A HOW-TO GUIDE: An Overview of the 2021 National Health Center Training and Technical Assistance Needs Assessment Development, Fielding, and Analysis

Note: October 2022 This document, authored by a team assembled by the National Association of Community Health Centers (NACHC), is intended to summarize the operational phases of the 2021 National Health Center Training and Technical Assistance (T/TA) Needs Assessment. The Assessment is a collaborative project of the 21 National Training and Technical Assistance Partners (NTTAPs) funded by HRSA to provide T/TA to health centers across the country. This How-To Guide provides the reader with a clear description of the timeline and steps required to successfully design, nationally deploy, and analyze the data set for applicable findings in a multiple partners collaborative effort. Learn more about the NTTAPs: https://bphc.hrsa.gov/technical-assistance/strategic-partnerships/national-training-technical-assistance-partners

PURPOSE

In 2021, the National Association of Community Health Centers (NACHC), in partnership with the HRSA National Training and Technical Assistance Partners (NTTAPs), implemented a National Health Center Training and Technical Assistance (T/TA) Assessment to inform current and future training and technical assistance offerings. This How-To Guide documents the activities, decision points, and timeline to develop, test, distribute, analyze, and disseminate findings from the national assessment. The How-To Guide concludes with recommendations for improving the assessment process in the future.

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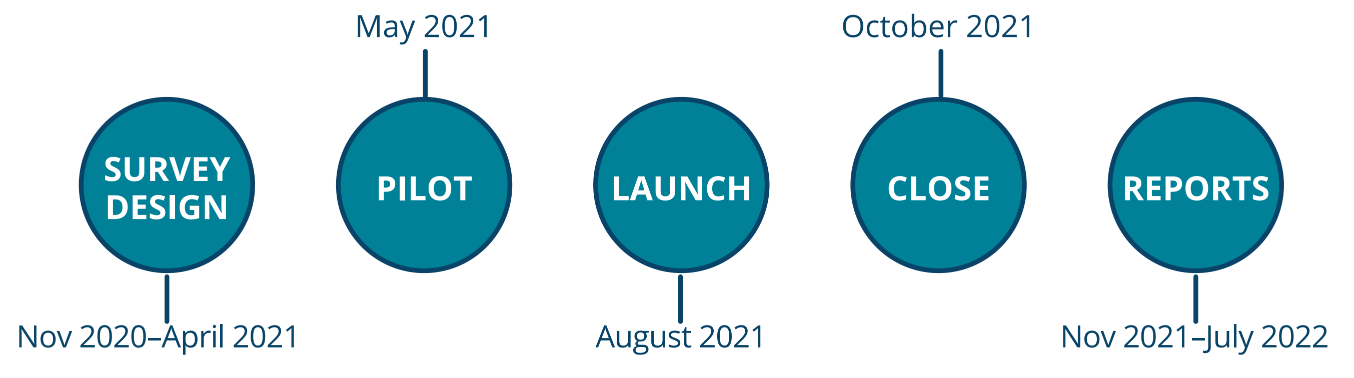
ASSESSMENT STEPS AND TIMELINE



The goal of the health center T/TA assessment was to understand and address current health center training needs, challenges, and priorities. Assessment findings inform the design and delivery of training and technical assistance most desired by health centers to improve the health of the patients and populations effectively and efficiently. The ultimate goal of this assessment was to ensure that the health center workforce has the training supports needed to thrive in the rapidly evolving health system. To achieve this goal, the assessment queried all staff at HRSA'sfunded health centers and look-a-likes (LALs).

One participation goal for the 2021 assessment was to increase the overall response rate to 60% of all health centers compared to the 56% response rate for the 2018 assessment. A second participation goal included increasing the percentage of health center operational and front-line staff respondents compared to the 2018 assessment to ensure a fuller understanding of T/TA needs across various health center staffing roles.

Numerous factors guided and influenced the design and dissemination of the assessment. First, the Needs Assessment Working Group, composed of multiple NTTAP representatives, provided input and guidance throughout the assessment process. Second, the assesment structure was aligned with the Bureau of Primary Health Care's (BPHC) Advancing Health Centers of Excellence Framework 7 key domains that BPHC intends to guide innovation and performance improvement. Current events, including the COVID-19 public health emergency and increased awareness of racial injustices across our nation, prompted revisions to the assessment to more clearly delineate emergency preparedness T/TA needs and increased focus on equity, diversity, and inclusion. Finally, due to more requests for health centers to participate in surveys from many sources throughout the pandemic and the potential for survey fatigue, the national assessment launch was intentionally delayed from March 2021 to August 2021.

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ASSESSMENT DESIGN

The 2018 assessment tool provided a starting point for the 2021 assessment tool. The following describes key revisions made to the 2018 assessment tool:

- Needs Assessment Working Group (NAWG) feedback, including the NAWG's top 10 recommended changes to the 2018 assessment tool and additional feedback provided during the drafting of the 2021 tool
- John Snow, Inc. (JSI), assessment and evaluation experts, were contracted to make revisions to de-duplicate questions; add an emergency preparedness domain; align with BPHC's special and vulnerable populations definitions and Health Centers of Excellence domains; re-group content, identify and address potential gaps, such as telehealth policy/practices; infection disease/ immunizations, workforce wellness, unique needs of special populations, and financial sustainability; and include open-ended questions related to emerging issues and BPHC health center maturity model
- JSI technical advisor contracted to revise and clarify language and increase focus on equity, diversity, and inclusion across the assessment
- NACHC and BPHC overall review of each iteration during the drafting process to ensure alignment with BPHC's funding priorities, which supported the assessment effort via a cooperative agreement with NACHC.

The assessment used the online survey platform called Qualtrics. A comparison of online survey platforms determined Qualtrics to be the best fit due to its features and flexibility in survey construction. Qualtrics had the ability to include forced responses, skip and display logic, and parent grouping of answer options. Each of these features helped construct the survey consistent with what the NAWG desired in the question format. JSI's data analyst also confirmed that Qualtrics would produce the data sets needed for the desired analyses.

The assessment tool underwent internal and external testing before the national launch. Both NACHC and JSI tested the tool for correct skip and display logic, forced response questions, and overall correct functionality and display. Formatting underwent minor changes prior to external testing. The NAWG recommended 42 health center staff for piloting. NACHC sent an email inviting those recommended to test the tool. Fifteen health center staff piloted the survey tool. The pilot-version tool included feedback questions at the conclusion of the assessment tool about length, clarity, topic, response relevancy, and suggested improvements. A total of 15 individuals completed the assessment and provided feedback. NACHC and NAWG reviewed and responded to pilot feedback.

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FIELDING PLAN

A seven-week fielding plan was used to identify a collective strategy for fielding the assessment to all health center organizations in ways that ensured a sufficient response rate to provide meaningful, actionable results. A fielding strategy was used as part of a multi-prong approach, including outreach to targeted points of contact at all health centers and a variety of targeted and general outreach to health center staff. Key steps and the timeline for fielding activities are provided in Table 1.

TABLE 1. FIELDING PROMOTION AND ACTIVITY TIMELINE

WEEK IN THE FIELD	ACTIVITY
Pre-fielding	Draft a needs assessment message to targeted respondents, including health center CEOs (identified through UDS data agreement between NACHC-BPHC), with background information and action steps for participation
Week 1	Email message with a personalized, non-anonymous link to each health center CEO
Week 1	Identify and correct error or bounce back emails
Starting at week 1 and continuing through fielding period	Collaborate with BPHC to schedule notices in the BPHC Digest weekly email and BPHC Bulletin email
	Seek engagement of NTTAPs to promote the assessment via existing communication streams (e.g., newsletter article/e-newsletter, webinars, meeting talking points, social media posts, phone calls transcript)
Starting at week 2 and continuing through fielding period	Seek engagement of Primary Care Associations (PCAs) and Health Center Controlled Networks (HCCNs) to promote the assessment among their membership. Incentivize PCAs by linking high response rates to more representative health center data to be available to them in their state-level profile and also data from respondents who opt into sharing results with PCA.
Starting at week 2 and continuing through field period	Use NACHC marketing listservs and social media to announce the assessment
Throughout fielding period	Send scheduled reminders to non-responders via email (with reminders coming more often as the assessment close date approaches, and message changing as needed to promote urgency or explain intent)
During NACHC's Community Health Institute (CHI)	Use the Community Health Institute, national conference occuring during the fielding period, to promote the assessment (e.g., post board, announcements at Committee meetings and sessions)
Midway through the fielding period	Perform follow-up calls to PCAs to request their assistance in encouraging health center participation. Provide a status report of the percentage of health centers that have responded to the assessment and a list of health centers that have not participated in the assessment
Weeks 5 thru 7 of the open survey	Make calls [or emails] to non-responders or targeted non-responders based on analytic strategy

NTTAPs were critical to promoting health center engagement and response through their regular communication channels. NTTAPs received sample messaging about the assessment to include in their newsletters, PowerPoint slide decks, meetings and phone calls, and social media.

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DATA COLLECTION

Assessment data was collected over a planned seven week period with an additional "extended" week. The assessment opened on August 12, 2021. The initial assessment close date of October 1, 2021 was extended one week to October 8, 2021, to allow more time for additional responses. Response rates were monitored throughout the collection period, including overall response rates, the response by respondent role at the health center, 330-funded, LAL, and by state.

DATA ANALYSIS

After data collection, the dataset was cleaned to exclude participants that:

- did not respond to any T/TA domains;
- did not respond to all questions concerning the eight T/TA domains (due to potential bias towards initial T/TA domains since questions were not randomized);
- were not a 2020 Federally Qualified Health Center (FQHC) or LAL (as verified by BPHC); or
- provided duplicate responses.

The cleaned dataset was merged with 2020 Uniform Data System (UDS) data to populate select health center characteristics for each respondent. Health center characteristics populated into the assessment dataset include:

TABLE 2. DEFINITIONS OF HEALTH CENTER CHARACTERISTICS

HEALTH CENTER CHARACTERISTIC	DEFINITION
Organizational size	Small health centers are defined as serving 10,000 patients or fewer and large health centers are defined as serving more than 10,000 patients
Geographic location	Rural or urban as self-reported in UDS
High proportion of uninsured patients	1 standard deviation (SD) above the mean
High proportion of Asian, Hawaiian, or Other Pacific Islander (AHOPI) patients	1 standard deviation (SD) above the mean; patients who identify as Asian, Hawaiian, or Other Pacific Islander, and includes Asian Hispanic/Latino/a/e, Asian Non- Hispanic/Latino/a/e, Hawaiian/Other Pacific Islander Hispanic/Latino/a/e, and Hawaiian/Other Pacific Islander Non-Hispanic/Latino/a/e, patients
High proportion of elderly patients	1 standard deviation (SD) above the mean; patients aged 65 and older
High proportion of military veteran patients	1 standard deviation (SD) above the mean
Health center funding or service type	Community Health Center Funding only, Migrant Health Center Grantee, Homeless Health Center Grantee, Public Housing Health Center Grantee, and School-Based Health Center (SBHC). SBHC was defined as health centers that reported having 1 or more SBHC sites within their scope of project.

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Statistical analysis, using SAS v9.4, occurred at two levels by the JSI contracted team: health center- and individual respondent-level.

- Assessment responses were aggregated at the health center level to capture one representative response for each FQHC and LAL. Responses from the same health center organization were identified and aggregated and put into Universal Data System (UDS) groups based upon shared UDS number and city. For organizations with multiple respondents, a T/TA domain was attributed to an organization if any respondent from that organization identified that domain as a need. After responses were aggregated at the health center level, we examined T/TA differences within UDS groups. Meaningful differences in T/TA domains within UDS groups were identified by large absolute differences in percentage relative to other T/TA domains.
- Assessment responses were also examined at the individual level to capture T/TA needs that did not appear at the health center level. Individual-level responses were analyzed as independent of one another.

Qualitative analysis was performed on open-ended text responses in the assessment using NVivo and theme analysis.

The objectives of the analysis were to quantify:

- Health center rate response to the survey, overall and by state/territory
- T/TA domains most commonly selected as a need
- T/TA subdomains most commonly selected as a need
- top three ranked T/TA domains
- T/TA needs across key health center characteristics utilizing UDS data

To describe:

- Key demographics of survey respondents by age, sex, race, ethnicity, and health center role
- Key characteristics of health centers utilizing the National Program Uniform Data System (UDS) (as noted in Table 1)

To evaluate:

- Health center maturity across T/TA domains
- Emerging issues or trends around T/TA
- T/TA needs that health centers have difficulty accessing resources

To assess:

- Health centers' utilization of T/TA webinars or training
- Sources of T/TA are used by health centers

In addition to the full data analysis, we performed four additional analyses to further understand T/TA needs among health center staff.

Drop-outs: At the request of BPHC, data were analyzed from respondents who dropped out of the survey before completing all eight T/TA domains. A separate, supplementary analysis was conducted on dropouts to further explore the T/TA needs of respondents who did not complete the entire survey.

Look-a-likes (LAL): A descriptive analysis of LAL findings by health center characteristics and top T/TA needs by domain

Health Center size: Analysis comparing findings by patient volume as reported in 2020 UDS, including the number of responses by each size group; top 3 T/TA needs (including subdomains and specific needs) by size group; specific T/TA differences between large, mid, and small health centers. Small is defined as less than 10,000 patients, mid-size between 10,000-25,000 patients, and large as greater than 25,000.

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Health center staff role: Analysis comparing executive staff responses to workforce staff responses by top 3 T/TA domain needs; analysis comparing top 3 T/TA domain needs by each workforce group: executive/senior leadership, front line, and operations staff, management staff/administration, direct patient clinical care, facility/non-clinical support, direct patient non-clinical care, and quality improvement

DISSEMINATION OF FINDINGS

Dissemination of assessment findings included posting on NACHC and the National Health Center Resource Clearinghouser websites and sharing via non-public collaboration platforms (e.g., NACHC's Noodlepod Online Communities) and email marketing blasts from NTTAPs and HRSA's Bureau of Primary Health Care. Table 3. depicts the various reports by targeted audience that resulted from the assessment.

TABLE 3.

	National Summary Report	One-page infographic	National Summary Informational Video	State Profiles	Supplemental Analysis	Data Spreadsheet and Codebook
NTTAPs	✓	✓	✓	✓	✓	*
BPHC	✓	✓	✓	✓	✓	✓
PCAs	✓	✓	✓	✓	✓	* *
General Public	✓	✓	✓	✓		

** with signed data users agreement*

*** unidentified health center data*

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LEARNING COLLABORATIVE

NACHC, in partnership with the NTTAPs, implemented a four-session Learning Collaborative to convene health centers to discuss the top results of the 2021 National Health Center T/TA Assessment and to inform future training and technical assistance offerings. The Learning Collaborative facilitated conversation and gathered information among health center peers in the context of the needs assessment data, equity, and promising practices, while also soliciting health centers' feedback on the results of the T/TA Assessment. Sessions were hosted every Friday for 60 minutes during June 2022; starting June 3, 2022 and ending on June 24, 2022. Learning collaborative objectives were to determine:

- Current awareness and utilization of HRSA-funded T/TA
- Barriers to T/TA engagement and utilization
- Upcoming T/TA needs based on emerging trends
- How T/TA needs differ based on staff type/role
- What special populations health centers are working with and how to best provide T/TA that accommodates those populations

Applications for the Learning Collaborative were open to health center staff with the primary target audiences of Human Resource/Employee Development staff, Chief Learning

Officers or Training Directors, and Supervisors with a secondary audience of PCA Workforce or

T/TA staff. Health centers were requested to attend all 4 sessions, although each could be attended by different health center staff. PCA staff that applied were asked to enlist a member health center to participate with them. NTTAPs were invited to participate in a listen-only mode.

Promotion of the Learning Collaborative occurred via NACHC's and other NTTAP's general mailing list of training event participants, their membership list, and PCA CEOs. Promotional material was posted on the Health Center Resource Clearinghouse and NACHC websites and promoted in the BPHC Digest.

The Needs Assessment Working Group determined the content for discussion during the sessions which focused on the top 3 T/TA Needs identified in the assessment findings, including Quality, Patient Care and Safety, Access and Affordability, and Workforce. With workforce identified as a primary driver, two sessions focused on the workforce: workforce recruitment and retention and workforce wellness. All session-specific learning collaborative materials (slides, notes, and recordings) is posted on NACHC's website. Participants received recommended pre-session reading materials, including the Findings Report from the 2021 National Health Center T/TA Needs Assessment and the Summary Infographic (scroll down NACHC's National T/TA Needs Assessment Page for Summary Results Infographic).

Session topics and dates:

- Workforce: Wellness, June 3, 2022, 12-1 pm ET
- Workforce: Recruitment and Retention, June 10, 2022, 12-1pm ET
- Quality, Patient Care: Telehealth and Using Data, June 17, 2022, 12-1 pm ET
- Access and Affordability: Outreach and Partnerships, June 24, 2022, 12-1 pm ET

Facilitators followed a guide for each session. Each session followed a similar agenda to provide consistency and allow for ample discussion.

- Welcome (5 minutes)
- Introductions (5 minutes)
- Background and Findings (10 minutes)
- Topic-Specific Discussion (35 minutes)
- Closing and Next steps (5 minutes)

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All sessions were co-facilitated by a JSI team member and Needs Assessment Working Group member. The sessions consisted of a short, 3-question pulse-check evaluation to make improvements for the following week's session. Participants received a final learning collaborative session evaluation at the conclusion of session 4.

A summary of each session included an attendance summary, innovative and promising practices, and barriers that impede success in addressing the key topic area and T/TA needs. An overall summary identified learnings across all four sessions.

RECOMMENDATIONS

The following are recommendations to support subsequent health center T/TA assessments based on learnings from the 2021 assessment.

Survey Structure

- Randomize survey questions to reduce survey bias. Randomizing the order of questions, pages, and/or answer options in the survey prevents bias introduced by order and/or survey fatigue.
- Include a question about trusted sources of information among health center staff to address T/TA needs, as recommended in prior survey feedback.
- Follow-up with respondents who initiate but do not complete the survey to remind respondents to finish the survey, as allowed by the survey platform.

PCA Engagement

- Engage PCAs to determine opportunities for increased coordination with and support from PCAs in an NTTAP-sponsored T/TA assessment process. Coordination could range from help with survey design to promotion of the survey to a partnership to co-disseminate a national T/TA survey periodically.

Additional Analyses

- Include additional special/vulnerable populations available in UDS characteristic data in future assessments, including a high proportion of patients experiencing interpersonal partner violence, patients who are veterans, and patients by sexual orientation and gender identity, especially LGBTQIA+ patients.

ABOUT THIS PUBLICATION

Inquiries about this document should be directed to the National Association of Community Health Centers, Training and Technical Assistance Division, *trainings@nachc.org*

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