Facilitating Community Health Improvement Capacity Through Nongovernmental Public Health Partners

Angela L. Carman, DrPH; Margaret L. McGladrey, MA

ABSTRACT

The purpose of this study was to evaluate the effectiveness of the *Facilitating the Community Health Improvement Process* training in increasing the capacity of nongovernmental public health partners to serve as facilitators and supporters of community health improvement coalitions. Ten members of WellCare Advocacy and Community-Based Program teams (CommUnity Advocates) serving communities across the country were identified to participate in the pilot training group. They completed pre- and posttraining surveys to evaluate knowledge of community health improvement process models and facilitation techniques, as well as qualitative interviews to assess use of training material 6 months after the training. Results of the project revealed successful use of content from the training, which enhanced the impact of nongovernmental public health partners as facilitators of community health improvement planning and implementation.

KEY WORDS: community health improvement, facilitation, partners, public health

The 10 Essential Public Health Services (EPHS) delineate the responsibilities of local and state governmental public health departments and provide the standards for national public health accreditation.[1] EPHS 4 states that these governmental public health entities must "mobilize community partnerships to identify and solve health problems." The Public Health Accreditation Board emphasizes the importance of EPHS 4 by requiring a community health assessment (CHA) and community health improvement plan (CHIP) to be completed collaboratively with community partners.[1,2]

CHIPs recognize the diverse factors that contribute to community health, including access to healthy food, health care, jobs, physical activity infrastructure, and educational opportunities.[3] Representation from community members working in these areas is needed to develop a CHIP that coordinates community assets and leverages the efforts and expertise of its members.[4-7] The organizations that traditionally have worked to impact community health (eg, hospitals, health departments, schools, local government, nonprofits) are categorized by the Centers for Disease Control and Prevention (CDC) as the Local Public Health System (LPHS).[2] A significant body of research has explored methods for engaging communities to accomplish a specific goal such as health improvement.[4-9] Many governmental public health entities utilize the Mobilizing Action through Planning and Partnerships (MAPP) model developed by the National Association of County & City Health Departments and partners to facilitate the CHA/CHIP process.

Users of community engagement models, such as MAPP, may find a particular value in identifying community partners not typically included in the LPHS. Several local health departments have successfully collaborated with a nongovernmental public health partner, WellCare Health Plans (WellCare), in their health improvement efforts. WellCare is a provider of government-sponsored health care, primarily through Medicaid, Medicare Advantage, and Medicare Prescription Drug Plan, with a corporate structure that includes Advocacy and Community-Based Program teams. These teams are designed to catalogue available social services and provide this information to member-facing teams who help WellCare members and their families navigate the local social support network, improve health outcomes, close service gaps, and lower the overall cost of health care.[10] Through these efforts, WellCare Advocacy and Community-Based Program teams frequently interact with governmental

Author Affiliation: *College of Public Health, University of Kentucky, Lexington, Kentucky.*

The authors declare no conflicts of interest.

Correspondence: *Angela L. Carman, DrPH, College of Public Health, University of Kentucky, 111 Washington Ave, Room 113C, Lexington, KY 40536 (angela.carman@uky.edu).*

DOI: 10.1097/PHH.0000000000000480

public health representatives and other members of the LPHS.

The overlapping objectives of WellCare teams and governmental public health organizations led to an opportunity not only for WellCare to be recognized as an LPHS member but also for WellCare CommUnity Advocates to assume the role of facilitator, convening traditional public health partners and social service providers. To expand their capacity in community-engaged health improvement work, WellCare CommUnity Advocates participated in a pilot training program on models of community engagement, identification of community partners,[11] team dynamics,[12] facilitation skills,[13] and evidence-based interventions for improved health.[14] The module, *Facilitating the Community Health Improvement Process*, was grounded in the concept of Collective Impact,[15-17] which enumerates specific skills needed to coordinate initiatives undertaken by multiagency coalitions.

Methods

The pilot training group for the *Facilitating the Community Health Improvement Process* module consisted of 10 WellCare CommUnity Advocates serving communities across the country. The pilot group included individuals with community engagement experience and those new to community-based work. The pilot group participated in a 1.5-day, in-person, interactive training developed and led by the first author that involved didactic sessions on community engagement models, as well as practice sessions in which participants identified community partners who could enhance the impact of health improvement. Participants also worked with health statistics to understand the disease-burden profile of specific communities, learned about the availability of evidence-based interventions, and practiced facilitation skills, such as how to bring a group to consensus, how to use questioning skills to solicit information, and HOW TO ASSUME the role of "backbone support" in coordinating community health improvement coalitions. Participants practiced each technique in real-world simulation scenarios.

Trainees completed a preprogram survey to assess their baseline knowledge of CHIP and group facilitation techniques. Following the in-person training, CommUnity Advocates completed an identical posttraining survey to assess changes in their understanding of and/or skill level in each area covered in the training module. The survey instrument included 20 statements about knowledge of CHIP and group facilitation techniques, with a 5-point Likert-type scale measuring participants' level of agreement with each statement.

Six months after the training, the second author (who was not involved with the training) conducted follow-up interviews with 5 training participants to assess how they had applied the community health improvement strategies and facilitation skills they had learned in their daily work. After meeting the criterion that they had remained in the CommUnity Advocate role for the past 6 months (some participants had transitioned to new responsibilities), interview participants were selected to represent the geographic diversity of regions served. Questions solicited information about CommUnity Advocates' use of techniques to identify new community partners, roles they had filled in CHA/CHIP processes, team dynamics and/or facilitation skills they had employed, and evidence-based interventions they had planned and implemented in their communities.

Outcomes

Survey analysis

The pretraining survey indicated different levels of knowledge of how community partnerships should be leveraged. While the majority of participants understood how partnerships play a role in CHIP, 60% did not understand that the CDC supports the use of partnerships as a key vehicle for implementing evidence-based health improvement initiatives. Seventy percent felt they could identify partners who could impact community health improvement and understood the need for preimplementation CHAs. However, only 50% felt they could locate the types of data needed for a community health improvement project and 90% were unfamiliar with the CHA/CHIP model used by most governmental public health partners (ie, MAPP). Although the majority (70%) of participants indicated they were comfortable facilitating groups, only 50% knew how to conduct a group consensus-building activity, only 40% understood the developmental stages of teams or coalitions, and only 40% knew how to use questioning techniques to assist a group with CHIP. Half of participants felt they could identify evidence-based public health interventions, whereas 40% indicated that they could not assist a community group in determining which evidence-based intervention would be best suited to specific needs.

A paired t test of pre- and posttraining mean scores for responses to the 20 survey questions indicated that training participation resulted in statistically significant increases in survey scores ($t = 14.91$, $P < .001$). All participants showed an increased understanding of how the CDC supports community partnerships. In addition, all participants

Implications for Policy & Practice

- Our study's pilot group participants reported having successfully used content from the training to enhance their impact as facilitators of community health improvement planning and implementation.
- We learned that the definition of LPHS can be expanded to include stakeholders such as managed-care organizations (MCO) that understand the importance of multisectoral collaboration around an issue as complex in terms of its contributors and solutions as community health.
- This project also has implications for public health workforce development.
- Many LPHS members lack understanding of how teams of community members should work together and the skills required to facilitate a multiagency group.
- Future workforce development efforts must enhance team-building and facilitation skills.
- Please contact the first author for information related to the content of *Facilitating the Community Health Improvement Process* module.

indicated that they could identify partners, identify types of data needed, conduct a group consensus-building activity, identify the developmental stages of teams, use questioning skills, and identify evidence-based interventions.

Interview analysis

During the 6 months following the training, participants in the follow-up interviews described working with a host of new community partners and on new CHA/CHIP initiatives in their service areas. Several participants discussed their efforts to revive dormant community coalitions and engage new partners in the CHA/CHIP process such as suicide prevention advocates and homeless/transient population service providers. According to one participant, the team-building strategies helped her lead coalition partners to envision their community more holistically and inclusively, "as opposed to having singular tunnel vision." All participants discussed applying the facilitation and team-building skills they had gained during the training in both formal and informal meeting contexts. For example, a participant described using a consensus-building technique both with her community partners and internally within WellCare in the following way: "A helpful tool is to be able to say not 'Does everybody love this? Are we all happy with it?' but to say 'Can you live with it? Can you support it?'" All participants stated that they felt equipped by the training with specific techniques to facilitate community engagement, indicating that they would welcome additional trainings to practice what they had learned.

Lessons Learned

This study highlights the critical role that WellCare CommUnity Advocates can play in providing backbone support for community health improvement efforts. CommUnity Advocates utilized skills learned in the training to convene partners and facilitate effective groups. According to one participant, "MCOs need to be a major part of changes that happen on a community level because we're the ones who are paying for it." These organizations are committed to sustaining long-term engagement with the communities they serve and can supplement governmental public health capacity as local health department budgets continue contracting.

References

1. Public Health Accreditation Board. Standards and measures. www.phaboard.org. Published 2012. Accessed July 2012.
2. Centers for Disease Control and Prevention. The public health system and the 10 Essential Public Health Services. http://cdc.gov/nphpsp/essentialservices.html. Published 2013. Accessed February 1, 2016.
3. Marmot M, Wilkinson R. *Social Determinants of Health*. Oxford, England: Oxford University Press; 2005.
4. Kretzmann JP, McKnight JL. *Building Communities From the Inside Out*. Skokie, IL: ACTA Publications; 1993.
5. Wolff T. A practitioner's guide to successful coalitions. *Am J Community Psychol*. 2001;29(2):173-191.
6. Prybil L, Scutchfield FD, Killian R, et al. *Improving Community Health Through Hospital—Public Health Collaboration: Insights and Lessons Learned From Successful Partnerships*. Lexington, KY: Commonwealth Center for Governance Studies Inc; 2014.
7. Kettering. *Naming and Framing Difficult Issues to Make Sound Decisions*. Dayton, OH: Kettering Foundation; 2011.
8. Pullen NC, Upshaw VM, Lesneski CD, Terrell A. Lessons from the MAPP demonstration sites. *J Public Health Manag Pract*. 2005;11(5):453-458.
9. Wray L, Epstein P. Harnessing the power of community collaborations. *PM Magazine*. 2012;94(2):7-11.
10. Plans WH. Community. https://www.wellcare.com/Corporate/Community. Published 2015. Accessed March 17, 2016.
11. Centers for Disease Control and Prevention. National Public Health Performance Standards—Essential Services. http://www.cdc.gov/nphpsp/essentialservices.html. Published 2013. Accessed November 2014.
12. Schermerhorn J. *Management*. 10th ed. Hoboken, NJ: John Wiley & Sons; 2010.
13. Wilkinson M. *The Secrets of Facilitation*. San Francisco, CA: Jossey-Bass; 2004.
14. Centers for Disease Control and Prevention. The Guide to Community Preventive Services. http://www.thecommunityguide.org. Published 2015. Accessed February 1, 2016.
15. Hanleybrown F, Kania J, Kramer M. Channeling change: making collective impact work. *Stanford Soc Innov Rev*. 2012;2012:1-8.
16. Kania J, Kramer M. Collective impact. *Stanford Soc Innov Rev*. 2011;9(1):31-35.
17. Carman A. Collective impact through public health and academic partnerships: a Kentucky public health accreditation readiness example. *Front Public Health*. 2015;3:44.