Quality Improvement & Innovation Partnership

Advancing Improvement in Primary Healthcare in Ontario

NEEDS ASSESSMENT RESOURCE GUIDE

January 2009

Amended December 2010

Ontario

ACKNOWLEDGEMENTS

The Needs Assessment Resource Guide for Family Health Teams is the result of the efforts of the Quality Improvement and Innovation Partnership's (QIIP) Evaluation, Needs Assessment and Performance Measures Working Group. The work of Lynne Lawrie, who compiled the resource guide on behalf of the working group, is gratefully acknowledged.

Evaluation, Needs Assessment and Performance Measures Working Group Members

Mike Green – Chair
Sten Ardal
Paula Brauer
Bill Casey
Linda Hilts
Brian Hutchison
Sherry Kennedy
Barbara Roston
David Wallik
Christel Woodward

For additional information about other resources contact:

Quality Improvement & Innovation Partnership
10 George Street, Suite 205
Hamilton, Ontario, Canada
L8P 1C8
Phone: 905-667-0770
Fax: 905-667-0771
info@qiip.ca
www.qiip.ca

QIIP is funded by the Ontario Ministry of Health and Long Term Care. The opinions expressed in this publication are those of the authors and do not reflect the official views of the Ontario Ministry of Health and Long Term Care.

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INTRODUCTION

This resource guide provides an overview of health needs assessment, with a focus on needs assessment approaches and processes relevant to the Family Health Team (FHT) practice reality. It is meant to complement other resources on needs assessment.

The resource guide is a product of the Quality Improvement and Innovation Partnership and its Working Group on Evaluation, Measurement and Needs Assessment.

BACKGROUND

The Quality Improvement and Innovation Partnership recognizes that FHTs across Ontario are in high activity mode, working to roster patients, hire health professionals for their teams, and design programs that will have a positive impact on their practice in terms of patient outcomes and practice efficiency. Information on needs is an important element underlying the above activities. The time and resources to acquire the information can be a challenge.

Many FHTs have undertaken processes to assist them in establishing some initial priorities. Some groups did this as part of the startup planning and initial development phases. FHTs have sought to identify needs as part of patient rostering and through patient surveying, organizational strategic planning sessions, and community consultations. All these types of efforts have assisted FHTs to move ahead with planning services and targeting some initial service delivery priorities.

This resource guide acknowledges the previous needs assessment processes, and reflects some of the approaches and lessons learned from those who have implemented needs assessment activities. Some specific information from three different sites is found in Appendix A. The contents of this resource guide will support future needs assessment activities of FHTs, and other primary care practices through a menu of approaches to needs assessment, from which to select based on their own particular group, community and capacity.

HEALTH NEEDS ASSESSMENT: Concepts and Definitions

"Any health needs assessment must establish a process to ensure the assessment is conducted within available time and resources."[1]

Levels of Needs Assessments

Needs assessments are commonly used at all levels of health care and, most often, related to goal setting.

At the international level, the World Health Organization is the most well known group to undertake this type of work. In Canada there have been extensive exercises related to understanding needs

[1] Assessing Needs Module, Health Planner's Tool Kit, Health System Intelligence Project, Ministry of Health and Long Term Care, Government of Ontario

and determining national health strategies. Ontario has recently undertaken consultations to set health goals for the province

The Local Health Integration Networks (LHINs) are charged with looking at the needs of their area, and implementing health systems that respond to those needs. Thus significant information around needs exist at the LHIN level. Accessing LHIN level reports is a relatively easy exercise by clicking on to the Ministry of Health and Long Term Care Web site, determining the LHIN to be searched, and moving into that LHIN's web site.

The two types of needs assessments more fully examined in this module are organizational and population specific. Organizations such as FHTs may conduct needs assessments for their geographic catchment area or for specific populations such as children, seniors, persons with mental health issues, etc.

"A single piece of needs assessment work may be worthwhile in the context of a larger organizational needs assessment or when a service is relatively prominent in an area of particular need. For example, in a disadvantaged area where mental health and addiction services already make up much of the total service array, a separate and distinct mental health /addictions needs assessment may be warranted in order to tailor the services most appropriately". [2]

Individual client level needs assessments are conducted daily in provider/patient consultations. Needs assessment at this level is beyond the scope of the current guide. Different needs assessments done in differing contexts highlight the need to define the scope of "needs assessment".

Definitions of Needs Assessment

It is helpful to adapt a consistent definition of what is a health needs assessment. The following definitions speak to common elements of needs assessments, namely going through a dedicated process to understand needs of people being served and setting in place actions to address those needs.

Definition 1

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequities. [3]

Definition 2

A community health needs assessment is a dynamic ongoing process undertaken to identify the strengths and needs of the community, enable the community wide establishment of priorities and facilitate collaborative action planning directed at improving community health status and quality of life.[4]

[2] Assessing Needs Module, Health Planner's Tool Kit, Health System Intelligence Project, Ministry of Health and Long Term Care, Government of Ontario
[3] National Institute for Clinical Evidence, UK
[4] Manitoba Community Health Needs Assessment

Definition 3
Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way.[5]

Based on the above, a definition specific to primary care groups and Family Health Teams in particular, may be as follows: Needs assessments done by Family Health Teams are a deliberate activity undertaken to describe the needs of current and potential patients within the practice.

One would then further stipulate that: The needs assessment information is used to identify opportunities to improve the health of patients and/or community based on the needs that are judged to be most urgent and most amenable to primary care, team-based intervention.

THE CASE FOR NEEDS ASSESSMENTS

Good Business Practice

In any business it is important to understand the needs of your clients. Needs assessments are routinely conducted in many sectors including health, education, and community services. Needs are also assessed within the private sector, but in that case they are more commonly considered market research around consumer wants and preferences. There is a significant difference between the purpose of these activities for the private and public sector. The private sector is often engaged in promoting or creating demand for particular products, whereas in the public sector, providers of services struggle to meet growing and diverse needs, demands and expectations.

Needs assessments undertaken by providers of health services can help them identify what is 'real need' based on the definitions or criteria that they select. Underlying needs assessment is the assumption that there are some specific common needs among a group of patients that can, and should, be proactively addressed by primary care practices. The key word here is proactive, as the opposite approach to needs assessments is to simply react to the patients as they flow into the practice, without examining the commonalities of needs and strategies available to efficiently and effectively respond to those needs.

> *"Measurements for specific morbidity in the population may be the best approach to identifying need for medical care, since these gauge directly the state of ill health for which people seek help…Prevalence data is of greater interest to people who are trying to predict demand for service."*
>
> Assessing Needs Module
> Health Planner's Took Kit, MOHLTC

Preparing for the Future

While primary care practitioners commonly use clinical guidelines and tools to assess the needs of patients, doing needs assessments for entire practice populations, or the community that feeds that practice population, is a larger and somewhat different process. The patient who comes through the door today and the patients demanding the most attention this week, may not necessarily represent the long term, embedded health needs or health improvement opportunities, within the

[5] Health Needs Assessment: Development and Importance of Health Needs Assessment, Wright, J. BMJ 1998

practice community. For all FHTs, but especially those in areas undergoing changes – such as population growth, growth in numbers of immigrants, increase or decrease of community service capacity – it is essential to understand and plan for the practice roster profile of three to five years down the road.

Maximizing the New Delivery Models for Improved Efficiency and Patient Outcomes

With the advent of Family Health Teams, we have moved to formalized groups of primary care providers, wherein physicians deliver care in concert with other health professionals such as nurses, nurse practitioners, dietitians, patient educators, pharmacists, and social workers. The strength of the FHT model will be realized through the implementation of evidence-based, proactive, collaborative patient care programs within the practices. These programs should be designed after the FHTs have gone through a priority setting exercise, founded on an understanding of the practice community needs and opportunities available from the team of health professionals available to respond to those needs.

THE PURPOSE OF A NEEDS ASSESSMENT

Every FHT will have to decide on the purpose for undertaking a needs assessment activity, and will need to invest resources to address the findings. The first task of needs assessment is to define the question to be answered.

For example the question could be broad as:
"What are the current and emerging primary care needs of our community?"

Or disease specific:
"What are the three most important needs of our practice population from a chronic disease perspective?"

Or very targeted:
"What two new initiatives will we undertake in our practice this year?

The question is extremely important, as it will define the scope of the activity, the information to be used and the partners to be engaged.

The Needs Assessment Check List

Having defined the purpose for undertaking a needs assessment, there are then a series of activities key to any needs assessment process. Within those activities or steps, the amount of time and resource dedicated to each can be determined by each organization. There is no magic formula to define 'what is enough information' or 'how much consultation is required'. To develop a process that will be useful for FHT planning, the process should seek to provide insights in the four areas noted below:

- practice assumptions around patient group needs are validated, clarified, or amended (e.g. lack of community mental health service options)

- information is obtained that was not previously known or accepted as fact by all members of the practice (e.g. number of frail seniors within the practice)
- information is obtained that has relevance for different members/professions within the practice (numbers of patients with risk factors for diabetes, heart disease, etc.)
- information becomes compelling and drives consensus within the practice (e.g. need for care coordination for patients with chronic illnesses)

To warrant the investment of time and resources, a needs assessment activity has to be linked to a process for identifying priorities and for taking action. That in itself implies that resources need to be balanced between a process to understand needs with action to address those needs.

A sample checklist which includes potential leads for each activity, and estimated time frame is attached as Appendix B.

Table 1 – Needs Assessment Check List

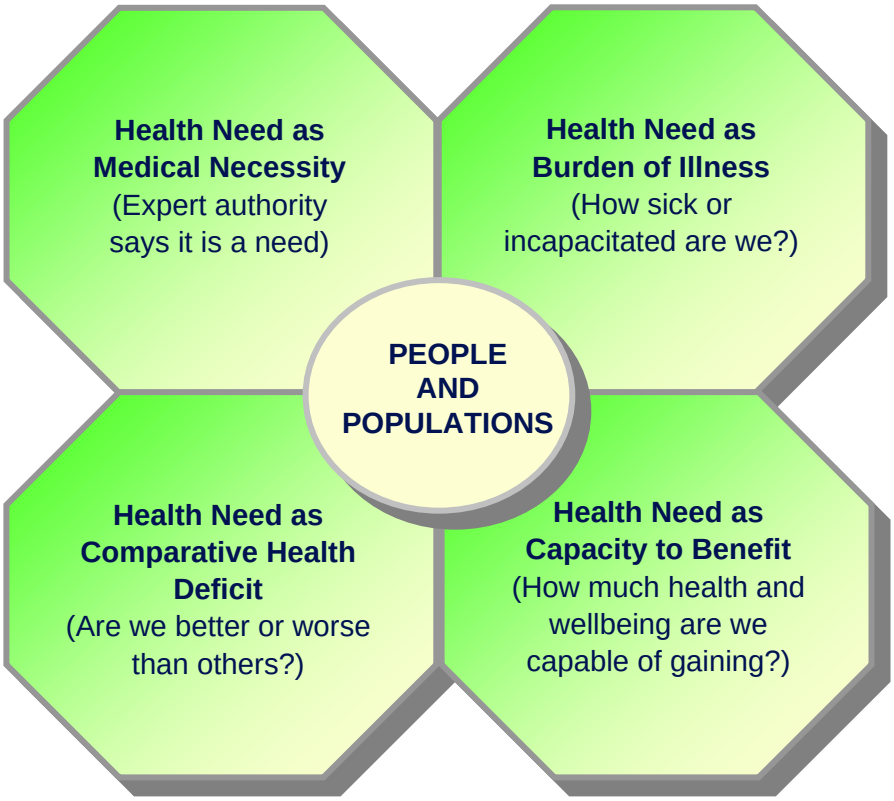
STEP 1	**Scope the needs assessment project (what question to be answered)**	• Define the population to be studied • Define the goals for the needs assessment (e.g. program design, implementation, recruitment, retention, etc) • Define the resources available to support the needs assessment (e.g. data from public health, Local Health Integration Networks, hospitals, CCACs, etc)
STEP 2	**Define the players, partners and information sources for the exercise**	• Identify project scope, potential participants • Access and review existing reports and data (e.g. hospitalizations for chronic illnesses, population demographics, risk factors, community health status reports, etc.) • Gather and synthesize qualitative input (e.g. practitioner perspectives, patient perspectives, community agency partner perspectives etc.)
STEP 3	**Identify needs**	• List needs based on information from step 2 - grouping where possible in to broad categories – e.g. social experience (age, ethnicity), disease, risk factors or other categories determined by the FHT
STEP 4	**Identify opportunities to address needs**	• Identify strategies/evidence based interventions to address needs • Identify FHT team competencies, current and anticipated • Identify potential programs, interventions, approaches to improve performance and health outcomes in priority areas.
STEP 5	**Set priorities for action**	• Apply criteria specific to FHT such as existing expertise, available funding, and partnerships with other providers, ability to achieve quick wins. • Confirm approach with key stakeholders (e.g. focus group of patients and community partners)

STEP 6	**Implement and study the impact**	• Utilize FHT range of health professionals to design programs, establish indicators for success, and reporting • Implement new approaches • Following a quality improvement tool, such as the Plan, Do, Study, Act approach, establish timetables for review and adjustment if necessary of programs, interventions, approaches • Use results for other program planning.

UNDERSTANDING 'HEALTH NEEDS'

Four different concepts of health needs are illustrated in Figure 1.

Figure 1 – Definitions of Health Needs



Source: The Health Planner's Toolkit, MOHLTC Health System Intelligence Project – 2006

All four of these concepts are relevant for those planning primary care services.

Medical necessity is well understood and sanctioned through government mandated payments (e.g. OHIP billing codes).

Given the lack of an absolute definition, health need expressed as comparative health deficit provides a way to look at health needs across different populations, perhaps geographically defined.

An example of applying this concept is to look at sub populations such as aboriginal groups within larger communities, comparing health status measurements.

The definition of need widely favoured by health economists is 'the ability of people to benefit from health care provision'. In other words 'need' only exists if there is some capacity to benefit from a particular health care intervention. Under this approach, interventions would be supported when there is good evidence that they produce benefits such as health enhancement, disease prevention or the postponement of death. In a primary care context, this approach promotes discussions around choices. For example patients who are seniors within a given practice may benefit both socially and medically from a strongly promoted falls prevention program. Time spent setting up this program with other team members and/or other community partners may be more useful than additional one to one physician/patient office appointments. While attractive, there is often less information on capacity to benefit, compared to the other three definitions of health need.

Lastly the burden of disease may be the area with most potential for FHTs doing needs assessments. It speaks to why people may seek primary care, and how often. It also aligns well with the government's initiatives on Chronic Disease Prevention and Management, and recognizes that proactive interventions at the primary care level may significantly improve patient health outcomes over the short and long term.

EXAMINING HEALTH NEEDS BASED ON BURDEN OF DISEASE

According to the MOHLTC Needs Assessment Module, "…conventional health needs assessment defines need according to the general burden of disease in the population."

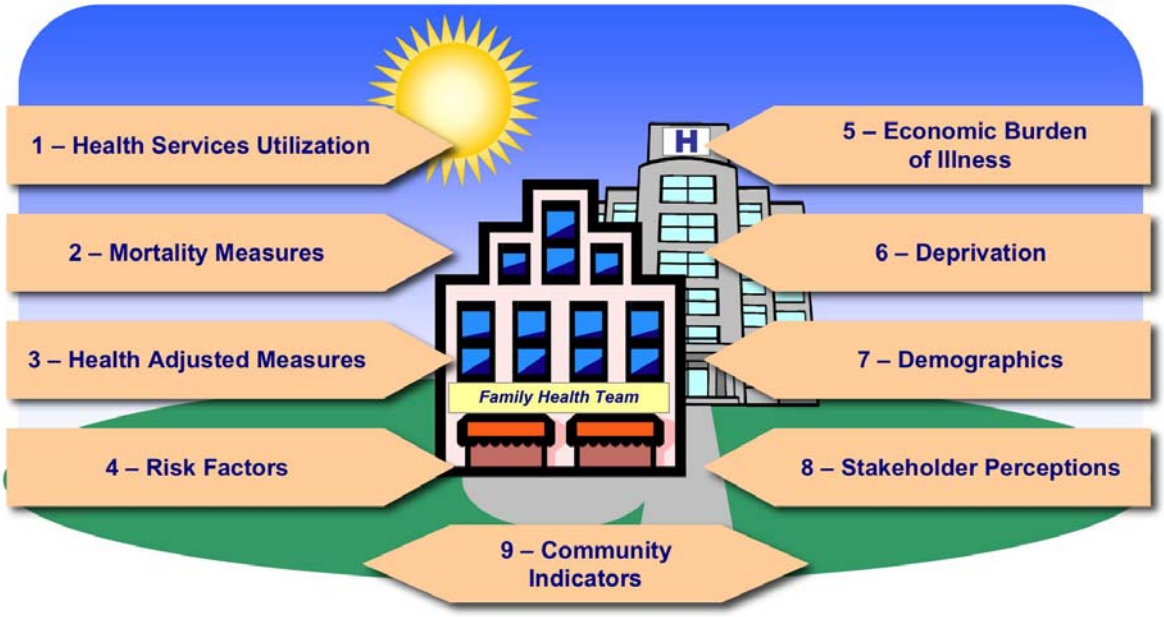
Prevalence and incidence (see Appendix C – Glossary of Terms) of disease are measures of disease frequently used in needs assessment as indicators of disease burden. Prevalence measures are important for planning curative and rehabilitative services, while incidence-based measures are more useful for planning preventive programming.

> *"Even in conventional needs assessments, however, choices must be made among indicators – choices which have implications for how health need is identified and described."*
>
> Assessing Needs Module
> Health Planner's Took Kit, MOHLTC

Burden of disease refers to measures that include both quantitative and qualitative information. The concept incorporates both personal health experience and disease frequency.

There are at least nine indicators that can be applied to understand the health needs from a burden of disease perspective. They are illustrated in Figure 2.

Figure 2 – Nine Categories of Indicators



Each of these types of indicators are examined very briefly with a view to where the information may be found and how the information may help with needs assessment at the primary care level.

Information is primarily collected and made available at the federal, provincial and Local Health Integration Network levels of geography. LHINs use data supplied by the Ministry of Health and Long Term Care and other sources to develop profiles of their area overall, as well as some sub-areas within the LIHN boundaries. LHINs will be a useful source to FHTs for planning. The Ministry's Health System Intelligence Project created a number of excellent resources and is a useful starting point for any group initiating a needs assessment process. Reports are available through the Health Analytics Branch at the ministry, with most accessible online at: http://www.health.gov.on.ca/transformation/providers/information/im_resources.html.

Public Health units are also a key source for information. Not only do they have information related to the health status of the community, they often have additional reports specific to their catchment area. For example, Toronto Public Health has done considerable work on tuberculosis; some northern units have done considerable work on aboriginal health.

Table 2 – Indicator Source Information and Application

Indicator	Source(s)	Relevance (for primary care planning)	Ranking (for primary care planning)
Health Services Utilization • Hospital admissions • Avoidable hospitalizations • ER usage • ACSC (Ambulatory Care Sensitive Conditions) • Hospital Length of Stay • Wait lists	• CIHI • MOHLTC • LHINs • CCACs • Providers (e.g. hospitals)	• Hospital/ER usage – speaks to primary care/after hours need • May indicate access issues for health services by area	High
Mortality Measures, e.g. • deaths related to specific causes such as breast cancer, CHF, asthma, heart disease, etc.	• Statistics Canada • MOHLTC • LHINs	• Indicate overall health of a population	Medium to High
Health Measures • Morbidity • Disability • Self assessed health	• MOHLTC • LHINs • CIHI • Statistics Canada (Health Surveys - CCHS)	• Indicate reasons why persons seek primary care/or be hospitalized	High
Risk Factors • Health behaviours such as smoking, heavy drinking, diet and physical activity	• Statistics Canada (CCHS) • LHINs • Obesity, smoking alcohol, Physical activity	• Indirect health predictor – morbidity, etc	High to Medium (unless available by patient)
Economic Burden	• Health Canada	• Influence on gov't policy, employee assistance programs	Low
Deprivation • Low income/poverty • Food insecurity	• Public Health • Statistics Canada (Census, CCHS)	• Predictor of health status	High
Demographics • Population growth • Population structure • Population distribution (i.e., rural/urban/suburban)	• Statistics Canada • Public Health, • LHINs, • Municipal Reports	• Indicates influences such as geography, age, region's growth	High
Stakeholder Perceptions	• LHINs	• Factors likely to drive usage of primary care services	Medium (unless available by roster population)

Indicator	Source(s)	Relevance (for primary care planning)	Ranking (for primary care planning)
Community Indicators	• Public Health, • Statistics Canada • CIHI	• Includes notion of social capital and its impact on health	Low (difficult to measure and access by FHT area)

Acronym Glossary

- **ACSC** – Ambulatory Care Sensitive Conditions
- **CIHI** – Canadian Institute for Health Information
- **MOHLTC** – Ministry of Health and Long Term Care
- **LHINs** – Local Health Integration Networks
- **CCACs** – Community Care Access Centres
- **Statistics Canada (CCHS)** – 2002 Canadian Community Health Survey
- **FHT** – Family Health Team

UNDERSTANDING DETERMINANTS OF HEALTH

As FHTs undertake their needs assessment exercises, questions will arise about the scope of needs, most especially the value of understanding needs beyond the medical. The social, political, geographic and economic determinants of health have significant impact on the health of patients, on their ability to benefit from treatment and lifestyle advice, and on the alternatives and extended supports that can influence patients' health.

Example*:* Healthy eating for patients with diabetes and their families is more difficult for those living in low-income situations. In those instances access to healthy food may be compromised by the cost of fresh food or by difficulty accessing supermarkets. Recognition of these factors may lead to differing types of interventions.

Example*:* Persons who are employed may or may not have access to drug and other health benefits through employer subsidized extended health benefit plans. Such plans may include access to Employee Assistance Programs that provides mental health or grief counseling, which then need not be offered by the FHT. Conversely, if the FHT provides services to a large contingent of unemployed persons, such services may be appropriately offered by the FHT.

Example*:* Seniors with poor social supports may have difficulty getting to appointments, getting out to shop, and will be more likely to be lonely and depressed.

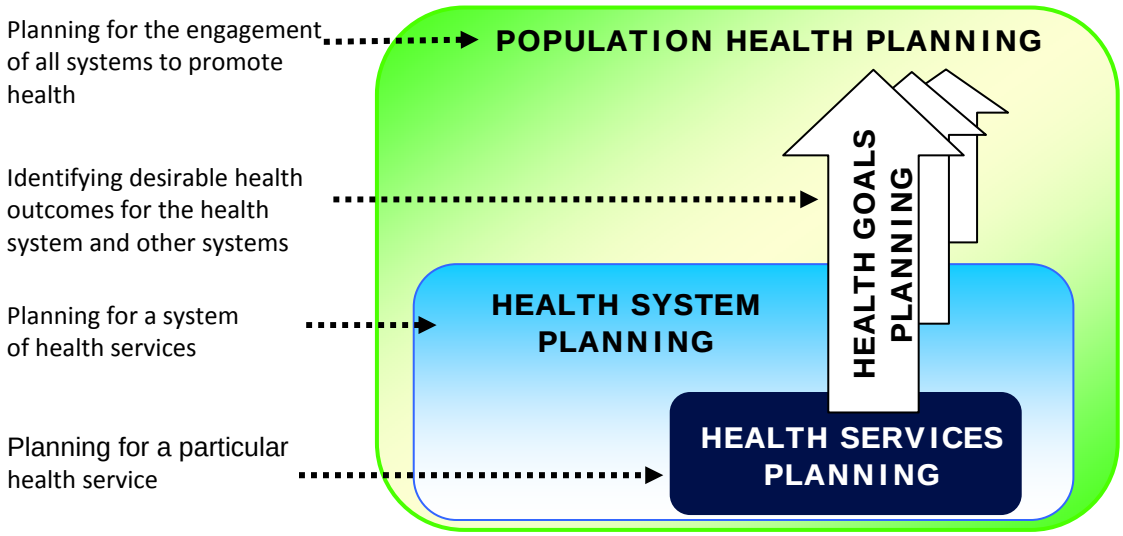
As the above examples indicate, primary care practitioners will often be confronted with patients whose health issues strongly link to social, economic and/or environmental conditions. Thus it is important to understand the interplay of these factors and to address them as much as possible in interactions with patients and their families. At the same time, the solutions or relief to the types of issues noted above are usually found outside the FHT office. Social workers within the practices are useful resources for connecting patients to outside supports.

Information about the determinants of health in areas in Ontario is available from sources such as LHINs and Public Health and provides important context for the FHT needs assessment and planning activities. However they would not be the primary focus for the FHT needs assessment exercise. A good way to look at the interactions between the various types and level of planning – population, health system, services can be found in Figure 3.

"…The health field can be broken up into four broad elements: human biology, environment, lifestyle and health care organizations. These four elements were identified through an examination of the causes and underlying factors of sickness and death in Canada, and from an assessment of the parts the elements play in affecting the level of health in Canada."

A New Perspective on the Health of Canadians (1974) Lalonde.

Figure 3 – Connections among Types of Planning



Source: The Health Planner's Toolkit, MOHLTC Health System Intelligence Project – 2006

ENGAGING THE TEAM

Working through a needs assessment process within FHTs will involve all members of the practice, at least to some extent. The ability of the team to dialogue and share information in general will affect the needs assessment exercise, as well as be enhanced by it.

For example, a team working through a discussion on the determinants of health for their population, in conjunction with the review of health status information, will provide useful context for the FHT moving forward. Through this discussion, two important events will occur, namely the members of the FHT team will have an improved awareness of their individual philosophies of health care, and secondly the FHT team will begin to make some decisions about the ways the practice will address the health needs of their practice under the new FHT model.

Some tools helpful to teams going through needs assessment processes and the related priority setting are noted below.

- SWOT exercise
- Affinity exercises
- Criteria weighting exercises

SWOT

SWOT is a tool commonly applied in strategic planning exercises and stands for Strengths, Weaknesses, Opportunities and Threats. Looking at the FHT in this way can be done in a relatively short period of time and will be useful to help the team establish criteria for their needs assessment. For example, if a major threat for the FHT is the lack of local specialized geriatric care, then the FHT may decide to put high priority on information and criteria related to frail seniors.

Affinity Exercises

Affinity exercises are excellent ways to identify issues, or prioritize among them. In its simplest form, each participant has an opportunity to respond to a question and post up their answer or answers. The next step is for one person, often an external facilitator, to lead the group through a process of putting like ideas together (establishing affinity), after which there are groups of ideas that represent more 'votes' or ideas than others. These are usually deemed to be the first layer for further discussion about moving forward.

Criteria Weighting Exercises

Each team will have to determine what weight to assign in examining evidence around needs, and possibly around ways to address the needs. One place to start could be to rank the nine indicators under the burden of disease umbrella, giving higher weight to information under indicators that are deemed more relevant for primary care provision. For example, a practice may determine that information about mortality, morbidity, self reported health and risk factors is most important. FHTs in large urban areas may want to put emphasis as well on demographics, especially population growth.

Another place to start to establish criteria would be to rank according to the values of the organization. For example, if access and equity are key values of a FHT, then information collected under deprivation and stakeholder perceptions would be ranked high.

A third option would be to identify types of information related to needs and then undertake surveys for ranking purposes of staff, patients and community partners. In the case of a survey to rank needs, it will be important to remind respondents to rank with a view to the ability of the primary care providers to address the need. A potential dual benefit to this type of survey is to use the survey to highlight the range of providers and services within the FHT, as background information to the questions.

Whatever process is undertaken to develop criteria based on information collected on needs, it should be specific to the FHT community, reflective of the FHT culture and values, and aligned with the ability of the FHT to use the information moving forward.

ENGAGING THE PARTNERS

A success factor in any program planning activity is the ability to engage key stakeholders early and often in the process of planning, as well as implementation and evaluation. While some program goals may be able to be achieved entirely within the FHT environment (such as numbers of persons screened for a particular health issue), programs aimed at specific populations (seniors, children, persons with mental health problems, etc.) will be more successful when linked to the activities of other community providers for these same populations.

Primary care is often referred to as the gateway to the broader health system. Implied in this is a coordination role that is often beyond the capacity of individual practitioners or even groups of practitioners. However the primary care level is the starting point for diagnosis and ongoing regular health care and health advice for most people. Some family practitioners view their role with

patients within a life cycle context, as they often see patients through many stages of their lives and many types of health care needs. Through these stages they may need other supports and services.

Some key partners are noted below, along with their areas of particular expertise and potential partner roles with FHTs.

Table 3 – Key Priorities, Expertise and Partner Roles

Organization	Mandated Services	Potential Partner Roles
Community Care Access Centre (CCAC)	• Seniors • Children with special needs • Post hospital patients requiring home care	• Assist with arranging services for frail, isolated seniors
Community Support Services (Seniors)	• Support services to seniors, including but not limited to, transportation, day programs, meals on wheels, friendly visiting	• Assist with activation and/or increasing socialization of frail or isolated seniors • Providing rides to appointments • Providing nutritious meals
Hospitals	• Acute care services • Emergency services	• Communication regarding discharged or deceased patients • Specialty consults • Programs, e.g. falls prevention
Public Health	• Population health • Targeted priority programs, e.g. healthy babies, healthy children	• Collaboration around well baby follow up • Collaboration on disease prevention strategies and programs, e.g. tuberculosis, SARS, HIV/AIDs • Crisis intervention (in some areas) re mental health
Community Mental Health and Addictions Services	• Support services for mental health and addictions, e.g. counseling, supportive housing, • Employment programs, peer support networks • Crisis supports	• Collaboration around patients with ongoing mental health or addictions issues • Links with ACT teams through hospitals and community-based agencies
Associations E.g. Alzheimer Society, Canadian Diabetes Association, Canadian Cancer Society, etc.	• Advocacy, research, education and support programs	• Source of information and referral for patients and their families

Organization	Mandated Services	Potential Partner Roles
Other Relative to local circumstances, e.g. groups supporting new immigrants and refugees, aboriginal counsellors, church groups	• Specific to group or organization • Generally formed for information and counseling purposes and to facilitate access to services	• Source of information and referral for patients and their families

ENGAGING THE PATIENTS

Needs assessment processes seem at their core to be highly technical activities, using health data and relying heavily on information about health care utilization and illness. With that in mind there is a case to be made for engaging some of the practice population in the needs assessment process. Patient input can be particularly useful for validation purposes once the initial review and ranking of information around needs has been done. Patient perceptions will also be useful in determining how that information is translated into action or programs.

For example, patient focus groups could be used to determine receptivity to group (versus 1:1) education sessions, care provision by non-physician team members, methods for information translation, etc.

Some examples of how FHTs have engaged patients within their needs assessment processes can be found in the descriptions in Appendix A.

OTHER CONSIDERATIONS

In any needs assessment process it is important to accept the fact that not all of the potentially relevant information will be available and answers to all of the questions emerging from a needs assessment may not exist. It is equally important not to be stalled when this happens. In 1995 when the Ministry of Health endorsed The Guide to Needs Impact Planning, created by a collaboration of Ministry and District Health Council participants, they acknowledged that needs assessments must sometimes proceed with the information on hand, and with assumptions rather than evidence. As the diagram in Appendix D illustrates, in these cases, one establishes a separate process to look into the research in the area in question, but where possible, continues to work with the facts, observations and expertise on hand in the process.

Needs assessments are a balance of science and art, in that they combine the learning from data with the observations and creativity of the people driving the process.

CONCLUDING COMMENTS

Needs assessments are important tools to assist FHTs to understand the population they serve or might serve in the future. A needs assessment process should be accompanied by a process to prioritize among the needs - and among the opportunities to address those needs. In fact the opportunity for a FHT to address a need may be the first criterion applied in a prioritization exercise. If an issue is largely beyond the scope or current capacity of the FHT (for example, specialized geriatric assessments) then it should not be a priority action item. In short, a need may exist and be legitimized through a needs assessment process driven by a FHT, but defining actions from the needs should be driven by the FHT mandate and resources. Through needs assessment processes, FHTs can identify care and/or knowledge gap issues, and look to partnership development as a possible solution.

Organizations initiating needs assessment processes should be clear as to the purpose and scope of the exercise, and the resources and time commitments to be allotted to the process. Many tools exist and there is a wealth of data available at the regional and, in most cases, sub-regional level. Over time, as electronic health records are in place for all patients, FHTs will be better able to analyze their data and work with profiles of their actual patients. In the meantime needs assessments built from a combination of information about the local community and the qualitative information provided by FHT team members, patients and other partners will be most useful.

APPENDICES

Appendix A – Examples of FHT Needs Assessment Approaches

Three FHTs, demonstrating needs assessment activities from rural, urban and northern communities, are included.

Example 1: North York FHT (Toronto)

Contact	Dr. David Kaplan david@davidkaplanmd.com *416-494-3003*
Context For Needs Assessment	• Needs assessment done as part of business plan development and FHT strategic planning
Population To Be Served	• Catchment area - aligned with hospital catchment • Enabled data sharing and joint planning
Planning Partners	• Hospital (primary partner) • CCAC • Public Health • Health and social service providers
Other Stakeholders / Programs	• Better Beginnings Now • Organizations serving new immigrants
Data Sources	• Hospital (North York General Hospital) • Local Health Integration Network (Central) • Community Care Access Centre (North York CCAC – formerly)
Information / Data	• Population health data • Hospital planning/utilization data • Physician practice profiles • Survey and focus group information
Activities	• Data review and analysis • Provider forums • Key informant surveys • Strategic planning sessions
Results	• Clinical priorities and cross cutting FHT strategies identified through this process. • Five clinical priorities are identified: 1. Palliative care 2. Mental health 3. Chronic disease management and health promotion 4. Maternal / child 5. Seniors / geriatrics. • Cross cutting strategies aligned with MOHLTC system goals and included enhancing access to primary care for persons living in the area (rostering orphan patients, after hours care expansion), and enhancing linkages, partnerships, coordination and overall system navigation (working in more integrated ways with hospital, CCAC, public health, community mental health providers).

Example 2: STAR FHT (Tavistock, Stratford)

Contact	Mr. Blain McCutchen (Business Manager) *519-301-2161*
Context For Needs Assessment	• Needs assessment done as part of business plan development and initial FHT start up/program development
Population To Be Served	• Stratford, Tavistock and surrounding geographic communities • Determined by FHT physicians practice populations, plus potential roster patients
Planning Partners	• Perth District Health Unit • CCAC Stratford • Huron Perth Diabetes Program • Huron Perth Healthcare Alliance - Stratford General Hospital • U of T Dept of Family and Community Medicine - Research Program
Other Stakeholders / Programs	
Data Sources	• Public Health reports • Former District Health Council reports • Local Health Integration Network (South West) • Community Care Access Centre
Information / Data	• Population health data • Physician practice profiles • Summary from team strategic planning session • Key informant interviews (physician and office staff)
Activities	• Data review and analysis • Community partners' input • Consumer input
Results	• Five key program areas are identified: 1. Mental health care 2. Chronic disease management and prevention/promotion 3. Child and maternal health care 4. Services for seniors 5. Palliative care • Also included - research

Example 3: Blue Sky FHT (North Bay)

Contact	Dr. Wendy Graham per Jessica.belecque@blueskyfht.on.ca *705 476-7747*
Context For Needs Assessment	• Needs assessments done - based on goals around serving community, and specific goals for chronic disease programming (and related hiring) and end of life care.
Population To Be Served	• Focus both on practice roster and community as a whole, as well as targeted populations, e.g. potential number of persons seeking end of life support outside of hospital, pain management (pressure on ER); potential persons with COPD, diabetes
Planning Partners	• Hospital, long term care providers, CCAC, End of Life Network, Rotary, Arthritis Society, etc.
Other Stakeholders / Programs	• FEDNOR (application for funding to support community needs assessment process for end of life care and support) • CARP
Data Sources	• Hospital, Public Health, practice roster analysis, LHIN, LTC facilities
Information /Data	• Burden of illness data, hospital admission and ER data, FHT practice billings analyzed for specific target areas
Activities	• Designated committee structure set up to lead needs assessment work. • Links established with partner organizations at the planning and delivery level. • System 'overwhelmed' so engagement very targeted to specific goals and outcomes, e.g. creation of local hospice programs and services • Working with hospital toward APP for physicians doing end of life care
Results	• After hours clinics established • Coverage of local nursing homes established • 1st call coverage for FHT patients in hospital • Designated 1st choice project for Rotary (hospice programs) • Implementing CDPM programs within FHT.

Appendix B – The People and the Timing of Needs Assessments within FHTs

Sequence	Activity	Lead	Timeframe
Step 1	• Scope purpose and context for needs assessment	Potential Leads • FHT Board • FHT Lead Physicians • FHT management group • Consultant working with any of above	.5 Day (may be less and done as part of regular board or team meeting)
Step 2	• Identify key players and partners	As above OR needs assessment working group	.5 Day (if done at board meeting, should be validated by sampling of FHT team members)
Step 3	• Identify Needs • Gather and review information	Needs assessment working group Consultant	3 – 5 Days
Step 4	• Identify opportunities to address needs	Needs assessment leads (or working group) And/or All FHT members And/or Consultant	1 – 2 Days
Step 5	• Set priorities • Set criteria and rank among opportunities to address needs	As above	1 – 2 Days
Step 6	• Implement programs, protocols • Study impact		Ongoing

The participants and timeframes above are estimates only. The approach will vary by FHT, and be based largely on available resources (ability to commit dollars and time of team members).

Use of Outside Consultant

FHTs may decide to retain the assistance of an external consultant and to define a maximum number of days in which to accomplish the task. The two main reasons for using an outside resource would be efficient process facilitation and reduction of FHT staff time in management of the activities. In this case, the consultant to be retained should have access to key stakeholders, inside and outside the FHT, with which to validate conclusions prior to bringing them forward to the larger decision making group.

FHT Needs Assessment Leads or Working Group

Whatever the approach, the process requires ongoing ownership by designated persons from within the FHT. This could range from a physician and nurse partnership as leads, to a working group

comprised of one member of each profession within the FHT. External partners are essential for Step 3, and should be considered as participants and contributors to Steps 4, 5 and 6.

The Essential Players

The decision to undertake a needs assessment process, and the related priority setting and action, will usually be made by the leadership of the FHT. The ideas, though, may arise from any member of the FHT or other stakeholders. The focusing of the needs assessment will ideally be the result of a series of conversations among interested and informed team members, board members, patient advocates or community partners.

A needs assessment process will usually be undertaken to guide planning and priority-setting for overall FHT services. That being said, individual practitioners within FHTs, for example the social workers or dietitians, may recommend and lead needs assessment activities specific to particular services or population issues.

Appendix C – Glossary of Terms

Quantitative and Qualitative Information
Quantitative information comes from numbers and is considered hard data. For example the numbers of deaths in persons 50 and over due to smoking in a particular area is quantitative information.

Qualitative information is information that is derived from observations, interviews and stories. For example, a report based on key informant interviews asking people their perspectives on a new intervention would be a document derived from a qualitative process. While qualitative information is sometimes considered 'soft' data, it has significant value for understanding the perceptions and receptivity of a population, key factors in designing health care programs.

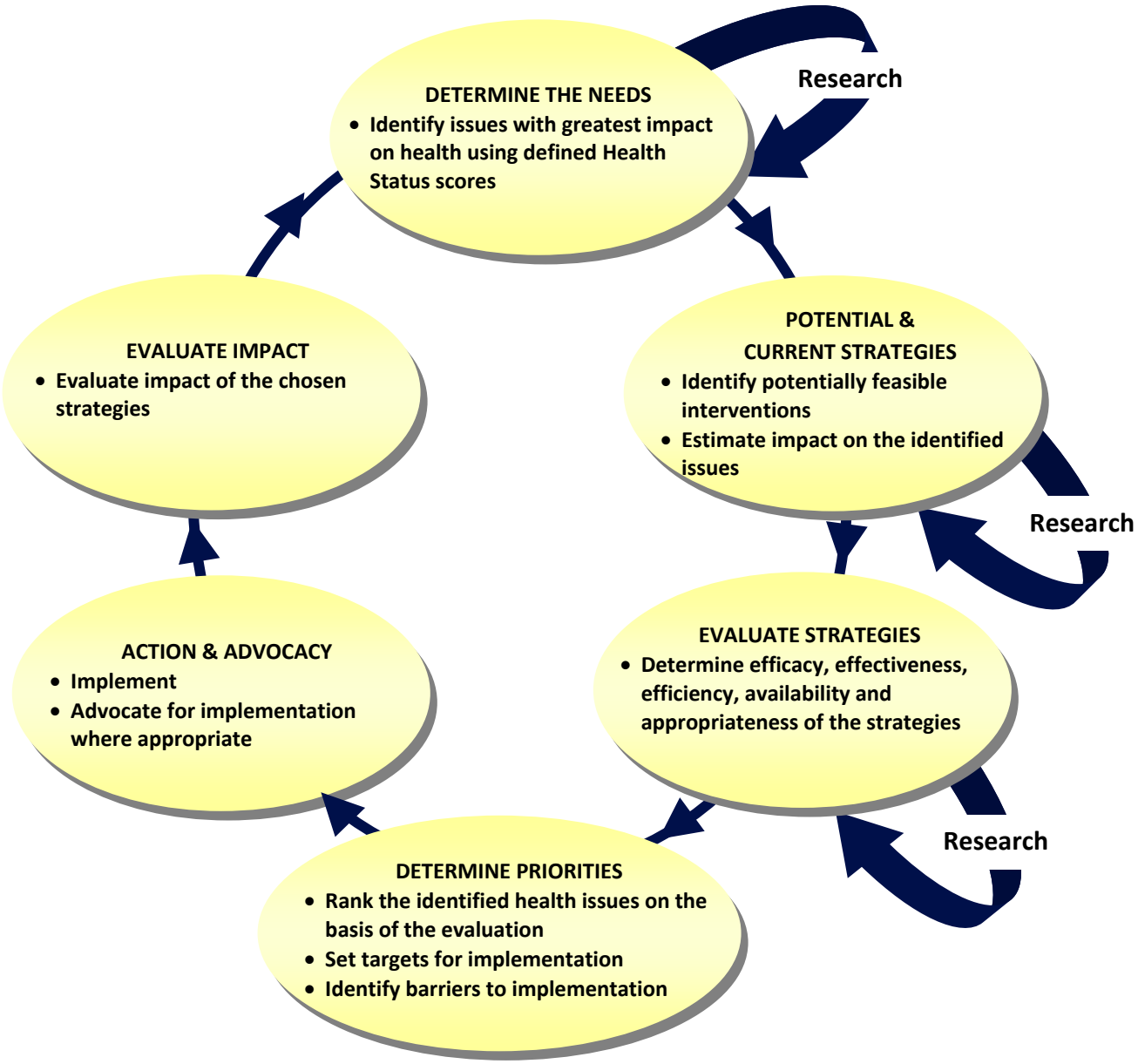
For example, the Canadian Community Health Survey, which produces information on self-perceived health, is a major source for health planning and priority setting activities by governments, health planners and providers.

Prevalence
The prevalence of a disease is the proportion of a population that has a disease or illness at a specific point in time. Prevalence is particularly important when the duration of the illness is long, for example, asthma or diabetes, implying ongoing need for services.

Incidence
The incidence of a disease is the rate at which new cases occur in a population during a specified period; the mortality rate is the incidence of death, mortality from specific conditions being the incidence of death from those conditions

Morbidity
State of being ill or diseased. Morbidity is the occurrence of a disease or condition that alters health or well being.

Appendix D – Needs Impact-Based Model



Source: The Health Planner's Toolkit, MOHLTC Health System Intelligence Project – 2006