NEEDS ASSESSMENT IN ACTION PROFILES

Innovative Approaches to Identifying the Needs of Underserved Communities

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

Table of Contents

2 Acknowledgments

3 Introduction

4 Family Health Centers of Georgia, Inc. (Atlanta, GA)
Building Relationships as a First Step in the Assessment of a New Patient Population

8 Terry Reilly Health Service (Boise, ID)
Maximizing Data Sources to Assess the Needs of a Changing Homeless Population

11 Community Health Partnership of Illinois (Chicago, IL)
Integrating Needs Assessment Questions into Outreach Encounters with Migratory and Seasonal Agricultural Workers

14 Conclusion

15 About Health Outreach Partners

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Introduction

A community health needs assessment (CHNA)[1] is an effective tool that health centers can use to identify and document community needs, persisting barriers to care, gaps in services, and emerging health trends. Health centers often use the assessment findings to prioritize, plan, and make improvements. A needs assessment is a critical component of delivering effective health services, as it allows health centers to better align their services to the communities' needs and ensure the delivery of quality care to underserved populations.

DEFINITION

Community Health Needs Assessment is a process that enables organizations to:

- Create a health profile of a community or any specific sub-group
- Identify primary risk factors for poor health outcomes
- Identify the barriers to health care access
- Prioritize and take action to address the health needs of the community

Taken from HOP's Community Health Needs Assessment Toolkit, 2015. To request a copy of the toolkit, go to www.outreach-partners.org/resources/resource-request-form/.

Although there are several basic fundamentals involved in the needs assessment process, there is no standard approach. Health centers design their methodology based on their assessment questions, population of interest, and available resources. The needs assessment may be administered formally or informally, and may occur once or continue indefinitely. Ultimately, a needs assessment is a worthwhile endeavor that provides health centers with relevant, quality data about the health status of a community from a variety of sources.

NEEDS ASSESSMENT IN ACTION

Health Outreach Partners (HOP) recognizes that conducting a needs assessment is a major undertaking for any organization: it is a process that requires significant resources and staff time. Many health centers have expressed a desire to learn about effective strategies utilized by their peers. In response, HOP created *Needs Assessment in Action Profiles* as a resource for health centers. This resource offers examples of three innovative needs assessment approaches that have been successfully implemented by health centers, as well as lessons learned from the process. The health centers profiled include Family Health Center of Georgia (Atlanta, GA), Terry Reilly Health Service (Boise, ID), and Community Health Partners of Illinois (Chicago, IL).

As the profiles demonstrate, health centers are finding creative ways to gather valuable health and social needs data, such as: investing time in relationship-building to survey a new patient population of low-income seniors, mining existing internal and external data sources for information on the rising number of homeless families, and integrating needs assessment questions into outreach encounter forms with agricultural workers. The profiles are intended to serve as a resource for health centers interested in applying proven strategies to the planning and implementation of their own needs assessment. Additionally, for readers that may have questions, each profile includes the health center's key contact information. For those who need further assistance, HOP can provide support in the planning and implementation of their needs assessment efforts.

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[1] The term "needs assessment" is used throughout the document to refer to a community health needs assessment.

Family Health Centers of Georgia, Inc. - Atlanta, GA

Building Relationships as a First Step in the Assessment of a New Patient Population

Although health centers strive to serve a wide spectrum of communities, there are some populations that they have yet to reach. As a first step, some have used a needs assessment to collect information from new populations that they currently do not serve. Family Health Centers of Georgia (FHCGA), a Federally-Qualified Health Center (FQHC) based in Atlanta, GA, conducted a needs assessment of low-income seniors to determine how their model of care could meet the health and social needs of this potential new patient population.

BACKGROUND

Founded in 1975, FHCGA is a primary care medical home that operates as a "one stop shop" by providing primary care, dental, pediatric, behavioral health, laboratory, and pharmaceutical services through a system of coordinated sites, including three school-based health centers. They primarily serve the African-American and Latino communities in Fulton, Cobb, DeKalb, and Clayton Counties in Georgia.

FHCGA is a Public Housing Primary Care (PHPC) program grantee, and in the past provided care to public housing residents on-site at housing developments. However, between 1996 and 2011, the Atlanta Housing Authority demolished all housing developments in the city as part of their effort to improve and revitalize public housing. As a result, eligible, low-income residents now receive housing vouchers that provide them with the financial means to live in private housing. In an effort to continue services to this population, FHCGA, in partnership with Fulton County Health and Wellness, began providing care and outreach to residents in various mixed-income housing communities.

FHCGA decided to conduct a needs assessment to identify the main health and social needs of low-income seniors in order to enhance health center services for this population. FHCGA formed a needs assessment project team that included members from across various departments and programs, including outreach. They divided into two teams, one for planning and oversight and the other for gathering data. The health center's Director of Public Housing, Director of Social Services, Director of Health Education, and Director of Marketing comprised the planning team, and the outreach team carried out the data collection.

BUILDING RELATIONSHIPS

FHCGA anticipated that recruiting participants for the needs assessment would be challenging, especially given the seniors' lack of familiarity with the health center. Prior to beginning their data collection, the outreach team spent about six weeks building relationships in a selected housing community. This proved to be a crucial strategy for recruitment.

FHCGA's outreach team first established a relationship with the Director of the housing community, who then allowed them to attend the resident council meetings. The outreach team gave several presentations about the health center and the upcoming needs assessment. As the council president and residents became more familiar with them, FHCGA was allowed to organize several events for the seniors on-site, including health education workshops, blood pressure screenings, and Bingo games. During these events, the outreach team promoted the needs assessment and recruited participants by explaining its purpose and the benefits of participation. FHCGA also set up a raffle as an additional incentive. The council members, who are viewed as the leaders of the community, also helped with recruitment by encouraging the seniors to participate.

"Build rapport with the community. Don't expect to be able to go door-to-door without having relationships."

- Fredericka Roper, Program Coordinator

Residents share a meal during Senior Wellness Game Day. (Photo Courtesy of FHCGA)

METHODOLOGY

While the outreach team recruited participants, the planning team developed a survey tool for the senior residents in one mixed-income housing community. The survey was simple, audience-appropriate, and written at a fourth grade reading level. Consisting of 20 questions, the survey solicited information on the health, social, and financial needs of the seniors, as well as demographic information. The planning team estimated that it would take 15-20 minutes to complete the survey and included a confidentiality disclosure for participants.

In preparation for data collection, the planning team trained the outreach team, so that they would be familiar with the survey questions, understand clearly what information was being sought, and gain practice conducting the survey. As data collectors, the outreach team had to be prepared to answer any questions that the participants had – especially those related to the purpose of the needs assessment and the potential benefits of participation – without making promises of new programs and services.

DATA COLLECTION

Data collection occurred over a two-month period. The outreach team administered the survey by going door-to-door; participants were given the option to either complete the survey together with the outreach team or on their own. If the participant chose the latter option, an outreach team member returned several days later to retrieve the completed survey. Initially, the outreach team faced resistance from some of the seniors who did not want to provide their social security numbers. FHCGA's planning team reassessed the importance of collecting social security information and realized that this information would not provide any relevant information regarding the needs of seniors and potential services. Consequently, this question was removed from the survey. The outreach team found the seniors more accepting of the revised survey, and in the end, FHCGA achieved a 75% response rate.

Residents participate in Senior Wellness Game Day. (Photo Courtesy of FHCGA)

SHARING AND USING FINDINGS

Upon completion of the data collection phase, the planning team and the Chief Health Officer analyzed the data. One significant finding from the needs assessment was that a high number of seniors surveyed suffered from cardiovascular disease. Seniors reported that they lacked information about the disease, its causes, and how to manage it. Additionally, FHCGA found a high number of seniors who were non-compliant with their medication regimens. For example, when FHCGA outreach staff would take the blood pressure of seniors during their visits to the housing community, most of them shared that they had not taken their medication that day.

Once the needs assessment findings were shared internally, FHCGA applied for funding and received a grant from the National Institutes of Health (NIH) to conduct a cardiovascular disease intervention for all residents at housing communities. The six-week program provided low-income seniors and other residents with health education classes and support on cardiovascular disease prevention and management. Each participant attended a 45-minute session weekly, which included blood glucose and cholesterol tests to monitor changes in levels. Healthy snacks were also provided to the participants, as a way to educate them on nutritious eating habits. A total of 400 residents participated in the first year of the intervention. Due to its popularity, FHCGA made the program available for a second year; many of the first year participants joined again.

Residents engage in chair aerobics during Senior Wellness Game Day. (Photo Courtesy of FHCGA)

LESSONS LEARNED

FHCGA's needs assessment of low-income seniors took a total of six months to complete. When reflecting on the lessons learned from the process, the needs assessment project team emphasized that allocating adequate time is critical, especially when reaching out to a new population. FHCGA invested significant time upfront to build rapport with the community, which allowed them to reach a large number of seniors and gather sufficient data. FHCGA also credits their flexibility and openness to making changes along the way as part of their success. Finally, the project team highlighted the need to create a strong communication structure where all involved have a clear understanding of the process and their respective roles. This includes ensuring that responsibilities are defined and that the team is continually updated on the progress of activities throughout the process.

The needs assessment process is a worthy investment of health center resources and staff time because it can yield meaningful data, build or reinforce trust and relationships with the community, and help to solicit funding. FHCGA's needs assessment enabled them to hear directly from seniors about their most pressing health and social needs. As a result, FHCGA was able to design an effective and popular intervention that was responsive to the health conditions that many seniors were facing.

For more information about FHCGA, visit www.fhcga.org. To learn more about FHCGA's needs assessment, contact Ms. Fredericka Roper, Program Coordinator, at froper@fhcga.org.

Terry Reilly Health Service - Nampa, Idaho

Maximizing Data Sources to Assess the Needs of a Changing Homeless Population

Homelessness continues to be a key public health issue in Idaho. For the past several years, the State has seen an increase in the number of homeless families, as well as unsheltered and "first time" homeless individuals.[2] In order to provide this population with appropriate services, Terry Reilly Health Service, a Federally-Qualified Health Center (FQHC) based in Nampa, Idaho, conducts an annual needs assessment rooted in quality improvement measures. Working with community partners, Terry Reilly collects and analyzes data from a variety of sources in order to identify the unique needs of the changing population of individuals and families experiencing homelessness in the Boise, Caldwell, and Nampa communities.

BACKGROUND

Since its inception in 1971, Terry Reilly Health Service has provided quality health care services in seven different cities throughout Southwest Idaho. It currently provides medical, dental, and behavioral health services to more than 30,000 people each year. While its services are open to all populations, the center is strongly committed to serving individuals and families experiencing homelessness.

As a Healthcare for the Homeless (HCH) program grantee, Terry Reilly's clinics in the Boise, Caldwell, and Nampa communities provide individuals experiencing homelessness with an access point to comprehensive health services. It is estimated that 30% of the Boise clinic patients are experiencing homelessness. One of the two clinics in Caldwell operates within a homeless shelter, and the two clinics in Nampa provide targeted services to the local homeless population. Terry Reilly also collaborates with seven shelters, including both homeless and domestic violence shelters, to provide on-site clinical services in these three communities. Services include primary care, diabetes education, pharmacy and laboratory services, psychiatry, counseling, and case management.

> *"The face of homelessness has changed. The number of homeless families is growing and their unique needs are very different than those of the typical homeless individual."*
>
> \- Bethany Gadzinski, Clinical Quality and Compliance Manager

Terry Reilly conducts a needs assessment every year to assess the quality of their services, monitor any changes or trends among their patient populations, and identify service gaps. The needs assessment is further used to maintain

[2] Idaho Housing and Finance Association. Homelessness in Idaho 2015 Point-in-Time Count Report. *Accessed on January 7, 2016.* http://www.idahohousing.com/Portals/0/Media/grant%20programs/2015%20State-of-Idaho-Point-in-Time-Count-061615.pdf

funding for the center and to fulfill a key HRSA requirement for health center program grantees.[3] The assessment consists of collecting and analyzing existing data, and in some instances may include soliciting information directly from patients.

METHODOLOGY

Terry Reilly's Clinical Quality and Compliance team leads the needs assessment process, which takes about six months to complete. Starting in October of each year, the Clinical Quality and Compliance Manager develops a list of key internal and external data sources that the team then researches for approximately three months. They begin by reviewing internal clinical data about their homeless patients in Southwest Idaho. This includes working with various staff, such as the Risk Manager, Data Analysts, and outreach workers, to collect both quantitative and qualitative data. Quantitative data is primarily culled from the Uniform Data Systems (UDS).[4] Qualitative data is collected from various sources, including outreach field reports, "tracer" reports (a program that shadows a patient through their entire clinic visit), and patient focus groups.

In addition to reviewing internal data, Terry Reilly collects external data through their community partners regarding the general homeless population of Idaho. One such partner is the City of Boise. Through funding from the U.S. Department of Housing and Urban Development (HUD), the City of Boise has developed a strong Continuum of Care (CoC) program[5] and works closely with many local service providers. The CoC program includes establishing a shared health information management system (HIMS) across local providers who receive HUD funding. For Terry Reilly, access to the HIMS has been indispensable for completing their needs assessment, as it provides vital external data on the needs of individuals and families experiencing homelessness beyond their patient population.

SHARING AND USING FINDINGS

Once the relevant internal and external sources are analyzed, the Clinical Quality and Compliance Manager synthesizes the data. The findings are released each April and presented to various stakeholders within and outside of the organization.

The Quality Improvement Committee of the Board of Directors is the primary audience within the health center. The Clinical Quality and Compliance team works closely with the Outreach and Development Director to summarize the needs assessment data and develop a comprehensive report and dashboard to present to the Board. Based on the findings highlighted in these reports, programmatic changes are often made. Most recently, the findings revealed high no-show rates among Terry Reilly's homeless patients. Focus groups with the patients revealed that having to return for additional services created a barrier to care. Terry Reilly redesigned their workflow so that when homeless patients now come to the clinic they are assigned a case manager, who ensures that they receive all necessary services on the same day of their appointment.

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[3] Health Resources and Services Administration (HRSA). Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act). *Accessed on January 14, 2016.* http://www.bphc.hrsa.gov/programrequirements/index.html

[4] HRSA. Uniform Data System (UDS) Resources. Each year, Health Center Program grantees and look-alikes report on their performance using the measures defined in the UDS. *Accessed on February 1, 2016.* http://www.bphc.hrsa.gov/datareporting/reporting/index.html

[5] US Department of Housing and Urban Development (HUD). Continuum of Care (CoC) Program. *Accessed on January 25, 2016.* https://www.hudexchange.info/programs/coc/

Through their annual needs assessment, Terry Reilly has been able to track and analyze the significant growth in the number of families experiencing homelessness in Southwest Idaho. Additionally, the assessment has provided valuable insights about health disparities among children of homeless families, such as lower rates of well-child immunizations and a greater need for behavioral health support due to the serious trauma associated with homelessness. The center now partners with local schools to identify homeless families, with the aim of becoming their primary care provider. They have also collaborated with schools to apply for funding to increase care for homeless families.

Terry Reilly has found that co-morbidity is extremely high for individuals experiencing homelessness. In response, Terry Reilly engaged behavioral health consultants to identify ways that providers could best support patients in their treatment and improve clinical efficiency. This resulted in the center recently hiring two new psychiatric Nurse Practitioners who assist with prescriptions.

Terry Reilly has used the assessment findings to build stronger ties within the community by gearing their services to meet both individual and family health and social needs. The needs assessment has also helped Terry Reilly to garner funding to expand their services. For example, the health center secured a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide intensive support to the chronically homeless, as well as a HRSA Behavioral Health Integration grant to provide in-house treatment to those with substance use disorders.

LESSONS LEARNED

Completing the needs assessment is not an easy task. Although Terry Reilly has access to a great deal of data, the data that is available varies significantly across sources. Health centers and other organizations often do not collect or store data on patients or community members experiencing homelessness. Therefore, achieving a comprehensive and accurate assessment requires that staff dedicate a significant amount of time to thoroughly reviewing each data source. For health centers interested in undertaking this kind of process, the Clinical Quality and Compliance Manager recommends a minimum of three months to collect and synthesize the data. She also stresses the importance of knowing your audience when presenting needs assessment findings. Identifying the most relevant data for your audience and presenting it in a meaningful way can help in acquiring new funding and gaining organizational support for programmatic changes.

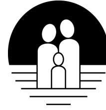
Terry Reilly recognizes the value in working collaboratively with community members and partners. These relationships have been especially important in gathering quality data. As part of the City of Boise's CoC program, service providers gather on a monthly basis to discuss the needs and differences observed in the homeless population. Terry Reilly is actively involved in these monthly convenings. They also participate in the annual Point-in-Time (PIT) count, a national count of sheltered and unsheltered homeless persons on a single given night in the U.S.[6] Terry Reilly uses their needs assessment to remain highly involved in contributing to the research and work to end homelessness in Idaho.

For more information about Terry Reilly, visit www.trhs.org. To learn more about Terry Reilly's needs assessment, contact Ms. Bethany Gadzinski, Clinical Quality and Compliance Manager, at bgadzinski@trhs.org.

[6] Housing and Urban Development (HUD). PIT and HIC Guides, Tools, and Webinars. *Accessed on January 7, 2016*. https://www.hudexchange.info/hdx/guides/pit-hic/.

Community Health Partnership of Illinois - Chicago, IL

Integrating Needs Assessment Questions into Outreach Encounters with Migratory and Seasonal Agricultural Workers



The patient populations of health centers are constantly changing. To maintain a current understanding of them, health centers need to collect information about their communities continually. Community Health Partnership of Illinois (CHP of IL), a Federally-Qualified Health Center (FQHC) based in Chicago, IL, regularly collects needs data from their patient population of migratory and seasonal agricultural workers. CHP of IL developed a tool referred to as the Outreach Health Risk Assessment (HRA), which is used to collect information on the health and social needs of their patients during outreach encounters.

BACKGROUND

For over 30 years, CHP of IL, a Migrant Health Center (MHC) program grantee, has been providing primary health care services to Latino migratory and seasonal agricultural workers. Through a network of contracted physicians and practitioners in northern and central Illinois, CHP of IL delivers various programs and services to a patient population of more than 7,000. Offered services include primary care, oral health, cancer prevention, reproductive health, occupational health and safety, HIV prevention, and health education. Community outreach is the centerpiece of their service delivery model.

CHP of IL looks beyond improving access to care and seeks to address other factors contributing to the health of their patients. During outreach, CHP of IL provides basic screenings, which typically include measurement of patient glucose and blood pressure, distribution of health education materials, and completion of the Outreach Health Risk Assessment (HRA). The HRA is the outreach encounter form used to document individual patient health status and assess their health and social needs. The information collected is also used to inform and improve services to meet overall patient needs.

The CHP outreach team & promotores meet for their Annual training. (Photo Courtesy of CHP of IL)

METHODOLOGY

The HRA was originally developed as a method to quickly gather a patient's health status during outreach. Over the years, the HRA has evolved to also collect information on health and social needs in order to provide a broader picture about the patient. During each encounter, outreach workers assess the patient's needs related to food, clothing, housing, health, and other social services. The HRA is designed with the language needs of CHP's patients in mind. Currently, it is available in both English and Spanish, as the majority of the workers that CHP serves are Spanish-speaking and born outside of the U.S.

The needs assessment question in the HRA asks the patient:

Do you have any problems or immediate needs? *¿Tiene Usted alguna inquietude o preocupación?*

If yes, please circle: *Si la respuesta es "si", por favor indique:*
Food/*Comida* Clothes/*Ropa,* Housing/*Vivienda,* Health/*Salud ,* Other social services/*Otro servicio social*

Once this information is collected, the outreach worker provides a summary of the patient's needs at the bottom of the form, checking off whether there is a need for health education, a medical/dental appointment, or social services. There is also space to provide further explanation about the identified needs. The patient receives a carbon copy of their HRA so that they can keep track of the outcomes of their visits. Each patient copy of the HRA has built-in referral guidelines, including reminders about the types of documents to bring to their clinic visit, such as a list of current prescription medicines, child immunization record cards, and income verification documents.

An outreach worker performs a health risk assessment with a community member. (Photo courtesy of CHP of IL)

SHARING AND USING FINDINGS

The needs data collected in the HRA helps CHP plan their outreach activities for the upcoming year. Specifically, it helps to determine the types of partnerships CHP needs in order to provide social service referrals, and the types of donations they need to solicit. CHP's outreach workers often bring donated

clothing, food, and hygiene kits with them during outreach to give directly to patients based on their responses to the HRA needs question. Outreach workers also refer patients and their families to other community-based organizations based on HRA responses.

Staff input HRA information into CHP of IL's Electronic Health Records (EHR) system in order to keep track of patients and monitor their progress. The EHR allows them to generate a report of the total number of patients seen during a certain date range, which is used to assess seasonal trends in the patients served.

It is easy to forget the sacrifices that are made by agricultural workers to produce the food that feeds this country. So, we are committed to improve the health and wellbeing of those that grow our food.

- Jason Pace, Farmworker Services Manager

LESSONS LEARNED

Trust is an important factor for successfully collecting health information. The HRA asks personal health and life questions, which some patients are not comfortable sharing. In the beginning, CHP found that people were unwilling to share information to complete the HRA. As CHP staff continued to return to the camps and work sites, they were able to gain the community's trust. Therefore, CHP invests time in building the trust of their patients by maintaining a constant presence and following through with their services.

Due to their long workdays, agricultural workers are often tired and have little free time to devote to health outreach encounters. CHP outreach workers are also limited in the time available to talk with each patient. The simplicity of the HRA form has proven an effective means for CHP to gather information from their patients in a concise and efficient way.

For CHP, finding the best way to meet the needs of migratory and seasonal agricultural workers has been both challenging and rewarding. CHP has identified an effective way to hear directly from their patients on a continual basis by including a needs question into their outreach encounter form. Although the health center is not always able to address all of the their patient's identified needs, the constant flow of information from their patients through the HRA helps to shape the types of services the center does provide, in addition to identifying persisting any gaps in services. Furthermore, this method of communication helps the center to maintain strong relationships with the community they serve.

For more information about CHP, visit www.chpofil.org. To learn more about CHP's needs assessment, contact Ms. Maria Hufnagel, Outreach Coordinator, at MHufnagel@chpofil.org or Mr. Jason Pace, Farmworker Services Manager, at jpace@chpofil.org.

Conclusion

A needs assessment is a dynamic process characterized by various roles, responsibilities, activities, and outcomes. Admittedly, it has its challenges even with the best of planning: it can be time-consuming, information may be challenging to collect, and changes may need to be made throughout the process. However, the needs assessment process is a comprehensive and meaningful way for health centers to gain insight into the needs of underserved communities, and also plays a critical role in supporting the delivery of effective health services. As the three profiled health centers demonstrate, hearing directly from the community is invaluable for developing truly responsive services and for giving communities – especially those who are most vulnerable and underserved – a voice to share what they most need to manage and maintain their health.

Lessons Learned

- Recognize that a needs assessment is a worthwhile investment, because it provides health centers a way to hear directly from their patients and community on an ongoing basis and to garner valuable data to ensure their services are appropriate and responsive.
- Allocate adequate time for a needs assessment, as it is an ongoing process, takes time, and requires resources.
- When reaching out to a new population, invest significant time upfront to build trust and rapport with the community, so as to reach a large number of participants and gather sufficient data.
- Be flexible and remain open to making changes along the way, as there will always be unforeseen circumstances and issues that arise, even with the best of planning.
- Make your data collection tool simple, when collecting data directly from the community. Keep in mind that your patients and community members may have limited time and varying reading levels.
- Collect relevant data that will answer the needs assessment questions, by clearly defining what you want to know and asking the right questions. It is common to want to ask as many questions as possible, but data overload may make it difficult to differentiate between what is important and what is interesting.
- Create a strong communication structure where all those involved have a clear understanding of the process and their respective roles and responsibilities. Also, continually update the team on the progress of activities throughout the process.
- Know your audience when presenting needs assessment findings. Identifying the most relevant data and presenting it in a meaningful way can help in acquiring new funding and gaining organizational support for programmatic changes.

ABOUT HEALTH OUTREACH PARTNERS

Who we are

Health Outreach Partners (HOP) is a national organization providing training and technical assistance (T/TA) and key resources to community-based organizations striving to improve the quality of life of low-income, vulnerable, and underserved populations. HOP has over 45 years of experience in the field of outreach, and offers support to organizations interested in exploring a more customized application of these ideas.

Why outreach

Outreach plays a critical role in facilitating access to primary care, case management, health promotion, disease prevention, and social services for underserved communities. HOP's mission is to build strong, effective, and sustainable grassroots health models with a particular focus on health outreach programs.

Contact us to see how we can help build your organization's capacity in serving low-income, vulnerable, and underserved populations. Learn more at our website: http://outreach-partners.org/.

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