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Building Local Knowledge for Developing Health Policy Through Key Informant Interviews

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Abstract
Key informant surveys offer Extension educators a way to build knowledge about their local health systems and provide a catalyst for developing health policies. Key informant surveys of 138 leaders in 14 rural counties revealed the top 10 health goals across these counties. These goals are a starting point for public dialogues to develop a local health agenda and engage Extension in strengthening local partnerships around health education, intervention, and policy development.

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Introduction

A goal of the new health promotion movement is for local communities to develop a process for "enabling people to increase control over and to improve their health" (Minkler, 1999). Solving population health problems is not the sole responsibility of health institutions. Local citizens and community groups must also participate in public dialogues and feel empowered to act on those health concerns that they jointly define (Morton, 2001). The Cooperative Extension system has two important roles in this new health movement: intervention strategies for changing health patterns and public policy development.

Extension is a key conduit of research on agriculture, food, communities, and the environment. Each of these research areas has links to human health and suggests a myriad of education and behavior intervention programming. For example, seven of the ten leading causes of death in the United States (coronary heart disease, hypertension, stroke, breast, colon and uterine cancers, and diabetes mellitus) cite diet as a significant causal factor (Tillotson, 1993). Water pollutants threaten drinking water and fish and shellfish as food sources. Agricultural practices are important nonpoint sources of degraded waters (Ribaudo, Horan, & Smith, 1999). Food safety, pesticide residues, and food labeling and regulation are also issues that impact population health. Extension has access to the science and expertise in translating knowledge gained from research into improved health.

The second skill that Extension can bring to their local community is the ability to work with citizens and organizations to bring critical health issues to the surface and build problem-solving teams. Local health policy issues include:

- Food safety monitoring,
- Hospital closures and mergers,
- Accessible and affordable health insurance,
- Medicaid program design and funding,
- Public safety, and
- Poverty and housing impacts on health.

Extension has developed and implemented premier programs, including:

- The Expanded Food & Nutrition Education Program,
- Pesticide safety programs,

- Nutrition programs,
- Urban gardening programs,
- Air and water quality programs, and
- Leadership programs.

The challenge for many local Extension educators is to expand their world view beyond individual behavior change and programs to a system view of health as inter-related to the social, environmental, and economic culture of their community (Curtis & Taket, 1996).

Building Local Knowledge

One way to build Extension educator knowledge about their community systems is to use the key informant process of gathering local data. In the research reported here, Cooperative Extension educators surveyed 138 community leaders in 14 rural counties. This survey provided an environmental scan for Extension and local health groups and offered a hands-on professional development experience for Extension educators.

The key informant process was a structured opportunity to meet with key leaders who are making health policy decisions and to position Extension as a partner in local health policy development and program intervention. Equally important, the Extension educator was exposed to the varied perspectives, positions, and actions of local organizations and firms on health related issues. These perspectives are key to Extension's ability to bring diverse partners together and develop health problem solving collaborations.

This article describes the key informant methodology using Extension educators, presents a summary of health care goals across 14 communities, and offers an evaluation of Extension educators' experiences and learnings from this process. Last, the article encourages Extension educators to actively participate as community partners in developing the health policies of their community and region.

Methodology

The key informant survey is a data collection technique appropriate to the study of intermediate units such as communities, counties, and villages (Young, 1999). The "informant" is asked information about his/her community structure rather than his/her own personal characteristics. This technique is particularly useful in gathering information for use in policy development where the unit of program intervention is the community, county, or region.

Twenty-three Cooperative Extension educators in 14 counties were used to identify county leaders in 10 specified categories:

- Commissioner of Health,
- Chamber of Commerce director,
- Human resource director of major employer,
- Small business owner representative of the type of small businesses in the county,
- Office for Aging director,
- Director of a highly visible voluntary not-for-profit health organization,
- County legislator on health subcommittee,
- President/committee chair on member health benefits of the largest union in the county,
- Hospital administrator, and
- Medicaid-eligible person with leadership in her/his neighborhood or community.

These 10 categories were deliberately chosen to represent segments within rural counties that would have distinct viewpoints and interests relating to health. Every county, with the exception of one, was able to interview the specified person. One county did not have a hospital and so interviewed the director of the medical clinic in that county.

Extension educators were trained to administer a 1-hour in-person key informant interview survey that included a mix of open- and closed-end questions. The key informant survey had a two-fold purpose: to examine rural leaders' perceptions of local health and well being, and to provide a catalyst for developing public policies relating to health. This research offered the local Extension staff an opportunity to increase their knowledge of community perceptions and local health system infrastructure. As an environmental scan, findings also supported the development of educational programs and local public policy process for responding to health and community well-being issues.

General County Questions

Leaders were asked questions regarding:

- Health goals their county should strive towards,
- Expectations about health care services reorganization and managed care,
- Organization interactions around health issues,
- Leadership roles around health issues, and
- Information sources (Morton & Bills, 1998).

Each county received a final report summarizing the findings. Extension educators were encouraged to use these reports as discussion pieces to engage the community in a dialogue about health priorities, capacities, and future directions.

Organization-Specific Questions

Informants were also asked details about their organization. Responses provided the Extension educator with contextual information.

County health department commissioners listed major programs, number of employees, changes in funding levels, targeted health outcomes, integration of health services, and their role in local health care restructuring efforts. Commissioners also described changes in public health since 1990.

Hospital administrators reported on hospital capacity and occupancy rates, financial condition of local hospitals, Medicaid revenues, and uncompensated care rates. Administrators also estimated changes in physician practices and pharmacy services in the county since 1990.

County legislators on the health subcommittee listed major decisions and recommendations the committee had made in the last two years. They also described county, state, and federal funding changes since 1990.

Office for the Aging directors summarized their agency's mission and major programs. Directors also reported on the number of volunteer and paid employees, major health issues of the elderly, and their role in public health policy development.

Directors of an active voluntary association with health interests described their mission, programs, funding, major health issues facing the local population, and how they viewed their leadership role in the community.

Medicaid-eligible community respondents who were leaders in their neighborhoods reported personal experiences with illness and injuries, and what friends, neighbors, and family thought were major health issues in the community.

Employment and Health Questions

Four key informant interviews related to employment and health issues (union representative, small business owner, major employer, and local Chamber of Commerce).

Union representatives described the goods and services union members produced, number of people the union represented in the county, and changes in union membership. They also summarized the union health insurance benefit package, cost sharing, type of plan (HMO, fee-for-service), and the relationship between employers and employees regarding health insurance.

Human resource administrators of each county's largest employer and small business owners reported on business conditions, employer-offered health insurance, premium cost sharing, and the relationship of health insurance to total employee compensation.

Chambers of Commerce directors summarized the county business climate, listed major employers in the county and whether they offered health insurance, and estimated the percent of small businesses in the county that offered employee health plans. Chamber directors also described their Chamber-offered group health insurance plan and its average cost.

Goals Our Community Should Strive Towards

Goal identification and prioritization are central to building collaborative relationships for community problem solving (Mattessich & Monsey, 1998). Counties face a large number of health issues. Scarce financial and human resources mean communities must prioritize before they set their health agenda and develop strategies to solve their problems (Minkler, 1999). The Extension educator as a professional in community development and a partner in health has an important role in helping communities identify their common problems and developing a shared agenda. There are many ways to start the process. The key informant process offered one way.

Thirty-four community health goals grouped in seven categories were drawn from the literature and offered to respondents as possible goals that their community could strive towards. The intent of these intermediate- and end-result goals was to broaden community thinking about the range of health issues that affect human well being.

The interviewer read the following, "I would like you to focus on your community and think about the goals you would set for your community to achieve good health. I will ask you to rate the degree to which you think the indicators I list are goals which your community should strive towards. . . . On a scale of 1 to 7, with 1 representing not important and 7 representing very important, what number would you give (*outcome*)?"

The seven categories were chosen to represent different aspects of health issues in the community (health status, primary care, auxiliary health care services, specialty care services, community environment, local control over health decisions, and economic contribution of health care). The

set of outcomes under health status were the only "true" health outcomes (infant mortality, length of life, low birth weight, and disparities among population groups on these measures). The remaining six categories represented intermediate processes that could affect ultimate health outcomes.

Three categories focused on the medical system.

Primary care goals focused on:

- Number of uninsured persons,
- Wellness services and prevention education,
- Availability of primary care services,
- Local emergency service available 24 hours, and
- Quality of local primary care.

Specialty care goals included:

- Specialty care coverage in insurance benefit packages,
- Available local specialty health care,
- Quality of local specialty health care, and
- Available specialty health care from neighboring urban centers.

Auxiliary health care goals included:

- Individual financing for long-term care,
- Available local auxiliary health care,
- Available local long-term care facilities, and
- Quality of local long-term care.

The community environment category represented the social and natural environment and its impact on health:

- Public safety (decreased illegal drugs and crime rates),
- Occupational and accidental injuries,
- Suicides and deliberate personal injuries,
- Water quality,
- Air pollution, and
- Health threat from land fill and soil contamination.

The health system of local counties is nested in state and federal mandates and markets that extend beyond county borders. The local control category represented the health systems within the county and the amount of control they had or wished they had.

- Local coordination of health and human services,
- Local coordination of technology and information management systems relating to health,
- Local control over the kind and type of health services offered,
- Local control over which health care firms provide services,
- Local control over the financing of public health services, and
- Local control over the delivery of public health services.

The last category, economic contribution of health care to the community, acknowledges the impacts that the medical community has on rural counties.

- Shared responsibility for uninsured/charity persons,
- Firms locating in our county,
- More people using local health care services rather than out of region,
- More people employed in health services, and
- Proportion of county budget spent on health care.

This list was not meant to be an exhaustive list but a starting point for thinking about the systems within the community that contribute to population health. It is noteworthy that many respondents, both in the pilot testing and actual interviews, commented on this list. They admitted they thought about health as a medical care system and not in terms of causality.

Findings

The top 10 health goals that emerged across these 14 rural counties were:

1. Decreased number of uninsured persons.
2. Less health status disparities among population segments.
3. Increased availability of individual financing for long-term care services.
4. Increased public safety (decreased illegal drugs and crime rates).
5. Increased local coordination of technology and information management systems relating to

health.

6. Increased local coordination of health and human services.
7. Lower infant mortality.
8. Local emergency service available 24 hours.
9. Increased wellness services and prevention education.
10. Increased agreement to share responsibility for uninsured/charity persons.

The ratings within each county offer the most meaning for local policy development. These ratings are not statistical summaries but rather discussion points. Each county only interviewed 10 leaders. While these were influential opinion leaders, they are not the only viewpoints. Many rural counties contain a large variety of other organizations, firms, and agencies as well as citizens that should be part of this discussion. These groups need to be included in an expanded discussion of health goals. Including them not only assists in forming a balanced public plan, but each group has talents, skills, monies, networks, and infrastructures that can provide the resources for achieving goals.

Extension Educator as Key Informant Interviewer

The key informant interview process offered educators training and professional development opportunities. The training gave them an opportunity to step back from their roles as educator to neutral collector of information. This was not an easy transition. The role of "expert" in nutrition or water quality or some other subject matter had to be laid aside. One of the obstacles to educators becoming involved in health policy is the feeling of inadequacy regarding personal knowledge base. The educator may know a "piece" of the health puzzle but not have command of the whole picture. This can result in a reluctance to undertake a policy effort due to a lack of answers.

As an interviewer, the Extension role was to simply "listen." This listening and recording process built personal knowledge and institutional information for future health policy development. The public policy process brings together diverse and different groups and is based in the expectation that no one comes with "the" answer, but rather through a sharing process, ideas are exchanged and solutions are developed collectively.

Exit interviews with Extension educators from 12 different counties provided an evaluation of their training preparation and experiences with interviewing county leaders.

Many of their comments reflect insights on the fragmented information regarding health in their communities.

- I have a greater awareness for the present health care system.
- Some interviewees were more informed than others (about their local health system).
- The county legislator did not feel comfortable with the questionnaire because he didn't know the information.

Educators thought the survey process increased Cooperative Extension's visibility regarding local health issues and linkages to other organizations interested in health. On average (using a scale of 0 = not at all) to 7 = a lot), educators rated their increased visibility as 5.2. Educators, on average, believed their local Cooperative Extension service was perceived as a strong leader in health education/outreach. They were less confident that Extension was perceived as a leader in grass roots health policy development.

However, the project had an impact on a number of educators as they considered health policy as a potential Extension program.

- Grass roots policy development efforts could be a greater focus for us. We recently helped a community forum on hunger issues get off the ground.
- Perhaps we can do more policy education, but I think we will need to be involved in group facilitation leadership first.
- I did not find any of the interviews exceptionally difficult. . . . All seemed to enjoy taking part and expressed an interest in knowing what would become of the information.
- I learned quite a bit from the interviews and the way people handle themselves.
- This was a very exciting survey to carry out.
- We'd like to share the result with Alliance (health network) as soon as results are available.
- I have a broader view of all aspects of health in the county; we generally deal with nutrition and fitness and healthy eating.
- It is scary to see that those with the most power don't have knowledge of the big picture.
- I see as a role of Extension—to help get the players together and organize/plan the agenda.
- We should be represented at meetings of the rural health network (we have not been invited to attend but maybe we should make the suggestion).

Conclusion

The health system in the United States is undergoing unprecedented change. The new rules of the marketplace are forcing all stakeholders to redefine their present and future roles (Lasker, 1997). Although change and severe fiscal constraints make for a volatile environment, this same uncertainty presents opportunities for new and existing stakeholders to build collaborations in the community interest. Cooperative Extension has valuable knowledge and skills to offer local health partnerships that are developing health policies and practices. Key informant interviews regarding local health structure and perceptions about health goals can expand the knowledge base from which educators develop health education and policy programming.

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