includes provisions that include a value-based purchasing program. This provides incentives to hospitals in the form of enhanced payments if they meet certain quality standards for Medicare discharges beginning in fiscal year 2013, and has reduced costs of care (Edwards, Silow-Carroll, Lashbrook & health management associates, July 2011).

The Affordable Care Act offers improved community health by requiring a community health needs assessment be done every three years, and strategies implemented to address the results, and also by increasing access to healthcare coverage through a Marketplace where consumers can review and purchase health insurance plans. ACA also provides coverage for children and adults with pre-existing conditions and provides expanded coverage for preventative services. (Healthcare.gov, 2013)

2.2.1. Social determinants of health

The affordable care act and the triple aim of healthcare shifted healthcare models to also focus on addressing social determinants of health (SDOH) to achieve population health outcomes.

Social determinants (SDOH) are really the factors of where a person is born, lives, grows, works and ages (World Health Organization) and also impact the health behaviors a person develops. Healthcare recently has acknowledged that 80% of a patient's health is made up of SDOH, and that in order to impact population or community health, which is part of the triple aim, we need to address the SDOH (Model 1).
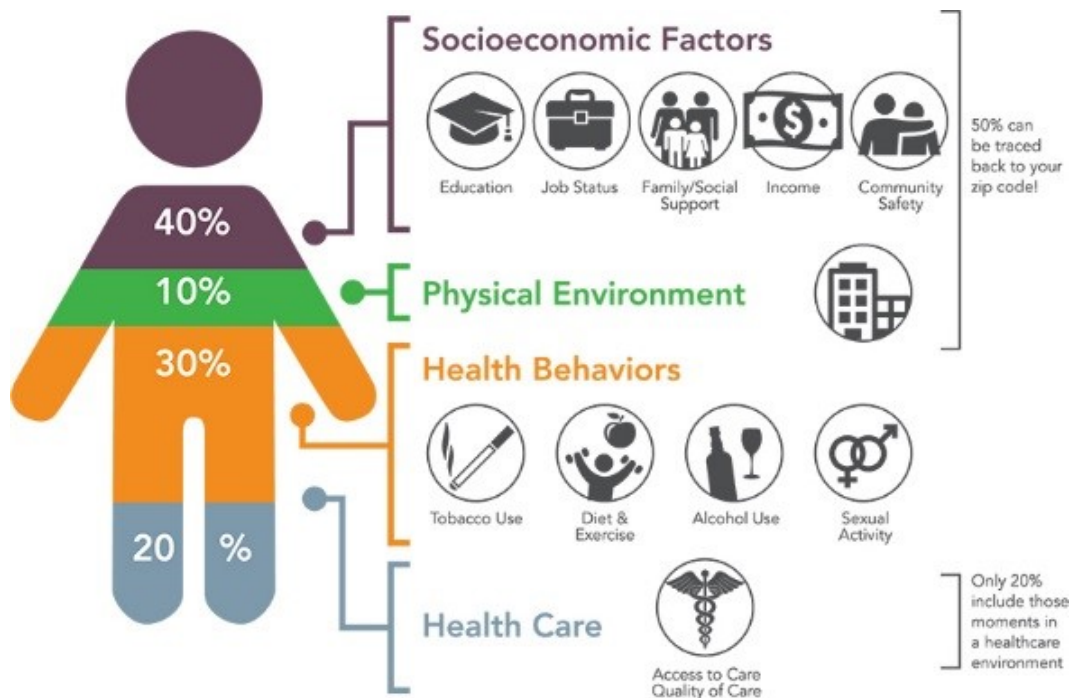
Model 1: Social Determinants of Health. Reprinted from Institute for Clinical Systems Improvement, October 2014, Retrieved by:
https://www.promedica.org/socialdeterminants/pages/default.aspx

2.2.2. Community health needs assessment

As the Affordable Care Act implemented the requirement of Community Health Needs Assessments (CHNA's), thus the focus on SDOH should naturally be a piece of the focus of its work in order to achieve population health improvements. This is reinforced by Ahnquist, Wamalaa and Lindstrom (2012), as they state, "Results from multivariate logistic regression show that both measures of economic capital and low social capital were significantly associated with poor health status, with only a few exceptions" (p. 932).

That all being said, addressing CHNA and the SDOH are not simple as preventative work is hard to measure, and healthcare traditionally is based on a results model of treatment. This is further supported by Horne and Costello (2003) who state, "The medical profession views only the most rigorous data as acceptable- the so-called 'hard' as opposed to 'soft' data sources …The emphasis on any effective health care system should be on meeting the basic needs of each community and the provision of services that are easily accessible and acceptable to all, involving full community participation" (p. 348). However, gaining full community participation is not an easy task, and even though the CHNA process suggested by the CDC includes guidance, there is a lack of cohesive CHNA work across the country. Making it more complicated is that hospitals are simultaneously being challenged to reduce the cost of care and increase quality, which has led to lean organizational management strategies, a focus on patient experience and incentives to increase community collaboration, while not increasing staffing to do so (Peter Jacobson, personal interview, February 24, 2017).

Even though specific professions historically addressed SDOH outside of healthcare systems, there seems to be a lack of recognition in healthcare of the utilization and impact that macro social work, public health or community development can have on achieving the triple aim of healthcare. This could partially be because, "Rosenberg (1983), referencing an earlier observation by Bracht (1974), noted that the profession (Social Work) short-changed itself in having a role in managing, coordinating, and planning the functions of the emerging health care systems by maintaining a focus only on what we perceived to be the manner of conducting one-on-one clinical work" (Spitzer & Davidson, 2013, page 19). In addition, there seems to be little research done by health systems on which professions are most appropriate.

2.3. Social Work & Healthcare

2.3.1. History of social work

Social Work practice has a long history of positively impacting populations by focusing on social determinants through micro, mezzo and macro level interventions in healthcare since the early 1900's. Social development, community organization and community development all are a focus of social work since its beginnings. Social Work, community development and health can be tracked together way back to the early 1900s when Jane Addams paved the way to improve the, "…deteriorating social and environmental conditions of Chicago's industrial neighborhoods which led to improved housing conditions, prevented child labor, enabled labor organization, increased regular garbage collection, and expanded the national dialogue on women's issues and actions toward peace" (Gamble, 2010, p. 4). Jane helped develop the profession in the late 1800s/early 1900's through two movements, the settlement house movement (the social worker was the facilitator of community change) and the Charity Organizations Society (COS), or practice involving individual aid and change processes. The basis of the settlement house movement, influenced by Jane, is that the goal of social work is on community & societal reform to improve conditions and not on individuals (Kelly, October 10, 2013).

These ideals became the basis of social work which advanced the notion that national society is responsible for addressing the impact that a fast changing and evolving industrial world has on human lives. Professionals agreed that this needs the attention of a system approach. According to Hopps and Lowe (2013), "This includes a professional who will direct attention to the intersection of psychological development and educational growth of individuals and the socio-political-economic world in which they lived and are nurtured" (p. 3).

15

2.3.2. Function in healthcare

The function of social work in health care is, "to remove the obstacles in the patient's surroundings or in his mental attitude that interfere with successful treatment, thus freeing him to aid in his own recovery" (Cannon,1923, p 15). But healthcare has changed, and so has social work in healthcare; "Social work in health care emerged with immigration and urbanization associated with industrialization, and the resultant shift from physician visits to the patient's home and workplace to hospital-centered care. This change is alleged to result in a loss of the doctor's perspective of the psychosocial influences on physical health" (Cowles, 2013). This has been problematic as it removed the lens of the physician to see what environmental, social and economic factors might be influencing their patients' health, and so the presence of social work in healthcare changed.

Social workers play a diverse role in health care as the major functions of hospital social work include direct interaction with the patient, or micro practice. This role includes: screening and case finding; crisis intervention; bereavement and grief counseling; psychosocial assessment and intervention; brief counseling and group work; documentation and record-keeping; discharge planning and case management; post-discharge follow-up and outreach; emergency services; and inter-professional collaboration and advocacy (Reisch, 2012). However, the community intervention or focus on macro practice has become minimal.

Some social workers in healthcare focus more in a macro practice role though. Studies show that rural social workers are focused on macro practice & community engagement more than urban social workers. The role of the rural social worker often includes not only micro practice, but also serving as a community organizer or social service administrator. Many rural communities experience a shortage of professionals and so social workers find themselves

coordinating, developing and maintaining resources in the community (Davenport & Davenport, 2008).

Macro social work, or community practice, is one of the three focus areas of social work and has been part of social work practice since the adoption of the profession in the late 1800s. Macro practice social work has inclined at times and declined throughout the years. Currently, some social workers move in and out of macro practice, and others focus on macro practice within their role. Indeed, social work is a dynamic profession in that, both knowingly and also perhaps in less rational ways, its identity has been responsive to social conditions and climate which is reinforced by Reisch and Gorin (2001) as they state, "Social work practice and education have long been influenced by development in the broader U.S. economy, particularly as they affected such issues as employment and unemployment" (p. 9). In recent years, according to Allison Tan (2009) it (Macro SW practice) has become, "…relegated to brief mentions in policy and practice courses" within the academic setting (p. 2). This is seconded by Jacobson (2001) who states that the emphasis on therapy within the practice is so substantial that many of the skills and activities long associated with macro social work (community organizing, advocacy, system reform work, activism, human capital development and community economic development) are no longer considered 'social work'.

But, as communities tend to experience more significance of poverty, professional isolation, ethical challenges, and resources, an effective social worker must embrace the culture and be committed to the community and people in it (Mackie, Zammitt, & Alvarez, 2016). A research study in 2007 identified that social workers should, "…engage in community practice and assessments and that assessments should focus on the "community in environment" or social

17

and economic context" (Riebschleger, 2007, p. 206). This reiterates a need for stronger focus on macro practice and community development in rural communities.

2.4. Social Work and Community Development

2.4.1. Social work academia

The education curriculums of Social Work according to the Council on Social Work (2001) in the Education Curriculum Policy Statement state the purposes of social work are:

- to enhance human well-being and alleviate poverty, oppression, and other forms of social injustice

- to enhance the social functioning and interactions of individuals, families, groups, organizations, and communities by involving them in accomplishing goals, developing resources, and preventing and alleviating distress.

- To formulate and implement social policies, services, and programs that meet basic human needs and support the development of human capacities

- To pursue policies, services, and resources through advocacy and social or political actions that promote social and economic justice

- To develop and use research, knowledge, and skills that advance social work practice

- To develop and apply practice in the context of diverse cultures

In the United States all social work practitioners, regardless of level of practice, are bound to a common Code of Ethics written by the National Association of Social Workers and focus on the value of social justice. All social workers are required to, "advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political,

cultural values and institutions that are compatible with the realization of social justice" (Reamer, 1998, p. 283).

There are also four related purposes for professional social work:

1)   The promotion, restoration, maintenance, and enhancement of the social functioning of individuals, families, groups, organizations and communities by helping them to accomplish tasks, prevent & alleviate distress, and use resources

2)   The planning, formulation, and implementation of social policies, services, resources and programs needed to meet basic human needs and support the development of human capacities

3)   The pursuit of policies, services, resources, and programs through organizational or administrative advocacy and social or political action to empower groups at risk and to promote social and economic justice

4)   The development and testing of professional knowledge and skill are related to these purposes

(Council on Social Work Education, 1994)

2.4.2. Community development academia

A best practice within macro social work and public health, which has now become its own academic program is community development.   A website on "Community Development" (n.d.) states that community development,

"…strengthens the capacity of people as active citizens through their community groups, organizations and networks; and the capacity of institutions and agencies (public, private and non-governmental) to work in dialogue with citizens to shape and determine change in

their communities" and "It plays a crucial role in supporting active democratic life by promoting the autonomous voice of disadvantaged and vulnerable communities. It has a set of core values/social principles covering human rights, social inclusion, equality and respect for diversity; and a specific skills and knowledge base"

In addition, Gamble (2010) goes on to say that, "Community practice work in sustainable development will draw upon the values inherent in social justice, human rights, and the rights of nature" (p. 12). This also reinforces the emphasis on social justice values.

2.4.3. Public health

Public health also needs to be examined in relation to academia in CHNA as it has been a profession and academia for almost 100 years in addressing population health. Public health provides "guidance and direct assistance through planning, implementation, and evaluation of population- based health education and promotion interventions and partnership with community groups, organizations, and coalitions to support strategies that promote public health" (Public Health Education & Health Promotion, Oct 14, 2018). Historically, the profession began during the early 1900's in response to epidemic diseases in times of crisis. Wickliffe Rose organized the commission, to develop a new profession dedicated to promoting health and battling disease at the population level- creating the curriculum for public health (Institute of Medicine Committee on Educating Public Health Professionals for the 21st Century, 2003).

Historically, public health professions struggle with funding for education programs. Public health education has included environmental, sociopolitical and biomedical areas in the past, but the program has adapted to offer a wider variety of focus areas including epidemiology and biostatistics, social policy and the history and philosophy of public health, and management and organization for public health. Not only has the curriculum changed, but in 2001 estimations

shown that approximately 80% of public health workers lack specific public health training (Institute of Medicine Committee on Educating Public Health Professionals for the 21st Century, 2003).

2.4.4. Similarities

Macro social work practice and community development are intrinsically similar, and public health is closely related as a field of study as well. In recent years Tan (2009) states that, "Community Development Theory is the most practical framework for social workers seeking lasting change for individuals and the communities and societies in which they live" (p. 6). Community Development focuses on the centrality of oppressed people in the process of overcoming externally imposed social problems. This has led to changes in curriculum as currently macro social work now focuses on sociological theory as well as psychological as community development is the majority of the curriculum in macro Social Work academic programs.

In the "Analytical Skills for Community Organization Practice," which is a guide for skills in social work macro practice, Hardina (2002) teaches eight different models of community practice as community practice and development is part of macro social work curriculum. Even though Community Development does not have a council on education, community development mirrors much of the social work purposes, as it is, "…perhaps best used to describe those approaches which use a mix of informal education, collective action, and organizational development and focus on cultivating social justice, mutual aid, local networks and communal coherence" (Ghasidas Vishwavidyalaya Bilaspurp, & Guru, 2015, p.14). In addition, Estes (1997) states that community development practice has always been at the conceptual center of social work practice for the following three reasons:

1) community work seeks to unite previously unorganized people into effective groups and coalitions that work together in pursuit of a shared social agenda (e.g., improved schools, safer neighborhoods); 2) community work seeks to strengthen traditional family, kinship, and neighborhood ties in the community and to develop new social arrangements that are essential to the effective functioning of communities; and 3) community-based social services are among the most effective and cost-effective approaches for serving the poor.

Simultaneously, community development enhances public health as Jeni Miller (2015) states, "In public health we know that where you live has a profound effect on your health…we don't have the tools to know what to do about it… but, there is a sector that does: community development" (p. 9). Community development is noted as a best practice in public health, or at minimum as a collaborative partner in public health work.

Participatory Action Research is a practice taught within Community Development, is also taught in macro social work practice and is defined by McIntyre (2008) as "…offering people that opportunity- the opportunity to act on events that directly affect them and that contribute to their individual and collective well-being" (p. 40). PAR includes planning, acting, observing and reflecting which continues to provide insight as a cyclical process. PAR engages the person and empowers them to create sustainable change together. Stoecker (2013) expands the principle of participation and sustainability by adding that, "People who share a common direction and sense of community can get where they are going more quickly and easily because they are traveling on the thrust of one another" (p. 21).

All three academic areas focus on community structure, process and empowerment, and include organizational and community development and policy which are practiced in a variety of

roles.   The separation of social work, public health and community development is that

community development is based in sociology, social work in is based on psychology theories,

and public health is based on the theory of disease.   But they are far more in common than

different. Brueggameann (2006) states that macro social work roles include community

development and organization, leadership, policy advocacy, social change processes, program and

organizational development and international practice.   Examining the roles in community

development, public health and macro social work; there are similarities between the professions.

It appears that community development is an intersection between macro social work and public

health, but also has its own individual profession as well (Table 1).

Table 1: Community Development, Social Work and Public Health Skills & Knowledge

Community Development Roles	Public Health	Macro Social Work Roles
Community educator, consciousness- raising, training, informing	Assess individual and community needs	Policy analysis and advocacy
Technical - participatory research, project development, community assessment experts, community asset mapping	Manage health education programs & personnel	Community & human services specialist
Liaison, policy analyst, advocate in addressing structural inequalities, and public relations	Writing Grants	Community & organizational program development
Facilitation: community organizing, strategic planning, program implementation, management and evaluation methods, group mediation	Evaluating health education programs	Research and analysis
Community economics, sustainability and budget management	Conducting research	Community Education
	Developing educational methods	Community Advocacy
	Developing social media and marketing campaigns	Community Organizing

Note. Data for Community Development, Social Work, and Public Health Skills and Knowledge from Pittaway, Emma & Georgia Swan (2012), Introductory Guide to Macro Social Work; Generalist Social Work Practice, (2013) & Institute of Medicine Committee on Educating Public Health Professionals for the 21st Century, (2003).

2.4.5. Limitations in healthcare

This is all too common that the role of social work, community development and public health are misunderstood, or the value of the academia is not recognized.   Supporting this theory; there are barriers to collaboration in healthcare including the lack of understanding each other's role (Widmark, Sandahl, Piuva, & Bergman, 2011). More than 70% of macro social workers in a survey reported that their position is open to other professions, a majority of the positions held

require technical macro-focused expertise, and studies suggested that in order to continue to prepare students for macro positions that advanced macro-specific education should be a component (Prizker, & Applewhite, 2015). Even though medical settings are ranked as the third most common area of practice among social workers (NASW 2009), the focus of those positions has been in mental health services and micro social work practice. This is seconded by Gorin, Darnell, and Allen (2014) as they also state the opportunities for increased roles in social work are micro focused as, "…navigators, assisters, certified application counselors, or ombudsman", or in improving care coordination (p. 16).   Only 6.5% of Social Workers specialize in macro practice, only 18% of the social work licensing exam is on macro practice, and research appears to show a, "troubling move toward truncation of training and practice in organization, community & policy intervention" within the social work field. (Donaldson, Hill, Ferguson, Fogel & Erickson. 2014. p. 59; CSWE, 2012).

Additional barriers also present themselves; such as that social workers do not measure value well & lack intervention or outcome based measurements in general. Social work has an implementation gap, or distance between available evidence –based interventions and interventions delivered in care, and the research data on it is limited due to it " …lack(ing) a strong tradition of quality-of-care research" (Hopps & Lowe, 2013, p. 13).

Furthermore, Hopps and Lowe (2013) state that, "The gap between what we know from scientific research and what is used in social-work policy, administration and direct practice is a long-standing concern of social work" (p. 4). The field needs to improve evaluation and documentation of quality of care received by communities. Challenges in analysis plans includes determining the action at an organizational and policy environment &, "…the next generation of

studies needed will address sustainable integration of interventions within health care systems and the implementation of macro based interventions vs. micro" (Hopps & Lowe, 2013, p. 17-18).

In relation to public health, there is also a lack of value and a short changing in developing rigorous, data driven methods, and being able to tie those to economic evaluation and intangible subjects like social justice improvements (Neumann, Peter, Jacobson, & Palmer, (2008). Furthermore, they state, further, "people don't attribute value to public health and its impact on community health" (Neumann et al., p. 19). This is seconded in the fact that the majority of articles found about public health and CHNA are about public health departments partnering with hospitals in CHNA work, but very little can be found that really supports hiring public health people to do CHNA work.   However, in googling community health need assessment manager positions, a degree in public health appears sometimes as a requirement, but not social work or community development.

Even though community development arises as a "best practice" in healthcare and population health, there is not one community health needs assessment manager position that this researcher could find that includes "community development" education as a suggestion or requirement.   Instead, articles focus on the bridging of bring community development professionals into the same room as health care professionals, which is demonstrated by Walker, Miene and Hightshoe (2017) as the summit on "Healthy Neighborhoods, Healthy Communities" brought public health, health care and community development professionals together to collaborate, however, it failed to mention the potential for public health and community development professionals to work in health care.

2.5. Population Health and Healthcare

Multiple initiatives to address population are arising across the country, but focus primarily on internal health systems. Hospitals and physicians are getting feedback on their performance. They are learning best practices from each other and from the robust clinical data collected by the programs (Jacobson, Peter, personal communication, February 24, 2017). However, the weakness of these initiatives are that they again are only inclusive of physical health professionals, they lack community focus and there is a lack of empowerment of the community to address the root causes of SDOH.

Healthcare studies show that health disparities are due to differences in socio-economic variances as well. A number of outcomes confirmed the existence of well-known difficulties in accessing healthcare, such as difficulties with physical access to secondary care services. There is a poor understanding of primary health care services & the role and function of the varying professionals. This provides an opportunity & challenges to develop health improvement programs in order to reduce inequality in health. (Horne & Costello, 2003, p. 340).

Progress towards developing standards for CHNA's took place across the nation, but limitations and lack information on what educational backgrounds are the most appropriate for someone in the CHNA management role still exist. In 2011, a national conference held primarily focused on developing best practices for CHNA & implementation; including factors such as shared accountability between agencies, defining community factors, data analysis, community engagement and strategy development and execution (Barnett, 2011). Not one part of the 147 page document outlines which educational fields are beneficial to hire to be effective in the CHNA management role.

Similarly, the Association for Community Health Improvement (n.d.) developed a Community Health Assessment Toolkit, and even though it outlines the steps needed to do CHNA, there is no recommendations on their site or information about educational programs that prepare an individual to be successful in this role.   Even though it is acknowledging that healthcare needs upstream approaches to healthcare, part of the challenge is that, "…approaches to community involvement, CHNA and participation in decision making vary" (Horne & Costello, p. 349). There are supportive resources to help implement CHNA and Implementation plans, but there is not a requirement or recommendation on education, individual manager skills, or knowledge base.   Therefore, CHNA managers include diverse backgrounds and many are unprepared or up to the challenge of effectively addressing the SDOH.

2.5.1. Opportunities

Introducing public health, community development and social work professionals as primary academic programs for CHNA work is an opportunity for health systems. The two traits identified by Michael Weyers research on community development workers in Africa to be the most important in order to be successful are, "…1) pushing discomfort and hope simultaneously by empowering the public to be experts on their situation & using collaborative procedures to take ownership of their future using assets, strengths and abilities of the community 2) They help community members overcome learned helplessness & build resilience by empowering them to take charge" (Weyers, 2011, p. 94-95).   Overall, they concluded that teaching community-development social workers to focus on empowerment, passion to inspire and a vision are the most important things in developing sustainable communities (Weyers & Herbst, 2011).

There are other frameworks proposed to help healthcare organizations address upstream health issues, or SDOH. However, there is a need for more effective measures to understand the

impact of income, education and related community interventions that impact health. Last, we need consistent and ongoing financial support for organizations that provide enabling social services and support. As said by the Robert Wood Johnson Foundation (RWJF) (August 21, 2013), "We need to develop a comprehensive ecosystem that addresses the social determinants of health".

2.5.2. Moving forward in health care

Health care facilities need to recognize what will move health forward in the ACO model of care, and should be aware of academia that supports CHNA and related work. The Robert Wood Johnson Foundation's mission is to "Improve the health and healthcare of all Americans" (August 21, 2013). RWJF provides grant funding to health care agencies on a competitive basis that are working towards these efforts. This provides incentives for health care agencies and communities to work together to improve patient health. "Moving beyond coordination to integration will require the health sector to see community development as its partner in addressing the 'upstream' factors that influence health" (RWJF, Nov 8, 2013). Furthermore, acceptance of diversity bears directly on social justice, and social justice is a fundamental objective of community building and community practice (Weil, 1996) and a platform for collective action (Sampson, 2012).

Participatory Action Research (PAR) has been utilized in community health needs assessments in healthcare to gain perceptions of needs and also to increase local participation in activities. Community development, "…maximizes the community participation to address health holistically to address some of the fundamental issues, aka social determinants that lead to poor health" (Horne & Costello, p. 342). Empowerment Evaluation, a community development framework, has also been proven to be an effective framework within the medical field in making

system changes; "The use of empowerment evaluation concepts and tools fostered greater institutional self-reflection, led to an evidence-based model of decision making, and expanded opportunities for students, faculty, and support staff to work collaboratively to improve and refine the medical school's curriculum" (Fetterman, Geitz, & Gesundheit, 2010, p. 820). The definition of Empowerment Evaluation is "…the use of evaluation concepts, techniques, and findings to foster improvement and self-determination" (Fetterman, 2001, p. 3). EE expands the ability to determine purpose, roles and actions compared to traditional research and is effective at building capacity.

In Michigan the U of M has been involved in what they call a CQI model, or a collaborative quality initiative. The Institute from Healthcare Improvement (2013) states that there was a shift in thinking; "We should become a health *improvement* organization, not a health maintenance organization" (p. 13). This model includes gathering community stakeholders and creating partnerships between participating hospitals and physicians. The initiative breaks the pattern of competition and creates an atmosphere of collaboration and learning instead.

A second Community Development initiative in California is taking place in the Sunnydale neighborhood; one of the most desolate neighborhoods in terms of poverty, lack of access to food, housing and healthcare. This initiative has been built to redevelop the area with new mixed housing units, a grocery store, pocket parks and a community center. The study seeks to measure, "… the health effects of the redevelopment on its residents" (Robert Wood Johnson Foundation, August 21, 2013).

Spitzer and Davidson (2013) state that there is a, "Heightened focus on non-medical barriers to health care and the need to negotiate increasingly complex service delivery systems will, however, demand greater brokerage and collaboration skills" which reiterates the

opportunity for macro practice and community development in health care (p. 975). Allison Tan (2009) suggests that in order to bridge the divide that macro social work practice should focus on the framework of Community Development Theory as a solution in today's society, that there is a resurgence of the importance of macro social work practice, and that, "Community Development-based social workers can provide a new, innovative face to the social work profession" (p. 2).

The World Health Organizations message about disparity, inequity and advocacy targeting marginalized or dis-enfranchised populations that are oppressed and/or vulnerable frames the SDOH as a social justice issue, which is therefore integral to the social work profession specifically in macro practice (Healthy People 2020, 2016). This provides an opportunity for social workers to expand their services to address social determinants, to utilize the variety of roles a social worker is trained in and to design effective evaluation methods to measure the impact of their work. "Heightened focus on non-medical barriers to health care and the need to negotiate increasingly complex service delivery systems will, however, demand greater brokerage and collaboration skills" (Spitzer & Davidson, 2013, p. 975). Christine Rine, (2016) states in an article in Health and Social Work that, "it is incumbent on the profession to adapt and evolve within current practice arenas while actively seeking new spheres of proficiency in the future landscape of policies, initiatives, programs, and interventions that are built on an SDOH perspective" (p. 143).

2.5.3. Community development, public health & SW opportunities

Collaboration has been a key element in positively impacting population health, one of the most promising frameworks to build collaboration is through collective impact, which is distinct in that, "Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared

measurement, continuous communication, and mutually reinforcing activities among all participants" (Kania & Kramer, 2011, p. 3) Community Development, Public Health and Macro Social Work both recognize the importance of collective impact, and the Community Capital Framework (Model 2) , a model discovered by Flora and Flora (2012), exhibit how building on community capital, or assets, leads to community cohesion and the outcome is healthy people, ecosystems, vital economies and social wellbeing in communities. The importance of community capital is seconded by Beaudoin, (2009) who states there is high potential for health interventions and policies that target the development of bonding social capital specifically, along with other capitals.

Model 2: Community Capital Framework. Reprinted from Flora and Flora (2012), retrieved from http://www.dailyyonder.com/files/imagecache/story_side/imagefield/Comm-Capitals-Framework360.jpg.

The National Association of Social Workers (2009) identifies that "Effective rural (social work) practice involves locality-based community development" (p. 297). The history of rural

social work supports that statement as its focus has been on resolving issues of access to services, equity, isolation, and supporting and advocating for marginalized and at risk populations which requires a range of personal intervention and community skills (Davenport & Davenport, 2008).

Macro social workers in leadership positions with human service organizations or positions with community and policy influence can bring important benefits. According to Gamble (2010), "Social workers can provide leadership and organizational assistance to community groups interested in establishing cooperatives, complementary currencies, and alternative economies with goals for food and housing security, promotion of health and education, and solar- and wind-energy sources" (p. 11). Macro practice social work skills and knowledge include helping communities to improve quality of life through community engagement & empowerment leading to productive, healthy resilient communities (Ungar, 2005). Social workers can help local communities network with others to develop the social, economic and cultural resources required to build resilient communities through the use of participatory research, social learning, community organization and social/political practices. (Gamble, 2010). "Social Workers bring a combination of technical expertise and an understanding of the importance of contexts and relationships in guiding agency and government policy…, create a pipeline for future social works students and professionals to accrue these positions", yet fewer are serving in these positions than in the past (Pritzker & Applewhite, 2015, p 191). Social Workers need to take advantage as a profession of the opportunity of macro practice in healthcare.

Mendes (2008), as a teacher of community development to social workers, reiterates the level of importance of macro practice as community intervention based on asset development is more effective than individual casework interventions in addressing social needs and the focus on system, environment and policy creates sustainable preventative solutions. Even though this is

33

proven to be true as casework or micro practice is inherently deficit oriented as the problem has

been identified so services are reactive, and it doesn't address the systemic root of the problem,

less than 10% of social workers include a primary focus on macro practice today.

Public Health can contribute to the CHNA work as it includes the summary and analysis

of primary and secondary data to characterize the health of the community, and this is used to

help assess the needs, develop programs and inform policies.   Similar to macro social work,

community development is noted as a best practice in public health work to achieve health

outcomes.

In general, all three professional educations provide great skills and knowledge to address

CHNA it seems, community development is noted as a best practice within public health and

social work professions, but is also its own program.   As health institutions are doing CHNA

work, it is crucial to understand what skills, knowledge and values are perceived as the most

important by those within the health system as there doesn't seem to be consensus, so that it can

inform those academic fields of the desires of health professionals, and inform health

professionals of the academic programs that provide such skills.

CHAPTER 3: METHODOLOGY

Not enough literature is available to know what health administrators perceive as the most valuable skills, knowledge and values for a CHNA manager or personnel. With the emergence of population health strategies, Community Health Needs Assessment requirements and a continuous changing healthcare system there is a lot of room for exploratory research. This is one beginning to identifying a piece to a large puzzle and starts the conversation on an important, but not yet studied topic.

3.1. Research Question

What are the perceived most important skills, values and knowledge for the CHNA manager to be effective in their role by CHNA personnel? How do the identified skills match with macro practice social work, public health, and community development education skills, knowledge and values?

3.2. Research Theory and Methods

This study will use inductive research, qualitative methods and data evaluation methods to answer the research questions. Inductive research "involves the search for pattern from observation and the development of explanations – theories – for those patterns through series of hypotheses" (Bernard, 2011, p. 7). As this study is looking at an emerging area, inductive exploratory research is the most appropriate. Inductive research will allow exploration into the understanding of what people perceive as the most important skills, knowledge and values in CHNA management by personnel at one health system.

Grounded theory, which is a, "…systematic methodology in the social sciences involving the construction of theory through the analysis of data" (Conteh, 2017, p. 256), will be utilized to guide data collection as a research tool. Grounded theory is appropriate as it provides a set of

rigorous research processes, which leads to the emergence of concepts or theories. The researcher will utilize grounded theory as a general method of research and also qualitative research methods. In addition, a Likert scale will be utilized to measure significance of the self-reported knowledge base of the differing CHNA personnel and administration.

The researcher chose one healthcare system to complete the research that has multiple health facilities across multiple states, and multiple CHNA personnel within it. This system was chosen as a) the researcher works within this system- so it is easier to access, b) it is a large healthcare system and there are multiple CHNA staff to interview c) part of the observation includes the researcher's knowledge of the divergence in what education a CHNA manager should include, and what skills or knowledge is important. The researcher identified eleven CHNA related staff, including herself, across the facility and provided informed consent to each to participate in the research study. Utilizing Skype, the organization's video conferencing tool, the researcher interviewed each of the participants via video conference in March 2017. The researcher also utilized skype to video record her own interview and asked herself the questions on the survey. Each interview was recorded, downloaded into NVIVO data analysis software, transcribed by the software and coded within it. Survey questions included asking the participants what they perceive their own level of knowledge of CHNA to be, and what skills, values and knowledge they thought was most important for the CHNA managers (Appendices A, B & C).

In Table 4 the characteristics, including gender, job role/title and educational background are identified. After the perceived skills, knowledge and values were identified they were compared to the academia skills, knowledge and values of public health, social work and community development through evaluative data methods. For the purposes of the study, all

participants that are not CHNA managers will be referred to as administrators, as each has a role

in administration within the organization.

3.3. Data Collection

IRB approval was obtained from North Dakota State University and through Essentia

Health Research Institute before data collection could begin.   IRB approval from each was

applied for and both Essentia and NDSU. They each granted exemption as the study does not

apply as human subjects research, so the study was approved to proceed from each facility

(Appendices D & E).

Table 2: Participant Data

Gender	55% female 45% male
Job Titles/Roles	36% CHNA Managers 64% Administration with oversight or influence on CHNA managers: breakdown - Administrators of each location - Population Health Administration - CHNA Administrative Leaders - Mission Integration - CEO
Educational Background	83% of interviewees have a minimum of a Masters Degree 2 in Public Health 1 in Community Development 1 in Social Work 1 in Business Administration 2 in Healthcare Administration 1 in Health Relations 2 Physicians 1 in Public Administration 1 in Human Resources *1 participant has Social Work & Community Development Education and so the same person was noted under each leading to a total of 12
Location	Greater Minnesota

Utilizing Appendix A, B, and C, intensive interviews of CHNA managers and CHNA management (administrators) was conducted by the researcher. The interviews were recorded and analyzed using NVivo, a qualitative and quantitative software used to analyze data in research studies. Interviews were reviewed utilizing open coding in NVivo to identify patterns and concepts from the data, and included evaluative data methods. Data collection, analysis, memoing and sorting was ongoing, and overlapping in the study as the software tracked words emerging from the data, and rigorous review of the results and sorting of concepts or theory was necessary for validity.

All participants were asked to participate in the interview which includes ranking themselves on a scale of their knowledge, asking about their perception of the most important skills, values and knowledge needed for a CHNA manager to be effective through guided and open ended questions; see Appendix A, B and C. The interviews were kept in a password secured computer and software base to ensure confidentiality. All participants remain anonymous.

In addition, the researcher participated in the study as an observer with her own knowledge about CHNA within the organization, and conducted her own interview as she is one of the CHNA managers. The researcher described her own knowledge of experiences as a CHNA manager and integrated that into the knowledge learned in the literature review and results of the interviews. Her input is woven in along with other interviewees so it maintains anonymity and will not jeopardize the integrity of the study.

3.4. Methodological and Ethical Considerations

The study has limitations as it only includes interviewing eleven people, which is a small sample. However, this exploratory study is important as the topic is not yet studied. It is a start to a larger conversation.

Careful consideration was given as the researcher is a participant in the study and an employee of the organization of study. In addition, the researcher has dual roles of CHNA management across four locations, but only one of those was included in the study so as not to skew results. The researcher utilized her own knowledge, but practiced critical consciousness to keep biases out.

A risk could be that the study shows organizational or practice gaps at different sites, and so anonymity of who is reporting and from which site was important. A second risk is that some administrators may not appreciate the results of the study, as it is subject to identify weaknesses of the organization. As the study is comparatively small, ensuring anonymity is challenging. Informed consent specifically addressed anonymity for the individuals, and the organization involved in the study. Participation was voluntary, and so the validity of this study heavily relied on the participation of organizations and individual interviewees. No interviewees refused the interview or voiced concerns voiced about the study.

Data gathered has potential to be published, so clear written and verbal discussion on confidentiality and anonymity and how that will be protected was required. Participants were provided with a written copy of the terms of the study, and all agreed to them. The information from this study will be utilized as a learning opportunity for healthcare facilities/ people that work in healthcare facilities, for social work practice, and for community development practice.

CHAPTER 4: FINDINGS

4.1. Researchers Observations

As the researcher, and an employee of the organization, the observations were a summary of those made over the past three years in CHNA management. Observations include: a lack of consensus on what population vs. community health really is on an administrative level, a lack of a standard approach to CHNA work, and a lack of understanding on how to positively impact community health.

Being a CHNA manager is a very demanding job, and typically is a one-person, some are even part time staff, in a department within a facility. In many facilities the CHNA manager role is a small portion of a role allotted to someone serving as an administrator already. The role of the CHNA manager is to complete the community health needs assessment every three years and develop strategies with the community to address the top priorities, also identified by the community. In the past three years, there are three separate instances where CHNA managers specifically were asked to move forward with initiatives that are population health initiatives, but were not identified as CHNA priorities. When questions or concerns were brought forward about focusing on population health, and not community health, there was confusion from administration on multiple levels in understanding the difference, and why that mattered based on the researcher's perceptions. There are still ongoing requests being made of CHNA managers by administrators on all levels to address population health issues that are a priority of the health system, and not of the community. An example is the roll out and pressure to improve the number of completed advanced care directives, or pre-diabetes classes. Both are important in population health, however neither of these is related to the priorities identified by the community in the community health needs assessment.

A second issue is there is no consensus or standardization of how, or which framework to use, to be successful in CHNA work.   As a system, there has been no standard framework in the past three years on how to complete the CHNA assessment itself, what data to obtain, how to engage the public, how to develop strategies, measure and evaluate success within the community or within the health system.   There has also been no standard in how to impact community health indicators.   Many of the initiatives at different sites are "feel good" things, such as setting up a booth at a health fair, or handing out flyers that explain that sleep is important.   Few of the initiatives focus on policy, system or environmental changes- the basis for best practice for community change.   None of the initiatives led to measurable change in population health indicators within the communities to date, and this approach is problematic in CHNA work.

Each site differs dramatically in how they operate, how they choose priorities, who is engaged from the community to identify the priorities, and what they focus on.   One site primarily invests in educational activities around pre-diabetes and mental health education. Another site invests in addressing access to affordable housing.   Only one site utilized the primary survey data and secondary data to educate the community, held focus groups and allowed the community to select priorities, and not leaders of the community.

Internally, there has been disagreement in what can be included as a priority, even if identified as a top concern of the community.   At one point, there was a disagreement in whether or not the CHNA managers could address access to affordable housing.   To this day, there is still a divide in perceptions of what CHNA managers should be investing time and effort in for priorities, and how that is decided.

Additionally, the lack of value of educational programs that teach the skills and knowledge of how to do CHNA work has been apparent as the majority of the interviewees that

oversee the CHNA managers demonstrated disagreement on how to conduct CHNA with the people who are CHNA managers with this background or training.   None of the interviewees that oversee the CHNA managers have education in public health, social work or community development.   However, 3 out of the 4 CHNA managers have a degree in public health, social work or community development.

4.2. Perception of Skills, Knowledge and Values

The interview portion focused on eleven participants; including a mix of administrators who manage CHNA personnel and CHNA managers, including the researcher. Each was asked to rate themselves on a 5 point scale, 1 being not at all and 5 being excellent, of their understanding of the skills, knowledge and values important for a CHNA manager to be effective.

One of the findings is that all but one of the interviewees feel they are very knowledgeable about what the most important knowledge, skills and values for CHNA work is (Figure 5). Further results of "why do you feel you rate yourself there" of the people that are administrators over CHNA managers revealed they felt they were knowledgeable because of their experience overseeing a CHNA manager.   Only two people ranked themselves as a 5, one administrator and one CHNA manager. There were two outliers in this data question: 1) one administrator reported that academic models that teach community work are not really usable in CHNA work 2) one person reported that they were limited in knowledge and ranked themselves the lowest at a 3.

Table 3: Perception of Skills, Knowledge and Values

Rating	Number of Participants
1 Not at all	0
2 Not very well	0
3 Neutral	.5
4 Well	7.5
5 Excellent	2
CHNA Managers Average Score	4.25
Administration Average Score	4
Public health (PH), community development (CD) or social work (SW) Average Score	4.25
Non PH, CD or SW education Average Score	4

The average score on a five-point scale when asked about their personal level of knowing what knowledge, skills, and values are most important for a CHNA manager to be effective was a 4.09 (Table 3).   The administrators and the CHNA managers revealed a similar average scoring a 4 and 4.25.   In addition, the average of the interviewees with an education in public health, community development or social work vs. the average score of those who are not educated in those areas was a four.

Interestingly, one question specifically asked what knowledge is the most important for the CHNA manager. The result was knowledge of local community, following by having education in public health with 33% of interviewees being in favor of a public health educated person in the CHNA manager role (Figure2).

The second question asked about what each person thought the most important skills were for a CHNA manager.   Even though 100% of the interviewees noted that "Needs Assessment"

skills were one of the top five most important skills out of a list of 32 different options, many of

the responses to the most important skills or knowledge varied (Figure 1).   However, five other

themes arose as most important evenly; 42% of people equally thought that program

implementation, coalition building, strategic planning, program development and community

organizing were in the top five most important skills needed.

Of those with a public health or community development education there was consistency

as all three of the CHNA managers with that educational background noted program

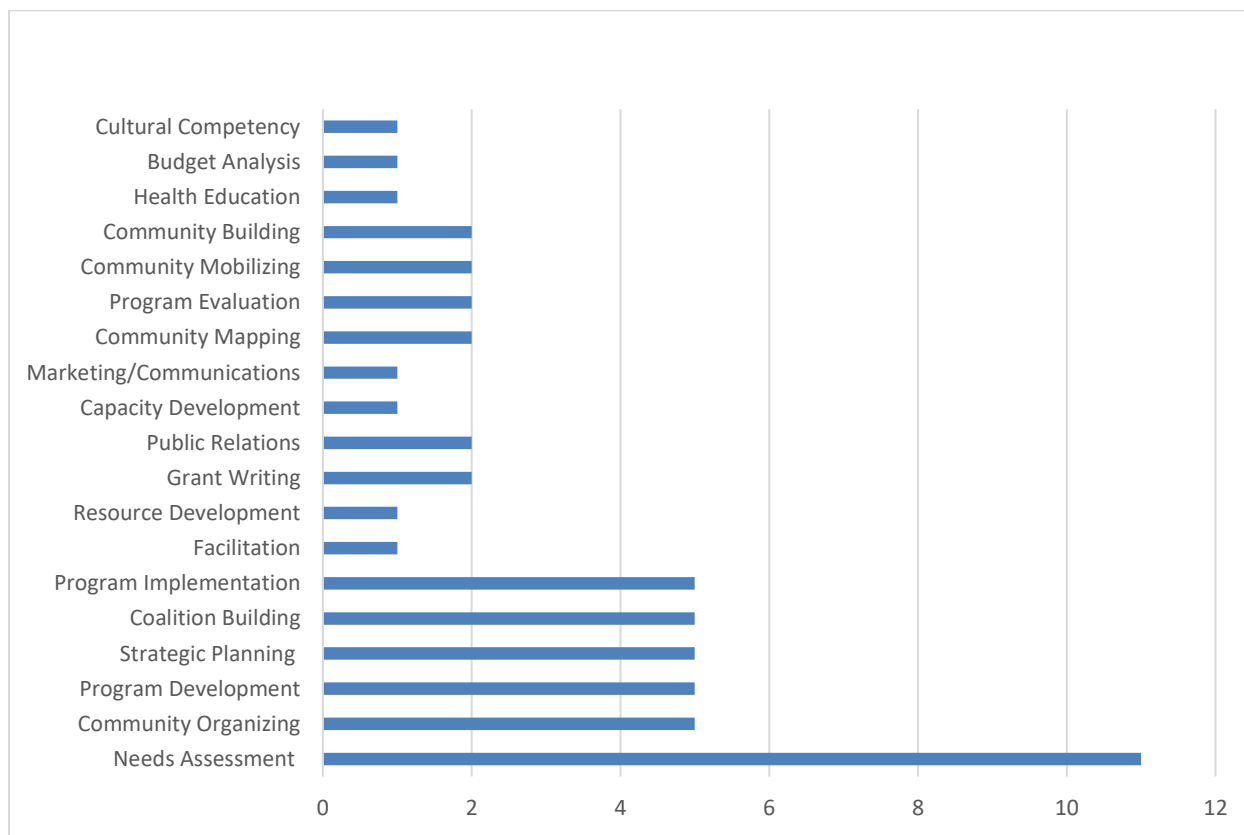implementation, strategic planning and community organizing as in the top five most important

skills.

Figure 1: Top Skills and Knowledge Needed for CHNA Program Manager

4.3. Values of CHNA Personnel

When asked what the most important values are for CHNA program managers, the answers were more consistent, with teamwork and social justice and equity being the top two results (Table 4). There were no outliers in this question. When asked why they felt these were the most important values, every person mentioned the importance of collaboration in the community and how the values they selected are inherent to doing that work.

Table 4: Values of CHNA personnel

Top Values Identified	# of interviewees selecting value
Social Justice and Equity	7
Respect	3
Teamwork	8
Cultural Competency	4
Local Knowledge	5
Perseverance	5
Open Minded	5
Innovative/Creative	3

4.4. Local Knowledge is Key

Throughout the survey, in questions 2, 4 and 5, the importance of local knowledge by the CHNA program manager was mentioned. In question number four, when asked what the most important knowledge of the CHNA manager is, local knowledge of the community- and assets within it, was the most common answer with 83% of respondents mentioning it (Figure 2).
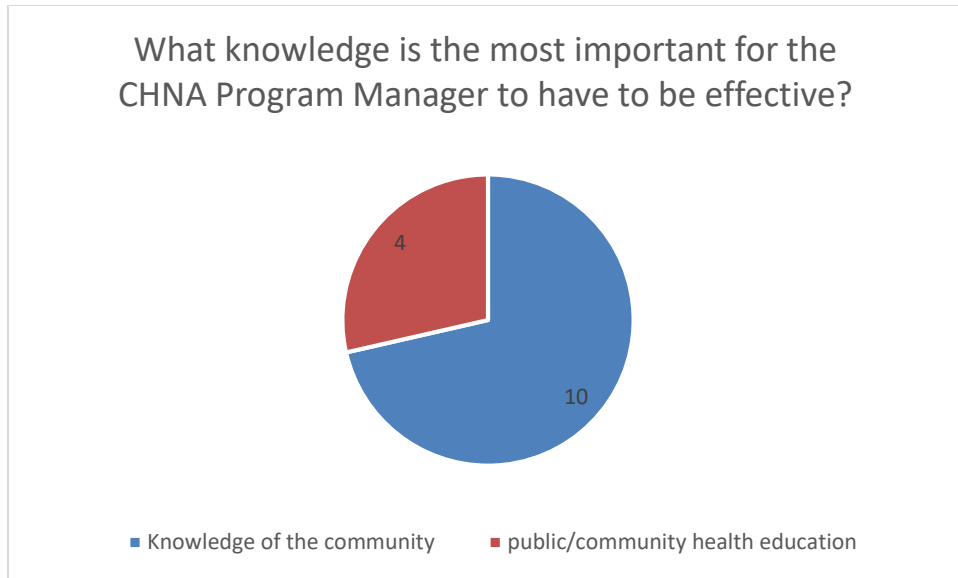
What knowledge is the most important for the CHNA Program Manager to have to be effective?

- Knowledge of the community
- public/community health education

Figure 2: Local Knowledge

4.5. Program Evaluation Methods are an Opportunity for Improvement

Throughout the survey, in questions 2, 4 and 5 when asked to explain information, the themes that arose were the need to be able to analyze data, develop data driven strategies, and evaluate programs and initiatives. In question five, when asked what any other important factors may be that had not been mentioned by them yet, six interviewees or 50% of interviewees mentioned processes or words specifically related to program evaluation, and three people out of the eleven expressed the need for improvement in CHNA evaluation as an organization. These were the only themes that specifically arose out of question five.

4.6. Comparative Data Analysis

Finally, the findings of the perceived most valuable skills identified are compared to the results of the literature review from each field of study (1st identified in table 1). As seen below, the most valued skills overlap with the educational skills and knowledge of each sector, but most closely is aligned with Community Development (Table 5).

Table 5: Comparing Skills, Knowledge & Values of Education vs. Results of Study

*Common teachings, or areas of similarity are highlighted with the same color boxes, and specific skills are the same colors within different boxes. Common words are highlighted to match.
Brown: Needs assessment & research, community asset mapping and local knowledge
Pink: Social justice or advocacy in addressing inequities
Blue: Facilitation includes strategic planning, coalition building, program development & implementation and community organizing as part of the field of study.

Community Development	Public Health	Macro Social Work	Skills, knowledge and values most important
Community educator, consciousness- raising, training, informing	Assess individual and community needs	Policy analysts and advocates	Needs Assessment
Technical - participatory research, project development, community assessment experts, community asset mapping	Manage health education programs & personnel	Community & human services specialists	Strategic Planning
Liaison, policy analyst, advocate in addressing structural inequalities, and public relations	Writing Grants	Community & organizational Program development specialists	Coalition Building
Facilitation: community organizing, strategic planning, program implementation, management and evaluation methods, group mediation	Evaluating health education programs	Research associates and analysts	Program Implementation
Community economics, sustainability and budget management	Conducting research	Community Educators	Community Organizing
	Developing educational methods	Community Advocates	Teamwork & Social Justice and Equity
	Developing social media and marketing campaigns	Community Organizer	Local Knowledge

47

Table 5 above shows that the top five skills, knowledge and values that are percieved as most valuable correlate the most with the skills and knowledge taught in Community Development with all seven matching areas. Secondly, Macro Social Work comes in, but only teaches one semester of community development skills vs. community development which is it's own educational program which the entirety is learning those skills. Public health does teach some of the skills percieved as most important, but not as many as the community development and macro social work fields.

The literature review findings combined with the final data and comparative analysis identify a few things. Even though social work, public health and community development are their own academic programs- community development is at the intersection of both social work and public health best practice (Table 5 & Figure 3) and teaches the most skills, knowledge and values that are perceived to be most important for CHNA managers.

Figure 3: Intersection of Community Development

CHAPTER 5: DISCUSSION

Interestingly, people are not allowed to be a nurse, a physician, accountant, social worker, or many other skilled professions without proper training. So, the lack of value for education, or understanding which fields of education a CHNA manager should be required, is troubling. Unfortunately, the results show the lack of recognition of the skills, knowledge and values taught by the public health, social work and community development educational fields. In addition, the researcher's observations show that administratively in the health system there is a lack of understanding of what the work of CHNA really is as well.

Utilizing exploratory interviews as methodology changes people. Being a participant in the interviews makes people examine their own worldview and explain why they feel justified in their decisions. The act of asking questions raises their consciousness of the subject area. In addition, being a participant they will access results of the study. Preliminary sharing of results with participants resulted in two people that verbally stated their disagreement with the study, but with no reasoning for disagreement. Other participants may be enlightened and perhaps may examine hiring practices in the future, or maybe will value the skills, values and knowledge of staff differently in the future.

Although, public health education was recognized by a few interviewees as important, community development was not mentioned despite having more of the skills and knowledge taught that aligned with the results of the study. Social work was also not identified. This study has shown that there are implications for potential growth in the fields of public health, community development and macro social work in the CHNA management area and that there needs to be work done to educate healthcare systems on the professions that prepare people in the workforce to be effective CHNA personnel. Furthermore, advocacy on the national level would

be beneficial as the CHNA is a federal requirement of non-profit hospitals, and so advocating for skilled individuals to be in the CHNA management role will help to ensure the success of the CHNA work.

Implications for public health, macro social work and community development are that the top skills and knowledge by far was the "needs assessment" skill. These fields would benefit from identifying what the needs assessment process is specific to the healthcare field, comparing the components to curriculum, and then advocating to health systems that they would benefit by hiring someone in those fields. Program implementation, coalition building, strategic planning, program development and community organization may be the next highest skills valued, but interviewees also stated the biggest need was in program evaluation. Therefore, it may behoove academia to advocate how they offer those skills as CHNA is a staple in healthcare systems, and it's valuable to provide skilled workers for a growing demand.

Having social justice and equity and teamwork as the top values is significant, as social justice and equity is the top value of community development and social work practice. Again, showing alignment with these fields. It is promising however, that healthcare administrators are recognizing the importance of social justice and equity issues.

Community development is the best practice in both public health and social work according to the literature review, and even though not mentioned specifically by anyone in the research study, the skills and knowledge they reported as most important are indeed the skills and knowledge taught in the program. This study shows that there is an opportunity specifically for community developers and academia to continue to advocate for presence in health systems, or for more collaboration on how it can support CHNA work at a minimum.

Interestingly, knowledge of the community came up as the most important for the CHNA manager to be effective in their practice.   Even though this may be true, it can be learned and there are skills, such as asset mapping or community capital frameworks, that are taught in community development that assist in learning all about a community in multiple aspects.   It leaves the question open- is it more important to have a CHNA manager that doesn't have any skills in the field but has some knowledge of the community through personal experience, or to have one that has the skills needed and can learn the community holistically.   As the researcher, but also participant, this experience leads me to believe that it is more important to have the education which will teach how to learn the community through a holistic approach and asset based lens, which is evidence based best practice.

Similar to findings in literature that stated that the academic professions are undervalued for their ability to address population or community health, this came through clearly in the findings.   None of the administrators interviewed have an education in the three related fields, and they ranked their skills, knowledge and value level just as high as the three participants with a public health, social work or community development educational background who are CHNA managers.   The notation that one interviewee stated that academic models are not applicable confirms the lack of value as well.

For any individual looking to enter the CHNA field, this study may be helpful to identify what type of education may be the best investment.   In addition, when health systems are hiring the results can be used to formulate interview questions about the level of skill in the most valued areas noted.

Shortcomings of the study are that even though this identifies the top perception of skills, knowledge and values, it represents only the views of participants in one health system.   There is

room for further research across health systems to identify if this is a system issue, or a

commonality across all systems.

Future studies would also benefit from focusing on the CHNA manager's education, skill

sets and knowledge and comparing that to the quality of their CHNA reports and population

health outcomes.   This would provide supplemental information on the most important skills that

actually produce effective outcomes.   Additionally, academic fields of public health, social work,

and community development should identify how they can further develop skills in their

programs and market the programs in health care.

REFERENCES

Accountable Care Organizations (n.d.). Center for medicare & medicaid services. Retrieved from

    https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/

Ahnquist, J., Wamalaa. S. P., & Lindstrom, M. (2012). Social determinants of health - a question

    of social or economic capital? Interaction effects of socioeconomic factors on health

    outcomes. *Social Science & Medicine,* 74(6):930-939.

Am I Rural. (2017). *Rural Health Information Hub*. Retrieved from

    https://www.ruralhealthinfo.org/am-i-rural/report?lat=46.82313&lng=-

    95.73026&addr=56501%2C%20MN&exact=0

Ashery, R. (2014, April 09). Primary health care. Encyclopedia of Social Work. Ed.   Retrieved

    from

    http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefor

    e-9780199975839-e-301.

Association for Community Health Improvement. (n.d.) Community health assessment toolkit.

    Retrieved from

    http://www.healthycommunities.org/Resources/toolkit.shtml#.W9DG5k2GPyA

Barnett, Kevin. (July 2011). Best practices for community health needs assessment and

    implementation strategy development: a review of scientific methods, current practices

    and future potential. *Report of Proceedings from a Public Forum and Interviews of*

    Experts. Retrieved from

    http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqq

    vn5z6qaeiw2u4.pdf

Beaudoin, Christopher E. (June 2009). Bonding and bridging neighborliness: An individual-

    level study in the context of health. *Social Science & Medicine,* 68(12): 2129–2136.

Bernard, H.R. (2011). Research Methods in Anthropology. 5th edition, AltaMira Press, UK.

    Retrieved from http://anthro.vancouver.wsu.edu/media/Course_files/anth-260-edward-h-

    hagen/research-methods-in-anthropology_chapter_7.pdf

Brueggemann, W.G. (2006). *The Practice of Macro Social Work* (3rd ed.). Stamford, CT:

    Brooks/Cole.

Cannon, Ida. (1923). *Social Work in Hospitals: A Contribution to Progressive Medicine*. New

    York: Survey Associates, Inc.

Case Management Society of America. (n.d.) retrieved from

    http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx

Community Development. (n.d). *English Oxford Living Dictionaries*. Retrieved from

    https://en.oxforddictionaries.com/definition/community_development

Council on Social Work Education. (1994). Handbook of accreditation standards and procedures.

    Alexandria, VA: Author. Retrieved from http://www.cswe.org/File.aspx?id=14115

Council on Social Work Education. (2001). Educational policy and accreditation standards.

    Retrieved from http://www.cswe.org/File.aspx?id=14115

Council on Social Work Education. (2008). Educational policy and accreditation standards.

    Alexandria, VA. Retrieved from

    https://cswe.org/getattachment/Accreditation/Accreditation-Process/2015-

    EPAS/2015EPAS_Web_FINAL.pdf.aspx

Council on Social Work Education. (2012). 2011 Annual statistics on social work education in

    the United States.   Retrieved from http://www.cswe.org/File.aspx?id=62011

Cowles, L. (2013, June 11). Health care: Practice interventions. *Encyclopedia of Social Work.* Ed. Retrieved from: http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-550.

Dartmouth Atlas Project, and PerryUndem Research & Communications. (February 2013). A revolving door: A report on US hospital readmissions. *Robert Wood Johnson Foundation.* Retrieved from http://www.dartmouthatlas.org/pages/readmissions2013

Davenport, Judith A., and Joseph Davenport III. (2008). Rural practice. *Encyclopedia of social work*. (20th Ed). Edited by Terry Mizrahi and Larry E. Davis. New York and Oxford: National Association of Social Workers and Oxford Univ. Press.

Edwards, et al. (July 2011). Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. Ed. Mark Friedberg, et al., Rand Corporation and American Medical Association. http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf

Estes, R.J**.** (1997) Social work, social development, and community welfare centers in international perspective. *International Social Work*. 40(1), 43-55.

Fetterman, D. M. (2001). Foundations of empowerment evaluation. Thousand Oaks, CA: Sage.

Fetterman, David M PhD, Jennifer Deitz MA, and Neil Gesundheit MD, MPH. (May 2010). Empowerment evaluation: A collaborative approach to evaluating and transforming a medical school curriculum. *Academic Medicine. Volume 85*(5), 813-820.

Flora, Cornelia Butler and Jan L. Flora. (2013). Rural communities: Legacy + change (4th Ed). Boulder, CO. Westview Press.

Gamble, D.N. (2012). Well-being in a globalized world: Does social work know how to make it

    happen? *Journal of Social Work Education*, 48(4), 669-689.

Gamble, D.N., & Weil, M. (2010). Community practice skills: Local to global perspectives. New

    York, NY: Columbia University Press.

Ghasidas Vishwavidyalaya Bilaspurp, Guru. (2015). SW 401 community organization.

    Department of Social Work. Retrieved from

    http://www.ggu.ac.in/download/Model%20Answer%2015/14.5.15-BSW-

    IV%20SW401%20Community%20Orgn.pdf

Global Definition of Social Work. (July 31, 2014). *The professional association for social work

    and social workers*. Retrieved from https://www.basw.co.uk/resources/global-definition-

    social-work?id=3293

Global Definition of Social Work. (2014). International federation of social workers. Retrieved

    from http://ifsw.org/policies/definition-of-social-work/

Gorin, S. Julie Darnell, J., & Heidi Allen. (Dec 2, 2014). Affordable care act. *Encyclopedia of

    Social Work.* Retrieved from

    http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefor

    e-9780199975839-e-830.

Hardina, D. (2002). *Analytical skills for community organization practice*. New York: Columbia

    University Press.

Health. (n.d.). *English Living Oxford Dictionary*. retrieved from

    https://en.oxforddictionaries.com/definition/health

Health. (n.d.). *Medical Dictionary.* retrieved from https://medical-

    dictionary.thefreedictionary.com/health

Healthcare.gov (2013). How does the affordable care act help people like me?

> https://www.healthcare.gov/how-does-the-affordable-care-act-affect-me/

Healthcare. (n.d.) *Medical Dictionary*. retrieved from http://medical-

> dictionary.threfreedictionary.com/health+care.

Healthy People 2020. (n.d.). Office of disease prevention and health promotion. Retrieved from

> https://www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-

> life-well-being

Hopps, June Gary and Tony B. Lowe. (2013). Social work profession: Political context.

> *Encyclopedia of Social Work.* Retrieved from

> http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefor

> e-9780199975839-e-622.

Horne, M. and J. Costello. (2003). A public health approach to health needs assessment at the

> interface of primary care and community development: Findings from an action research

> study. *Primary Health Care Research and Development*. 4: 340—352.

Institute for Clinical Systems Improvement. (October 2014). Going beyond clinical walls.

> Retrieved by: https://www.promedica.org/socialdeterminants/pages/default.aspx

Institute for Healthcare Improvement. (2013). The IHI triple aim: Changing care and

> communities. *Institute for Healthcare Improvement*. Retrieved from

> http://www.ihi.org/resources/Pages/ImprovementStories/IHITripleAimChangingCareand

> Communities.aspx.

Institute for Healthcare Improvement (March 27, 2013). Targeting patient transitions to reduce

> readmissions. http://www.ihi.org/knowledge/Pages/ImprovementStories/TargetingPatient

> TransitionstoReduceReadmissions.aspx

Institute of Medicine (US) Committee on Educating Public Health Professionals for the 21st

      Century. (2003). Who will keep the public healthy? Educating public health professionals

      for the 21st century. *National Academies Press (US).* Ed. Gebbie K, Rosenstock L,

      Hernandez LM. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK221176/

Jacobson, Peter. (Feb 24, 2017). Interview by K. M. Crabtree [in-person].

Jacobson, W. (2001). Beyond therapy: bringing social work back to human services

      reform. *Social Work, 46*(1), 51-61.

Kanea, John and Mark Kramer. (Winter 2011). Collective impact. *Stanford Social Innovation*

      Review. Retrieved from https://ssir.org/articles/entry/collective_impact

Kelly, Tammy. (October 10, 2013). Charity organization society and the settlement house

      journey. [Powerpoint Slides]. Retrieved from https://prezi.com/bkvnoa111_a0/charity-

      organization-society-and-the-settlement-house-journe/

Kindig, D., & Stoddart, G. (2003). What is population health? *American Journal of Public*

      Health, 93(3), 380–383.

Kretzman, John P. and John L. McKnight. (1993). Building communities from the inside out: A

      path toward finding and mobilizing a community's assets. *ACCTA Publications.*

      Retrieved from http://journals.sagepub.com/doi/abs/10.2190/PD41-GKWW-RU7X-

      M7Y4?journalCode=qcha

Mackie, Paul Force-Emery, Kimberly Zammitt, and Michelle Alvarez. (2016). *Practicing rural*

      social work. Chicago, IL. Lyceum Books

McIntyre, Alice. (2008) Participatory action research. *Qualitative Research Methods*. Series 52.

      Sage Publications.

Mendes, P. P. (2008). Teaching community development to social work students: A

critical reflection. *Community Development Journal, 2008.*

Miley, K., O'Melia, M & DuBois, B. (2011). *Generalist social work practice- An empowering*

approach. Boston, MA: Pearson Education.

Miller, Jeni. (November 19, 2015). It's all connected: Why community development and health

go hand in hand. *Build Healthy Places Network*. Retrieved from

http://www.phi.org/news-events/855/its-all-connected-why-community-development-

and-health-go-hand-in-hand/

National Association of Social Workers. (2009). Social work speaks. *Rural Social Work.* p 297-

302. Retrieved from

www.socialworkers.org/assets/secured/documents/da/.../Rural%20Social%20work.pdf

Neumann, P. J., Jacobson, P. D., & Palmer, J. A. (2008). Measuring the value of public health

systems: The disconnect between health economists and public health practitioners.

American Journal of Public Health. 98(12), 2173-80.

Health Expenditures. (2016). National center for health statistics. Retrieved from

https://www.cdc.gov/nchs/fastats/health-expenditures.htm

Peeters, J. (2012b). Social work and sustainable development: Towards a social-ecological

practice model. *Journal of Social Intervention*: Theory & Practice, 21(3): 5-26. Retrieved

from http://www.journalsi.org/index.php/si/article/viewFile/316/272

Pittaway, Emma and Georgia Swan. (2012). Community development evaluation manual.

Retrieved from http://www.startts.org.au/media/Services-Community-Development-

Evaluation-Manual.pdf

Pritzker, S. & SR Applewhite. (2015). Going "macro": Exploring the careers of macro

        practitioners. *Social Work*. Jul 60(3): 191-9.

Public Health Agency of Canada. (2013). What determines health?. Retrieved from

        http://www.phac-aspc.gc.ca/ph-sp/determinants/

Public Health Education & Health Promotion. (October 14, 2018). Master of public health.

        https://www.publichealthcareeredu.org/public-health-education/

Reamer, F. (1998). Ethical standards in social work. *National Association of Social Workers.*

        Washington, DC. 2nd edition. NASW Press.

Reibschleger, Joanne. (April 2007). Social workers suggestions for effective rural practice.

        Families in Society: the journal of contemporary human services. p. 203-213.

Reisch, Michael. (2012). The challenges of health care reform for hospital social work in the

        United States. *Social Work in Healthcare*. 51(10):873-893.

Reisch, Michael & Stephen Gorin.(2001). Nature of work and future of the social work

        profession. *Social Work*. 46(2): 104-104. Retrieved from

        https://www.questia.com/library/journal/1G1-70649138/nature-of-work-and-future-of-

        the-social-work-profession

Rine, Christine M. (2016). Social determinants of health: Grand challenges in social work's

        future. *Health Social Work*; 41 (3): 143-145.

Robert Woods Johnson Foundation. (August 21, 2013). Putting social determinants data to work

        for patients and providers. Retrieved from https://www.rwjf.org/en/library/articles-and-

        news/2013/08/putting-social-determinants-data-to-work-for-patients-and-provid.html

Robert Woods Johnson Foundation. (November 8, 2013). Community development focus on

emerging collaborations. *New Public Health.* http://www.rwjf.org/en/blogs/new-public-

health/2011/11/community-development-focus-on-emerging-collaborations.html

Sampson, R. J. (2012). Great American city: Chicago and the enduring neighborhood effect.

Chicago, IL: University of Chicago Press.

Scottish Community Development Centre. (n.d.). Retrieved from

http://www.scdc.org.uk/who/what-is-community-development/

Spitzer and Davidson. (April 2013). Future trends in health and health care: Implications for

social work practice in an aging society. *Social Work in Health Care*., 52(10).

http://www.tandfonline.com.er.lib.k-state.edu/doi/pdf/10.1080/00981389.2013.834028

Stoecker, Randy. (2013). *Research methods for community change: A project-based approach.*

Second edition. Madison, WI: Sage Publications.

Tan, Allison. (2009). Community development theory and practice: Bridging the divide between

'micro' and 'macro' levels of social work. *North American Association of Christians in*

Social Work. Indianapolis, IN.

Toward a Healthy Future: Second Report On the Health of Canadians. (n.d.) Retrieved from

http://www.phac-aspc.gc.ca/ph-sp/determinants/

Ungar, M. (2005). *Pathways to resilience: A handbook of theory, methods and interventions.*

Thousand Oaks, CA: Sage.

Walker, Alexa, Vickie Miene, and Tracy Hightshoe. (2017). Healthy neighborhoods, healthy

communities: A summary of the symposium for public health, health care and

community development professionals. *Institute of Public Health Research and Policy*.

Retrieved from https://www.public-health.uiowa.edu/wp-content/uploads/2018/10/Iowa-City-Symposium-Paper-1.pdf

Weil, M. O. (1996). Community building: Building community practice. *Social Work* 8(41): 481-499.

Weyers, M. L. (2011). The habits of highly effective community development practitioners. *Development Southern Africa*, 28(1), 87-98. Retrieved from http://dx.doi.org/10.1080/0376835X.2011.545172

Weyers, M.L., & Herbst, A. (2011). Changing the habits of Namibian community social workers: An experiment in training. *The Social Work Practitioner-Researcher*, 23(3): 269-289.

Widmark, C., Sandahl, C., Piuva, K., & Bergman, D. (2011). Barriers to collaboration between health care, social services and schools. *International Journal of Integrated Care* 11: 124.

	Item	5	4	3	2	1
Appendix A: Survey						
Please answer the following by checking your response 1= not at all; 2 = not very well; 3 = neutral; 4 = well; 5 = excellent						
1.	Do you feel that you know what skills, knowledge and values are the most important for the CH manager/director to be effective? Why did you rate yourself there?					
	Semi-Structured Interview Questions	**Share the skill set sheet & values sheet with the interviewees**				
2.	Share the skill set sheet (Appendix B). What five skills do you feel would be the most beneficial for the CH manager/director to be trained in, in order to be effective? Why? Which skill do you think is the most important?					
3.	Share the values set sheet (Appendix C). What top five values do you feel would be the most beneficial for the CH manager/director to be focused on in order to be effective? Why? Which value do you feel is the most important?					
4.	What knowledge do you feel would be the most beneficial for the CH manager/director to have in order to be effective? Why?					
5.	Are there other factors that you think are important for the CH Manager/Director to know or have that are not included in these lists or discussion? What are they?					

APPENDIX B: SKILL SET LIST

Supervision	Asset mapping
Organizational Development	Management Information Systems
Budget Analysis	
Needs Assessment Process	Quality Assurance
Education/ Training	Cultural Competency
Consultation	Models of Change
Logic Models	Fundraising
Program Development	Community Organizing
Strategic Planning	Community Building
Program Evaluation	Community Mobilizing
Board Development	Policy Analysis
Community Mapping	Legislative Advocacy
Coalition Building	Marketing/Communications
Capacity Development	Coaching
Program Monitoring	Staff Development
Contract Monitoring	
Public Relations	
Grant writing/Development	
Program Implementation	
Resource Development	

APPENDIX C: VALUES

Service

Social Justice/Equity

Dignity and Worth of the Individual - Empowerment

Importance and centrality of human relationships

Integrity

Cultural competence

Teamwork

Stewardship

Quality

Respect

Hospitality

Democratic

Innovation

Inclusive

Non-authoritarian

Community Self-Determination

Community Ownership

Enhance natural capacities and networks

Prevention

Sustainability

Local Knowledge

Diversity

Feedback

Shared Learning

Collective Action

Creativity

Open-Mindedness

Perseverance

APPENDIX D: NDSU IRB

NDSU NORTH DAKOTA
STATE UNIVERSITY

November 9, 2017

Dr. Gary Goreham
Sociology and Anthropology

Re: IRB Determination of Exempt Human Subjects Research:
Protocol #HS18104, "Community Health: Values, Knowledge and Skill"

Co-investigator(s) and research team: Karen Crabtree
Certification Date: 11/9/2017 Expiration Date: 11/8/2020
Study site(s): varied
Sponsor: n/a

The above referenced human subjects research project has been certified as exempt (category #2b) in accordance
with federal regulations (Code of Federal Regulations, Title 45, Part 46, Protection of Human Subjects). This
determination is based on the revised protocol submission (received 11/8/2017).

Please also note the following:
• If you wish to continue the research after the expiration, submit a request for recertification several weeks prior
to the expiration.
• The study must be conducted as described in the approved protocol. Changes to this protocol must be approved
prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
• Notify the IRB promptly of any adverse events, complaints, or unanticipated problems involving risks to
subjects or others related to this project.
• Report any significant new findings that may affect the risks and benefits to the participants and the IRB.

Research records may be subject to a random or directed audit at any time to verify compliance with IRB
standard operating procedures.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.
Sincerely,

Kristy Shirley

Kristy Shirley, CIP, Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult
http://www.ndsu.edu/research/integrity_compliance/irb/. This Institution has an approved FederalWide
Assurance with the Department of Health and Human Services: FWA00002439.

INSTITUTIONAL REVIEW BOARD
NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | ndsu.edu/irb

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

NDSU is an EO/AA university

66

Essentia Health

October 17, 2017

To whom it may concern,

Re: Community Health: Values, Knowledge and Skills

Thank you for submitting the Human Subject Research Determination Form and information for the project listed above. Based on a review of the documentation you provided, this project does not meet the definition of research with human subjects, according to the Office of Human Research Protections (OHRP) guidance: "*Research* means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."

Because the project does not meet the federal definition of human subjects research, it will not require further review by the Essentia Health Institutional Review Board or a scientific review committee. If during the process of data collection or analysis it becomes clear that findings could be generalizable or benefit others, please submit your project for IRB review at that time.

If you have any questions concerning this letter, please contact me at 218-576-0489.

I wish you success with your project.

Sincerely,

Deneice Kramer

Deneice Kramer, MBA, MA, CCRP
Manager, Human Research Protection Program

502 East 2nd Street
Duluth, MN 55805

essentiainstitute.org