Central Shenandoah Health District

MOBILE HEALTH RAPID COMMUNITY ASSESSMENT REPORT

January 2025

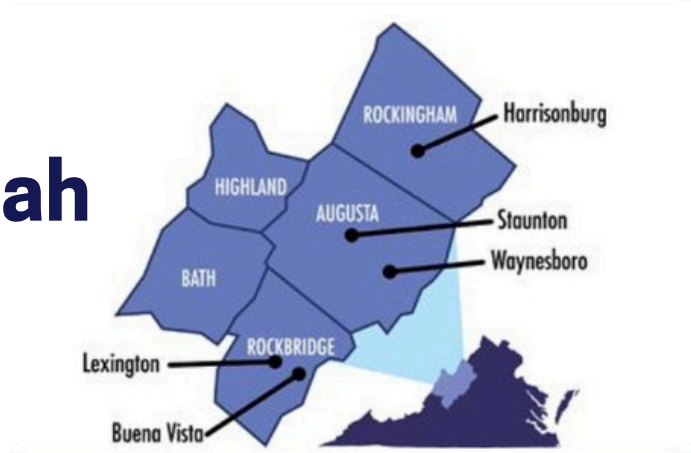
VDH VIRGINIA DEPARTMENT OF HEALTH

Central Shenandoah Health District
Public Health in the HEART of the Valley

540-332-7830
cshdinfo@vdh.virginia.gov
vdh.virginia.gov/central-shenandoah
@CentralShenandoahHealthDistirct

INTRODUCTION

Central Shenandoah Health District



The Rapid Community Assessment (RCA) was conducted as part of the Central Shenandoah Health District (CSHD) American Rescue Plan Act (ARPA) Targeted Community Outreach grant. The health district serves approximately 293,000 citizens across 10 localities. This includes the counties of Augusta, Bath, Highland, Rockbridge, and Rockingham and the cities of Buena Vista, Harrisonburg, Lexington, Staunton, and Waynesboro. The goal of the grant work plan is to build relationships between the local health district and local health services providers with low-income neighborhoods and rural populations through the establishment of a community mobile health unit. This RCA focused on identifying the needs, barriers, best timing/location of a mobile health unit, and the most effective avenues for communication of mobile health unit services within the different communities of the health district. The RCA was completed to allow CSHD specific data to be collected and used in developing mobile health unit operations. The results of this assessment are available at the local level; They can be used to address needs found through the survey and key informant interviews. In addition to benefitting the health district, the data in this report will also benefit community partners with their community health outreach efforts.

PROJECT OVERVIEW

The over-arching goal of this RCA was to gather data to aid in the creation of a mobile health unit program that meets the needs of low-income and rural populations within CSHD. The mobile health unit program is new to the district. Currently, there is no CSHD-specific-data to support effective planning and implementation. The goals for this RCA are broken down below:

- To engage with community members in a bidirectional way.
- To collect 300 surveys district-wide.
- To target areas and populations of the district often underrepresented in data collection.
- To gain a better understanding of the the needs, barriers/challenges, and most effective mobile health unit logistics for each locality.

The RCA consisted of a two phased approach; the first phase involved survey collection. A preliminary data analysis was conducted and used to develop strategies for the key informant interviews of phase two.

METHODOLOGY

METHODOLOGY 1

The RCA survey was developed to collect information and opinions related to general healthcare needs as well as mobile health unit operations. A total of 484 surveys were collected through outreach efforts including community events (3), door-to-door canvasing (10), tabling efforts (27), and survey distribution to 20 community partners. Surveys were available via REDCap (a confidential online survey tool) as well as printed paper copies in Arabic, English and Spanish. The surveys were distributed and collected over a 24-day period. Unlike traditional survey collection, community engagement was a primary focus when speaking with community members about the survey.

METHODOLOGY 2

Key informant interviews were conducted with 13 individuals; 11 of these interviews are being included in the analysis. Two interviews were excluded from further analysis due to interview standards not being appropriately followed, causing the questions to be misinterpreted from their original intent. A preliminary data analysis of the survey data was completed to identify areas lacking in representation to aid in determining key informants. Participants were interviewed as key informants who could speak on behalf of their communities' needs. Key informants represented 6 of the 10 localities in the health district, including the two most rural—and often underrepresented—locations.

DATA ANAYLSIS AND OBSERVATIONS

Data analysis was performed on both data from the survey and from the key informant interviews. Survey analysis was conducted using R Studio.

The survey consisted of 484 total respondents with majority being female (70.86%), aged 65 and older (33.05%), and identifying as "White and European American" (64.80%). Responses to the question related to income varied, with 21.28% of survey participants choosing not to report income. Of those who reported a measurable income level, the largest percentage (23.35%) reported an annual income lower than $20,000 USD. The largest insurance type was insurance through a current or former employer (28.51%) followed by Medicare (27.89%). To see a detailed breakdown of all the data collected during this analysis, click here.

Analysis of key informant interviews consisted of individual interview reviews by four staff members, who then met as a group to identify key themes across the interviews. It was intended to identify themes by locality, but not all localities were represented. This is recommended for future data collection and analysis. For more details on the key informant interviews, click here.

SURVEY ANALYSIS

The RCA focused on identifying the needs, barriers, best timing/location of a mobile health unit, and the most effective avenues for communication of mobile health unit services within the different communities of the health district. Below are the top results for the health district:

HEALTHCARE ACCESS CHALLENGES

- Delays in getting an appointment
- Limited appointment availability around working hours
- Needed providers are unavailable

CURRENT SERVICES THAT ARE HARD TO ACCESS

Healthcare
- Dental Care
- Mental Health Services
- Adult Primary Care

Social
- Affordable Housing
- Transportation
- Childcare

SERVICES PARTICIPANTS WANT

Healthcare
- Basic Lab Work
- Primary Care
- Cancer Screening

Social
- Housing Assistance
- Car Repair & Maintenance
- Food Assistance

To see locality specific data, click here.

KEY INFORMANT INTERVIEW ANALYSIS

BUILDING TRUST

- Services offered are not currently the same in each community, leading to frustration and lack of confidence in some local health departments.
- Health departments need to build relationships and have more of a presence in Highland and Bath communities.
- Trust is necessary for program success but takes time to build.
- Addressing misunderstandings and mistrust will be essential to building relationships.
- First impressions and experiences with mobile health unit will be influential.
- For this program to be successful, weaknesses will need to be considered and addressed prior to implementation. Interviewees were primarily service providers representing the community. Interviews with community members utilizing services will need to be conducted.

MOBILE HEALTH UNIT OPERATION RECOMMENDATIONS

- Ease is prioritized over waiting to see a provider.
- Integrate mobile health unit into the day-to-day flow of the community (events that are already happening).
- Increased focus on educating the public about services could increase program usage.
- Operations should be tailored to the specific community served.

COLLABORATING WITH COMMUNITY PARTNERS

- The possibility of preventing emergency department visits can be a strategy to create buy-in.
- VDH is limited in practice and scope. Meeting the needs of the district will require collaboration with community partners. It will be important to remain realistic with ourselves and upfront with the community.

REOCCURING INSIGHTS

- **Services:** When it comes to services the following questions should be considered: Are gaps being filled? Are the services offered meeting the needs of the community?
- **Trust:** Connecting with established trusted messengers of the community is essential. The environment of the health department needs to be trust focused.
- **Communication:** Communication needs to take place well ahead of time and be clear. Multiple avenues will need to be utilized to best reach all members of the community.

FEEDBACK

- **Partnerships:** The health department is unable to offer all services needed by the communities; partnerships will be key to meeting the expressed needs of the communities.
- **Interest:** Introduction of the mobile health unit will need a tailored approach and time to allow communities to develop interest and trust.
- **Identify Weaknesses:** For this program to be successful, weaknesses will need to be considered and addressed prior to implementation.
- **Rural Analysis:** Hard to reach rural communities are more complex in their needs. Prioritization of meeting basic needs and the ease of receiving care create underutilization of health care. Understanding these rural communities will take additional assessments.
- **Cultural Variation:** Migrant communities are unique and should be assessed individually by culture type if possible.
- **Funding:** Community Health Workers are vital to the community and bridging the gap between communities and VDH. Prioritizing future funding would be very important to keep up the momentum and build upon what has been done since 2020.

To see more detailed analysis click here.

NEXT STEPS

The information collected throughout this assessment will aid in the development of the CSHD mobile health unit program. Each community is unique and has different needs; this diversity will play an important role in the development of the mobile health unit. CSHD will use the data collected from this assessment to create a program focused on meeting the unique needs and addressing the barriers specific to each locality as identified. The data collected from this assessment was shared with community partners to inform their community health outreach programs.

LESSONS LEARNED

While this assessment was conducted over a timeline longer than a typical RCA, rural locations would have benefited from having more time and awareness leading up to the implementation of this assessment. These communities require time to adjust, allowing them to develop trust and interest. Additionally, when conducting key informant interviews, it would be beneficial to have a smaller number of staff responsible for scheduling and conducting the interviews to ensure a smoother process and to improve consistency across the interviews. The involvement of community partners was key and this was especially important for survey distribution.

CHALLENGES ENCOUNTERED

One challenge seen throughout this process was the quick turnaround when considering timelines. The time between survey development and implementation was very short; this meant that while some survey questions were taken from other sources, not all survey questions were tested prior to survey distribution. The survey distribution and collection period were just over three weeks, which proved challenging in terms of prioritizing locations and developing rapport/partnerships. Another challenge encountered was the lack of community partnerships and contacts in high need areas. This, in combination with the short timeframe, made survey uptake difficult in some areas. Additionally, staff capacity was challenging as the staff primarily assisting with this project have other duties that at times required prioritization. Due to the time constraints of the project and staff capacity it was difficult to reach the higher need communities.

The key informant interview phase of this project presented some of its own challenges. There was difficulty when scheduling interviews during the allotted timeframe due to time constraints/varying availability between three people at a time (interviewee, interviewer, and note taker). Technology also presented some challenges such as difficulty for staff conducting interviews, connectivity issues, and clarity with recordings. Reaching community members in addition to community partners working with those populations was challenging; the lack of trust created a barrier to securing interviews with members of some communities.

CHANGES IMPLEMENTED BASED ON LESSONS LEARNED

One change made during the assessment process was to extend the survey collection period in the more rural areas which struggled with survey uptake initially. Additionally, partnering with internal staff local to the area helped with providing community awareness of the survey as well as survey uptake. Best practices have been identified and formally documented to improve future assessments done by the health district. These include allowing more time for developing partnerships and survey collection, providing more detailed training for staff on interview bias and conducting interviews, allowing for additional time to practice interviewing, limiting the number of staff conducting interviews, and having a more defined approach for staff management.

CONCLUSION

RECAP OF KEY POINTS

Partnerships with local organizations will be instrumental in addressing the needs identified in this assessment. The data collected in this assessment will be shared with the community and community partners, as well as used in the development of the health district's mobile health unit program. Readers are encouraged to view the data at a more detailed level by visiting the CSHD website, which can be accessed here.

Central Shenandoah Health District

THANK YOU

VDH VIRGINIA DEPARTMENT OF HEALTH

Central Shenandoah Health District
Public Health in the HEART of the Valley

CONTACT INFORMATION FOR FURTHER INQUIRIES

540-332-7830
cshdinfo@vdh.virginia.gov
vdh.virginia.gov/central-shenandoah
@CentralShenandoahHealthDistirct