

## Fulfilling community health assessment requirements: Lessons learned from facilitating state-wide community health forums

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### ABSTRACT

**Background:** A prerequisite for National Public Health Accreditation is completion of a Community Health Assessment (CHA) that presents an exhaustive profile of the population served by a particular public health agency.

**Methods:** The Georgia Department of Public Health (GA DPH) contracted with the Center for Public Health Practice and Research at Georgia Southern University to facilitate five state-wide community health forums.

**Results:** Evaluation of the forums yielded qualitative data illustrating current challenges faced by Georgians, as well as assets that could be leveraged to improve health status.

**Conclusion:** Lessons learned from these state-wide community health forums can be applied to improve the overall process of gathering data for a comprehensive CHA throughout Georgia or other areas interested in pursuing public health agency accreditation.

**Key Words:** Accreditation, community assessment, community engagement

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### INTRODUCTION

Public health agencies interested in attaining accreditation must satisfy three prerequisites prior to applying. These include completion of a Community Health Assessment (CHA), completion of a Community Health Improvement Plan (CHIP), and completion of the Agency Strategic Plan (Public Health Accreditation Board, 2016).

The Georgia Department of Public Health (GA DPH) contracted with the Center for Public Health Practice and Research (CPHPR) at Georgia Southern University to facilitate state-wide community health forums as a required component of their CHA. The purpose of this report is to highlight lessons learned through this partnership to meet national standards for public health accreditation.

### METHODS

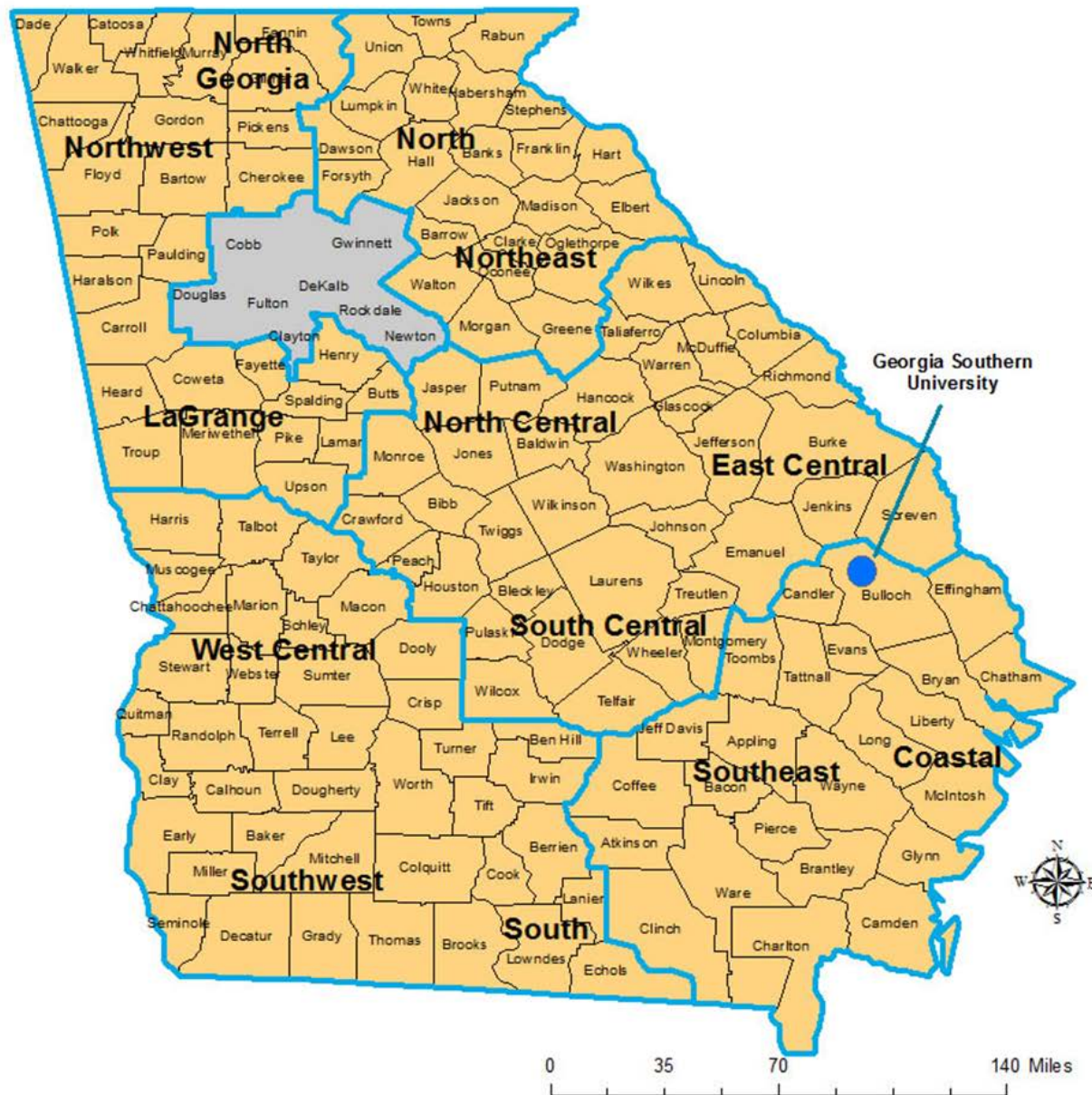
Beginning in July 2015, five regional forums were conducted (Figure 1). In collaboration with the GA DPH, regions were formed along public health district lines. Additionally, the GA DPH selected and managed all meeting locations; they also invited and recruited participants. Each forum lasted for three hours. GA DPH

team members made one-hour presentations and the CPHPR team facilitated two-hour open discussions. The discussions were guided by three questions developed and chosen by GA DPH: 1) What are the top health issues in your community? 2) What are the community assets available to help tackle these problems? and 3) What do you think the GA DPH should be doing to address the top three health issues? During each forum, the facilitators used large and small groups to elicit extensive discussion. The CPHPR team followed principles of the Nominal Group Technique (Centers for Disease Control and Prevention, 2006) to ensure that all participants were given an opportunity to speak. Approximately 20-25 minutes of discussion was devoted to each question.

After the open discussion of questions one and three, participants were given the opportunity to prioritize key discussion themes. For question one, each participant was asked to vote for the three most important health issues discussed by the entire group. Votes were processed and used to guide discussion of the remaining questions. For question two, participants first discussed community assets and the value these assets could have in designing interventions.

Figure 1: Map of Regions

# Georgia Study Areas



Map: Jeff Jones, PhD, April 2015, Georgia Southern University  
Data Source: Georgia Division of Public Health, June 2006

Discussions related to the second question prepared the group to address the third question, which related to action items for GA DPH. Following these discussions, each participant voted for their top five items.

CPHPR team to determine issues related to the State of Georgia. All forums were audio recorded, and field notes were written to assist team members in compiling and interpreting regional and statewide results (Figure 2).

The voting process aided in the prioritization of health issues and action items for each forum and allowed the

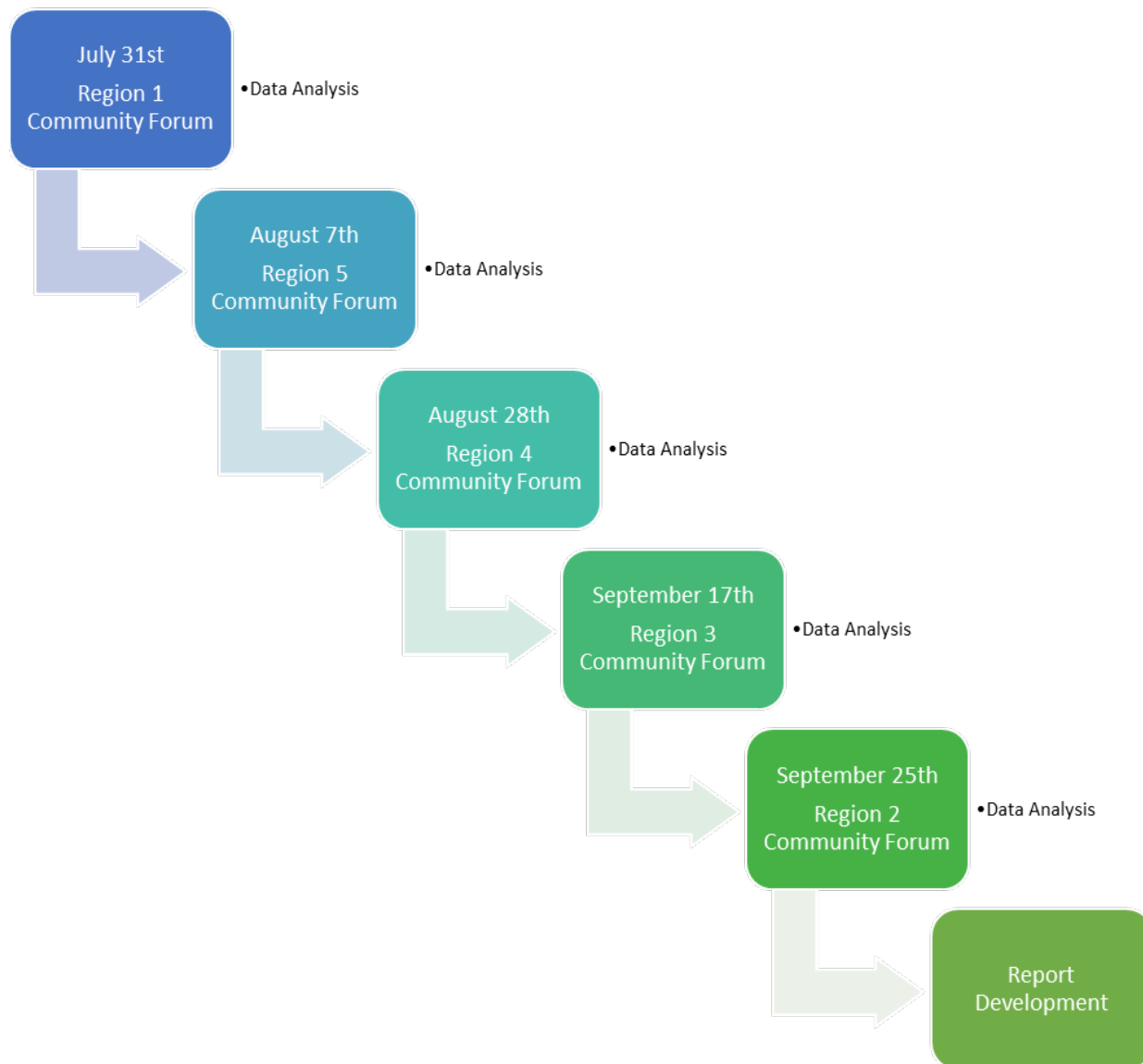
**RESULTS**

The CPHPR team collected and analyzed all qualitative data and produced a report to share with the GA DPH. This report included a process summary, all individual forum data, and a state-wide summary. GA DPH will produce a complete CHA by the end of 2016 and publish it on their website.

Although community discussions resulted in statewide themes and action steps, this process had limitations. First, since the Atlanta area and its public health districts were not included in the five regional forums, the prioritized statewide issues did not include Atlanta representation.

Second, some forums were not as well attended as others, particularly with respect to the first forum. Additionally, dividing the state into five regions meant combining large geographic areas for each forum. Thus, travel for those in more remote areas of the state led to underrepresentation of some health districts, particularly in the north. Finally, insightful contributions were provided by the participants, but they did not always suggest action items that GA DPH could address. Depending on the composition of each forum, personal agendas could drive the discussion, forcing the facilitators to redirect it to focus on community-based needs.

**Figure 2: Process Timeline**



The strengths of these community forums were numerous. Participants varied widely and included representation from local public health organizations, hospitals, Federally Qualified Health Centers, universities, other health-related associations, and other community partners. Additionally, participants remarked on how encouraging and supportive it was to have GA DPH representatives come to their community to present data and listen to local concerns. Notably, these forums gave participants an opportunity to share and highlight some of the relevant community assets that allow these public health and healthcare leaders the opportunity to deal with complex and chronic public health issues.

## DISCUSSION/CONCLUSIONS

In conclusion, the regional forums allowed participants to present assets available to local communities. This portion of the open forums was deemed helpful by participants; however, as recommended by those who attended the forums, better utilization of their community assets is needed.

The experiences shared by the forum participants support previous reports highlighting the usefulness and challenges surrounding community partnerships and engagement (Alcantara, Harper, & Keys, 2015; Jagosh et al, 2015). Participants appreciated the opportunity to connect with other local health and human service organizations, but they had a concern that they were unaware of what other organizations were providing to community members and their target audiences. Public health and healthcare professionals often practice in isolation, perhaps as a result of lack of resources and power sharing between groups. To form lasting partnerships, groups must first agree on the overall goal and roles of the partnership. This is accomplished by use of shared leadership (Northridge, Vallone, Merzel, Greene, Shepard, Cohall, & Heaton, 2000).

To address health needs and improve health status in their local communities, health providers and organizations should share resources to support a broader community reach. Collaboration is often attempted through the use of coalitions; however, they can fail because members have not agreed upon the purpose or designated responsibilities of each representative organization. To avoid this problem, community and public health organizations need a supportive environment (including training, incentives, and funding) to form and sustain long-lasting community partnerships.

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