

Conducting a Community Needs Assessment

The Community Health Worker Program

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Objectives



- Overview of goals of CHW Program
- Define Community Needs Assessment
- Discuss the process of conducting a Community Needs Assessment
- Explore strategies for targeted outreach
- Identity community resources and gaps

The Community Health Worker Program

- The goal of the CHW Program is to promote optimal health status among New York State's highest risk pregnancy and parenting families who are not currently in services by:
 - Providing outreach
 - One-on-one education
 - Referral and follow-up
 - Advocacy
 - Case Management
 - Home Visiting



Target Population



- The CHW Program is targeted to specific communities and populations with the following outcomes:
 - High rates of infant mortality
 - Out-of-wedlock births
 - Late or no prenatal care
 - Teen pregnancies and births, and
 - Birth to low-income women
- The emphasis of the program is on early and consistent participation in *preventive* and *primary health services* for at risk families

Community Needs Assessment - *Rationale*

- The goal of a Community Needs Assessment is to develop a profile or picture of the community in order to strategically plan outreach and utilize resources
- Key objectives:
 - Identify assets of a community
 - Determine potential concerns that it faces – gaps in services
 - Collaborate with local-community based organizations to address needs
- Process:
 - Planning and organizing
 - Data collection
 - Summarizing and disseminating findings
 - Sharing results

Community Needs Assessment - *Process*

- Includes the following:
 - Determining the focus of the assessment, timeline, tools and how the outcomes will be shared
 - Identifying partners and stakeholders
 - Developing a focus group
 - Designing and administering a survey to capture concerns and strengths of the community, including demographic information
 - Collecting and analyzing data
 - Summarizing and sharing results

Identifying Stakeholders

- A successful community needs assessment process requires the identification of:
 - Internal partners – within the CHW agency
 - External partners – relevant community stakeholders
- Stakeholders can be of the following entities:
 - Referral Agencies
 - Health Care Agencies
 - Clinician Groups
 - Business Groups
 - Social/Cultural/Religious Groups
 - Community Volunteers



Assembling a Focus Group

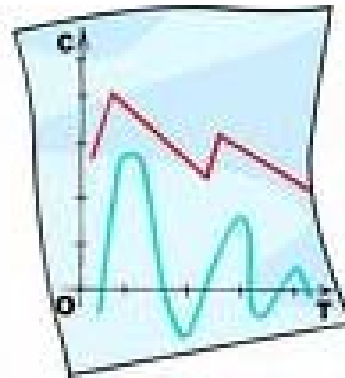
- A *focus group* is a small, informal group that can discuss and reflect on issues in the community – *reflective of target population*
- The group plays a key role in identifying questions for the needs assessment survey
- Examples of focus group members:
 - Current clients
 - Past clients
 - Relevant community members

Community Needs Assessment - *Survey*

- Items on survey are based on information provided by the focus groups, such as identified issues and concerns
- The survey should consist of closed and open-ended questions, in addition to a section requiring demographic information
- Surveys can be disseminated in various ways:
 - Via telephone
 - Mass mailings
 - Interviewing community members
 - Survey Monkey (www.surveymonkey.com)
- Survey Monkey:
 - A web-based survey instrument
 - Collects quantitative data through structured, or closed-ended questions
 - Allows for open-ended questions
 - Data is weighted, processed, and analyzed using descriptive statistical techniques

Data → Informs Outreach

- It is important for the CHW to be able to access and use local community *data sources* to assess:
 - the numbers of pregnant women in the community
 - Poverty rates
 - Birth outcomes
 - Infant mortality
 - Other indicators of risk



Data Sources

- New York State Department of Health
- Vital Statistics of New York State (2006)
 - Information for a Healthy New York
 - http://www.health.state.ny.us/nysdoh/vital_statistics/2006/
 - Revised in June 2008 – most up-to-date data
 - Next revision after 2010 Census data collection



Vital Statistics - *Pregnancies*



- Total Pregnancies by Woman's *Age* and *Resident County*
- Total Pregnancy Rates by Woman's *Age* and *Resident County*
- Total Pregnancies by *Race/Ethnicity* and *Resident County*
- Total Pregnancies and *Teenage* Pregnancies by *Type* and *Resident County*

Vital Statistics – *Spontaneous Fetal Deaths*

- Spontaneous Fetal Deaths (All Gestations) by Woman's *Age* and *Resident County*
- Spontaneous Fetal Deaths (Gestation 20 Weeks and Over) by Woman's *Age* and *Resident County*
- Spontaneous Fetal *Deaths* and Rates by *Race/Ethnicity* and *Resident County*

Vital Statistics – *Live Births*

- Live Birth Summary by Mother's Race/Ethnicity
- Live Births by Financial Coverage and Mother's Race/Ethnicity
- Live Births by Race and Birthweight, Race and Month Prenatal Care Began by Mother's Age
- Live Births by Mother Age and Resident county
- Live Births and Fertility Rates by Mother's Age and Resident County
- *Out of Wedlock* Live Births by Mother's Age and Resident County
- Low Birthweight (<2500 grams) Live Births by Mother's Age and Resident County
- Percent Early and Late or No Prenatal Care by Mother's Age, Race/Ethnicity, and Resident County

Other Data Sources

Let's discuss other data sources that you use in your outreach...

Additional Resources

- New York State Department of Health - Growing Up Healthy Hotline:
 - Provides information and referral for pregnancy planning, prenatal care, WIC, and related topics
 - **1-800-522-5006**
- The National Campaign to Prevent Teen and Unplanned Pregnancy:
 - <http://www.thenationalcampaign.org>
 - The DCR Report (Data, Charts, Research)
 - provides data and in depth answers to some critical questions about teen and unplanned pregnancy
 - <http://www.thenationalcampaign.org/resources/dcr/>

Outreach Efforts

- The CHW Program specifically targets high-risk pregnant and parenting women who are currently not in services
- Effective outreach is a critical tool in this effort and includes:
 - outreach specifically to clients or participants
 - outreach to other community based organizations that serve similar populations
 - outreach to physicians or clinics who may be seeing the most at-risk populations and other strategies

Outreach

In your experience as a manager, what are the barriers to outreach in your community?



Barriers to Outreach

- **Some typical barriers might be:**
 - Community health workers lacking the skills to do outreach in new ways and in new places
 - Community organizations not understanding the scope of work of the CHW program and making inappropriate referrals
 - Changing demographics in a community that might necessitate different outreach approaches
 - Lack of time and planning to do outreach
 - Exploring non-traditional outreach venues and approaches
 - Resistance from Community Health Workers to engage in outreach

Outreach

- In looking at your communities, please share some of the strategies you have used in outreach that you feel have been effective in identifying new clients for your program?
- What strategies have not been effective or have not resulted in new clients for your caseload?

Outreach Cont'd

- Several organizations have been exploring some evidence-based strategies for navigating the most at-risk clients into services.
- There is a new model of outreach that is now called *Enhanced Outreach* and has been an effective strategy for navigating potential clients into services.

Enhanced Outreach

- *Enhanced Outreach* is a model that has been developed with the premise that the most at-risk individuals need multiple encounters in order to build trust before engaging in services.
- The idea that a one time exchange with a potential client is enough to bring them into services has not proved to be successful.

Enhanced Outreach Cont'd

- So, if your Community Health Workers meet a potential client at a food pantry or shelter, they would need to reach out three or four times before the client agrees to services.
- This process of engagement is client-centered and the strategy is you are building trust so that the client agrees to services.

Traditional Outreach Strategies

- Gives out educational brochures
- Reaches “target” population in community
- Hands out prevention materials or marketing materials and brochures
- Participates in community-wide events such as street and health fairs
- Provides information about services
- Know information about the health and social services available in their agency
- Attends agency meetings and events

Enhanced Outreach Strategies

- Engages client in discussion
- Makes connections with “sub target” populations in the community
- Asks client what she needs or wants
- Helps organize events in the community to reach target population
- Escorts clients to service appointments
- Works with the broader community
- Knows information about health care agencies and about multiple social service agencies in their community
- Participates in non-traditional collaborative coalition meetings and events

Phases of Enhanced Outreach

- There are four phases to the *enhanced outreach model* that was originally developed by the Healthcare for Homeless Services in Washington, DC:
 - Approach
 - Companionship
 - Partnership
 - Mutuality

Approach

- The approach level is observation and introduction
- Time should be spent watching and observing how a person relates to others including what they seem to be experiencing in their environment
- This observation aids in developing an introduction
- A simple nod or greeting can be sufficient
- The key is to begin as someone who cares and define our role later when the relationship develops

Companionship

- This phase consists of sharing “a little journey with another”
- The approach should be walking with each other, listening to their concerns and hearing the other person’s story
- The key is to listen and ask questions without directing the person to one decision

Partnership

- This phase of outreach and engagement is established by introducing the person to others who can help or assist
- Partnerships can be built with case managers, medical providers or social service programs
- In the CHW Program, our staff is providing both outreach and case management so they are developing the partnership with the prospective woman

Mutuality



- This phase is achieved by seeing one another as fellow citizens or community member identifies mutuality
- The woman is encouraged to continue making use of services and resources during her journey

Combined Outreach

- Let's talk about how you might apply a combination of *traditional* and *enhanced outreach* strategies in your CHW Program...

Resources and Service Gaps

- Let's discuss some of the resources we use in delivering outreach services...
- What are some of the gaps in services that our clients experience?

Referrals

- Making referrals requires the support of a committed and involved community
- It is important to match the needs of the client with the appropriate services
- There may be some resistance from some segments of the community
- The CHW, regardless of the level of openness or resistance, can help to enhance outreach efforts by listening, engaging, educating and ultimately advocating on behalf of the clients
- Agencies should have internal and external resource directories of common referral sites and sources
- The CHW should conduct a *follow-up* of to determine whether the client accessed referral services and if the service are meeting her needs, etc.

Managing and Implementing a Referral System

- Identify common client needs
- Identify local agencies that have services to meet those needs
- Establish a relationship with agencies to develop partnerships and/or collaborations
- Address the need for Memorandums of Understanding (MOUs)
- Create release of information forms
- Make the referral
- Track the referral with a follow-up system
- Implement Quality Improvements for the system
- Document all referrals made



Pulling it all Together

- Understand goals of CHW Program
- Conduct Community Needs Assessment
- Identify problems – Who & Where
- Use data to inform outreach strategies
- Implement strategies – combination of *traditional* and *enhanced* outreach
- Establish a referral system
- Evaluate program continuously
- Share successes



CHWP - Training Schedule & Location

- **Community Health Worker Project Spring Core Training Part I**
 - **May 4-7, 2010**
 - **9:00am – 4:30pm**
 - Cicatelli Associates Inc., 2 Winner Circle, Suite 102, Albany, NY 12205
 - 518-724-2801
- **Community Health Worker Project Spring Core Training Part II**
 - **June 8-11, 2010**
 - **9:00am – 4:30pm**
 - Cicatelli Associates Inc., 2 Winner Circle, Suite 102, Albany, NY 12205
 - 518-724-2801

Hotel Information:

- For those of you who will need lodging, we have reserved a room block at the state rate of \$110 (single) at the following hotel:
 - [Homewood Suites by Hilton Albany](#)
 - 216 Wolf Road, Albany, NY 12205
 - Tel: 1-518-438-4300
 - Fax: 1-518-435-9064
- Please make sure when you call you use “ CHW Group” code in order for them to assist you- Note that these rooms are only being held and your agency will have to cover the costs
- Deadline for training registration and room reservation is [April 12,2010](#)

Contact Info

- We here at Cicatelli Associates are looking forward to a new year of training!
- As always, if you have questions or comments, please contact Alma Krcic at akrcic@cicatelli.org or 212-594-7741, Ext. 249