Building Community Capacity

This section provides an overview of the necessary partners, needs assessment process, and establishing goals for community change. This section offers partner suggestions, data sources for assessment, and prioritizing community needs. There are seven steps outlined:

- Step One: Identifying Stakeholders
- Step Two: Establishing a Plan
- Step Three: Determining Population Impact
- Step Four: Review & Assess the Data
- Step Five: Setting Priorities
- Step Six: Implement Action Plans
- Step Seven: Evaluation

TN Department of Health

DEMENTIA FRIENDLY COMMUNITIES TENNESSEE

Building Community Capacity

Assessing Needs & Establishing Partnerships

Communities addressing the needs of those living with Alzheimer's or another dementia and their caregivers may be at varying stages of development. Some may be in the exploration phase, but others may have established partnerships or local coalitions that raise awareness and provide direct support. The action steps below provide communities with a step by step guide to help assess needs, establish partnerships, determine priorities, set goals, and implement actions to achieve established goals.

1 STEP ONE: IDENTIFYING STAKEHOLDERS

The first step to conducting a needs assessment is determining internal and external stakeholders that may have a vested interest in dementia or related issues. Stakeholders may be individuals working on "traditional" health related issues such as elder abuse, falls prevention, disabilities, vaccinations, medication safety, and chronic disease prevention and treatment. Additional stakeholders may include agencies such as home health agencies, hospital partners such as emergency department staff, local elected officials, managed care organizations, economic and community development, academic institutions, health departments, federally qualified health centers, not for profit organizations, and long term care agencies. Some Tennessee specific organizations to engage include, but are not limited to, the following:

- Alzheimer's Tennessee
- Alzheimer's Association
- Tennessee Long Term Care Ombudsman
- Tennessee Area Agencies on Aging and Disability (AAAD)
- United Way affiliates
- Local caregiver support groups
- Faith organizations
- TennCare

There are several resources that assist in identifying appropriate community stakeholders and their potential contribution and/or benefit from participating in the overall needs assessment and implementation process.

QUICK TIP

- Engage populations that are at a higher risk for developing Alzheimer's disease or other dementias;
- Strive to include diverse, marginalized, and underserved communities;
- Avoid "group think" by identifying those that approach problems differently;
- Involve groups that bring different strengths to the table;
- Think of community members that would care about ensuring a healthy community.

Building Community Capacity
Assessing Needs & Establishing Partnerships

Links to the various tools are provided below and an example of one of the stakeholder analysis tool. Along with the stakeholder analysis tools, sample agendas and draft emails have also been provided for community use. Communities are encouraged to modify these materials to make them more appropriate for their local culture. Stakeholder assessment tools:

- Centers for Disease Control and Prevention
- Alzheimer's Association
- University of Kansas: Center for Community Health and Development
- Agency for Healthcare Research and Quality

Who are the key stakeholders we need to:			
Increase credibility of our efforts	**Implement the interventions that are central to this effort**	**Advocate for changes to institutionalize this effort**	**Fund/authorize continuation or expansion of this effort**
Physician associations Community associations	State and local health departments Housing authorities	Advocacy groups Maternal and child health groups Physician associations Community associations	Legislators and policymakers at Federal and state levels CDC Private industry Court system

Retrieved from https://www.cdc.gov/eval/guide/step1/index.htm

2 STEP TWO: ESTABLISHING A PLAN

Once appropriate partnerships have been developed, the group must develop a strategy to help define specific goals and objectives for the community assessment. If a lead organization does not exist, a key organization or individual must be identified to serve as the group leader to coordinate all needs assessment efforts and ensure established goals are accomplished. The lead organization is responsible for overseeing the financial needs (as appropriate), determining meeting frequency, setting agendas, and motivating team members to participate and act on priority issues. The strategy development phase includes the following components:

- Determine the core needs assessment team ensuring diversity among team members and various perspectives;
- Establishing a time line for accomplishing the overall needs assessment;
- Establish which team members will be responsible for specfic tasks;
- Determine what data will be utilized for the needs assessment and how to access the needed data;
- Choose a method for conducting the assessment (Click here to view various models).

3 STEP THREE: DETERMINING POPULATION IMPACT. .

There are multiple variables that must be considered when assessing the impact of Alzheimer's and other dementias on the local community and community members. The table below provides a list of variables that communities might consider.

Category	Description
Prevelance and Disparities	Number of persons and percentage of population with Alzheimer's and other dementias, by key demographic indicators (as available), such as age, gender, race, ethnicity, marital status, sexual orientation, income, educational attainment, home ownership, employment status, disability status
Mortality	Number of deaths due to Alzheimer's and other dementias, by key demographic indicators (as available)
Caregiving	• Number of family (unpaid) caregivers • Hours of care provided • Economic value of unpaid care • Impact of caregiving on caregivers • Unmet needs, such as for information, psychosocial support, respite
Modifiable Risk Factors	• Number of persons and percentage of population who smoke, have diabetes, are obese, have hypertension, are physically inactive, or eat an unhealthy diet • Health status of caregivers
Cost	• Use and costs of health care, long-term care, and hospice care for people with Alzheimer's and other dementias • Use and costs of community services, such as transportation, meal delivery, home health care, and case management • Financial impact of Alzheimer's and other dementias on families, including annual costs and effect on family income
Assets and Resources	Assets and resources that can be mobilized and employed to address needs and issues related to Alzheimer's and other dementias (e.g., public health groups, support groups, area agencies on aging, volunteer networks, clinical services, hospitals, adult day care services, home care services, community resources)

Adapted from Alzheimer's Association Needs Assessment Toolkit
https://www.alz.org/media/Documents/spotlight-needs-assessment.pdf

Building Community Capacity
Assessing Needs & Establishing Partnerships

ACCESSING RELEVANT DATA

Data collection for a needs assessment is a critical step in performing a needs assessment. Utilizing data, both qualitative and quantitative, can assist communities in presenting areas of greatest need, confirming or refuting assumptions, and allow communities to set priorities based on areas of greatest need. There are a variety of publically available data sources that can be utilize for a needs assessment related to Alzheimer's disease and other dementias related chronic conditions. Additional data sources may come from large employers, law enforcement agencies, community colleges/local universities, religious organizations, civic organizations, and local chambers of commerce. Obtaining data from a variety of sources offers local communities an understanding of where those living with cognitive decline and their caregivers may be impacted.

QUANTITATIVE DATA

Quantitative data helps communities use numbers, counts, rates, etc. to help define the scope of an issue in a community. The table lists indicators commonly assessed related to Alzheimer's and other dementias and where these data can be accessed. The team leading the needs assessment should determine the types of data they feel is relevant to their specific community.

Alzheimer's Prevalence	CMS Fee for Service Data
Traumatic Brain Injury	Traumatic Brain Injury Report
Smoking	County Health Rankings Behavioral Risk Surveillance System
Hypertension	Interactive Atlas of Heart Disease and Stroke
Diabetes	United States Diabetes Surveillance System
Obesity	County Health Rankings BRFSS
Drug Overdose	Tennessee Department of Health : Informatics and Analytics
County Demographics (age, race, gender, educational attainment, poverty level, insurance status)	United States Census US Bureau of Economic Analysis
Heart Disease Death Rate Alzheimer's Death Rate	Death Statistics: VRS
Caregiver	BRFSS

Building Community Capacity
Assessing Needs & Establishing Partnerships

COMMUNITY RESOURCE MAPPING

Before determining what resources are needed, it is crucial that existing resources are identified that can help meet the needs of those living with Alzheimer's or other dementias and their caregivers. Communities can focus on those resources available at the city, county, regional, or state level. These resources may include businesses, organizations, facilities, funding, policies, services, regulation, and initiatives. Identifying resources in the community helps determine gaps in knowledge and services, and allows communities to capitalize on existing infrastructure and develop action plans to address needs. Reviewing resources should be completed on a regular basis and should be a constant component of a community. Developing a series of questions to help determine current understanding of the existing services, perceived barriers, and needs to change culture and systems. The following provides a few examples of entities to contact, but there may be more in your local community that can be included in the assessment process.

There are several tools that have been developed that can be utilized or slightly modifided to assess the resources available in a community related to Alzheimer's or other dementias.

Organizations Providing Direct Services for those with Alzheimer's or other Dementias and their Caregivers: Alzheimer's Association, Alzheimer's Tennessee, Support Groups, Tennessee area Agencies on Aging, Area Councils on Aging, respite services, homes for the aged, home health agencies, palliative care, home and community-based services, respite, and assisted living facilities
Healthcare Providers: Primary care providers, occupational therapist, physical therapist, Dentists, Podiatrist, Optometrist, Pharmacists, Geriatricians, nurses, nurse aides, etc.
First Responders: EMT, police officers, fire fighters.
Faith Organizations: Churches, mosque, temples, synagogues, etc.
Community Supports and Services: Legal services, homeless shelters, and fitness centers.

QUICK TIP

Check out other communities of success! Minnesota has shown great success in implementing Dementia Friendly Practices across their state! Visit their website here: https://www.actonalz.org/dementia-friendly-toolkit

TN Department of Health
DEMENTIA FRIENDLY COMMUNITIES TENNESSEE

QUALITATIVE DATA

There are a variety of qualitative collection methods that may be utilized to assess the needs of a community and strengthen the quality and reliability of the needs assessment. This data can sometimes support and align with the quantitative data that is gathered or might refute the quantitative data, leading to a more in depth assessment of the data and understanding of why they may differ. The table below offers several examples of quantitative data collection methods and their definition. The advantages, disadvantages, and useful tips when utilizing each collection method can be found by accessing the North Carolina Department of health Community Assessment Guide Book.

Collection Method	Definition
Individual Interviews	A conversation between two people for specific purposes. These can be conducted face-to-face or via telephone.
Focus Groups	Involves gather information from a group of people, usually around 8 to 10 individuals. Often provides a more insightful conversation.
Observation	Allows the team to visualize situations and events and gather clues that inform conclusions about specific topics.
Postal Survey	Mailing questionnaires that individuals self-complete. These types of survey usually target a certain group or population. (example: zip code)
Telephone Survey	Survey conducted via telephone that asks a series of standardized questions to elicit responses.
Face-to-face survey	Interviewer meets with an individual at a specific location and conducts a personal interview.
Web-based survey	A set of standardized questions are developed on a web-based software and are sent to a group of potential respondents.

Adapted from North Carolina Division of Public Health Community Health Assessment Guide Book
https://publichealth.nc.gov/lhd/docs/cha/Archived-CHA-Guidebook.pdf

4 STEP FOUR: REVIEW & ASSESS THE DATA

Depending on the types of data gathered, there are a variety of assessment methods that can be employed once data has been collected. During the data gathering process, the needs assessment team should have an idea of how the data will be analyzed and who will be analyzing the data. During this step of the needs assessment it is important to consider what the results mean, if the data gathered is reliable, and the implications of the results. Key information should be pulled out of from the efforts. A variety of data collection and analysis tools can be found on the Centers for Disease Control and Prevention (CDC) website or on the Act on Alzheimer's website. Many of these tools have templates that can be utilized or modified to meet the needs of your specific community.

When assessing the data, the needs assessment group should ask themselves the following questions to help interpret the data and to begin thinking about the needs in the respective community.

- ☐ What limitations exist related to the data? Was the data gathered relevant to the assessment?
- ☐ Were there common themes that emerged in the results? Were these themes the same among all demographic populations? What differences exists among the populations?
- ☐ Are there findings that are surprising? How can these results be explained?
- ☐ Are the findings significant and meaningful in a practical way?
- ☐ Are there additional data that needs to be collected prior to developing action plans?
- ☐ Were there recommendations to better serve the population being assessed?

Once a community has appropriately organized and assessed the data, a member of the assessment team should summarize the data in an easy to use format to help set priorities and develop an action plan.

5 STEP FIVE: SETTING PRIORITIES

At this stage in the needs assessment, the team should have an understanding of the resources available in the community, gaps in service, and the burden of Alzheimer's disease on the community and among any subpopulations. There will often be a variety of needs identified when completing a needs assessment, so the team will need to prioritize based on the size of the problem, the threat to community, availability of evidence based or evidence informed interventions, potential impact on economic or social factors, the public health concern, and availability of resources at the local, state, or federal level and how these resources serve their specific needs. Both the CDC and the National Association of County and City Health Officials (NACCHO) offer more details regarding prioritizing needs during an assessment.

Once priorities have been established, the team should then develop a plan to address the needs, keeping in mind the communities strengths and weaknesses. Again, there may be multiple goals that can be implemented, but it is important that each community focuses on strategies that are achievable. Consider ranking each strategy to determine the strategies that are most feasible given any restraints that might exist. One example of prioritizing strategies is shown in the table below.

Priority Actions	Time Commitment	Resources	Competing Priorities	Total	Rank
Increase public awareness and reduce stigma.	4	4	3	11	**3**
Work with local officials to establish day programs for adults.	5	3	4	12	**2**
Increase referrals to community resources.	2	4	4	10	**4**
Work with businesses to establish support groups.	3	5	5	13	**1**
Work with providers on early detection and diagnosis.	2	3	2	7	**5**

Adapted from CDC Community Needs Assessment: Participant Workbook: https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf

Building Community Capacity

Assessing Needs and Establishing Partnerships

6 STEP SIX: IMPLEMENT ACTION PLANS

With each priority the team must develop a corresponding action plan that outlines a plan to ensure the implementation of each priority and determine how success will be measured. With each action, the team should assign an individual responsible for the implementation of the action, estimated time frame for completion., and resources needed to achieve the action step. Resources may be in the form of supplies, funding, or staff. If funding is needed, it may be necessary to establish a budget or a plan for accessing funding in the form of grants or another source. Teams should take into consideration organizations that may be actively providing a service to individuals in the community such as the Alzheimer's Association or Alzheimer's Tennessee and consider how these services can be leveraged and built upon so that work is not being duplicated and the appropriate team member is assigned to the appropriate action step. An example strategy and corresponding action plans is provided below. Be sure that each goal is SMART (Specific, Measureable, Attainable, Relevant, Time-bound), so that there is a clear expected completion date for each strategy and it is clear when each strategy and goal is expected to be accomplished.

Overarching goal: By the end pf 2019, increase the number of cognitive screenings being performed by Primary Care Providers associated with XYZ health system at annual Medicare visits among Medicare benefitiaries by 5%.

Measurement of Success: Utilize Medicare billing codes provided by the health system to compare the number of cognitive screenings before and after the intervention.

Action Steps	Assigned Individual	Target Date	Required Resources
Contact the chief medical officer at XYZ health system to determine several dates for primary care providers lunch and learns or inservices. Once determined, develop a registration portal and sign in sheets for each training.	Jane Doe	Months 1-4	• Registration software; • Contact information; • Staff time.
Develop the power points for the training and informational packets for providers with billing codes included.	John Doe	Months 4-8	• Folders; • Printing materials; • PowerPoint software; • Staff Time.

Building Community Capacity
Assessing Needs and Establishing Partnerships

SHARE EFFORTS WITH COMMUNITY

Once an action plan has been developed the team should consider how the plan should be disseminated to community partners and the public at large . The team may want to develop an official report or plan to share with partners and post on a website for reference. Other forms of communication may include newsletters, email blasts, news releases, local television broadcasts, and newspaper ads. As progress is made in achieving goals, the team should consider sending updates to communicate the progress. When determining the best methods of communication, key communication points should be determined so that messaging is consistent and reaches appropriate target audiences.

IMPLEMENTATION

As you are rolling out your plan continue to hold team meetings, quarterly at minimum, to ensure goals are being met and activities are on track. It may be necessary to provide additional support to one or more team members or adjust timeliness due to resource restraints. To track progress, ask each team member to enter their updates on a shared file or submit the progress prior to the meetings. Constant communication during the implementation phase is critical in ensuring successful implementation. It might be necessary to recruit additional volunteers to accomplish certain tasks.

7 STEP SEVEN: EVALUATION

EVALUATION

Evaluating our efforts is one of the most important parts of any community program or intervention. When developing strategies and action plans teams should determine how they know they were successful in accomplishing these strategies. As action plans are being implemented they should be continually assessed to ensure the desired results are being produced. If the desired results are not being accomplished, the action steps and strategy should be assessed and the team should either modify the existing plan or develop a new plan to accomplish the overall goal. Evaluation should be a constant process, not just occur at the end of the implementation phase. As established strategies for improvement are accomplished, share the success with community partners and other communities striving to improve their services!

References & Resources

1. **Alzheimer's Association Needs Assessment Toolkit, September 2016**: https://www.alz.org/media/Documents/spotlight-needs-assessment.pdf
2. **Centers for Disease Control and Prevention (CDC) Community Needs Assessment: Participant Workbook**: https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf
3. **Centers for Disease Control and Prevention (CDC) Building a Foundation of Knowledge to Prioritize Community Needs: An Action Guide**: https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf
4. **Centers for Disease Control and Prevention (CDC) Community Health Assessments & Health Improvement Plans**: https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf
5. **Centers for Disease Control and Prevention (CDC) Program Evaluation for Public Health Programs: A Self-Study Guide**: https://www.cdc.gov/eval/guide/index.htm
6. **National Association of County Health Officials (NACCHO) Community Health Assessment and Improvement Planning**: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment
7. **North Carolina Division of Public Health Community Health Assessment Guide Book**: https://publichealth.nc.gov/lhd/docs/cha/Archived-CHA-Guidebook.pdf
8. **University of Kansas Community Tool Box**: https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/vmosa/main