Public Health Ontario | Santé publique Ontario

Beyond Schedule A

Evidence-based program planning for community needs

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AFHTO Conference

Learning needs assessment results

- 41 people responded (52% response rate)
- Most respondents (36/41) have some idea or are very familiar with program planning
- Half (15/30 who responded to the question) have a planning template within their FHT (separate from the Schedule A)

Learning needs assessment results

Common challenges:

- Difficulty accessing the right data or “clean” data from the EMR
- Setting stretch goals
- Getting physician (or staff) engagement to process
- Designing programs to meet patient-defined rather than physician-defined need
- Understanding how to complete the Schedule A columns (particularly what goes into each column and to what level of detail)

Learning objectives

1. Discuss the principles for effective program planning
2. Apply the four cornerstones of program planning to annual planning and new program development
3. Develop SMART goals and objectives aligned with the community context, strengths and needs

Program Planning

What Is Program Planning?

- "Planning… involves a series of decisions based on collecting and analyzing a wide range of information."[1]

What Is Evidence?

Information or facts from a variety of both qualitative and quantitative sources, “that are systematically obtained (i.e., obtained in a manner that is replicable, observable, credible, verifiable, or basically supportable).” [2 p. 52]

Domains influencing EIDM [3]

Principles of Program Planning

1. Tie program to mission and strategic plan
2. Conduct program planning as a team
3. Explore opportunities for collaboration
4. Take a population health approach
5. Focus on outcomes
6. Plan key indicators of program success [4]

“Ideal” Program Plan Cycle

Steps[4]	Outputs[4]
Step one: conducting a situational /needs assessment	Completed needs assessment template : • Current context and landscape • Data identifying the problem • Prioritization of how possible programs
Step two: setting program direction	Completed program direction template: • Program description and goal statement • Target population • SMART objectives • Logic model
Step three: determining program elements	Completed program element template: • Program inputs • Program activities • Performance measures and targets
Step four: conducting a program evaluation	Completed program evaluation template: • Description of the program • Summary of outcomes • Recommendations

Step One: Conducting a Situational/Needs Assessment

Steps in Conducting a Situational/Needs Assessment

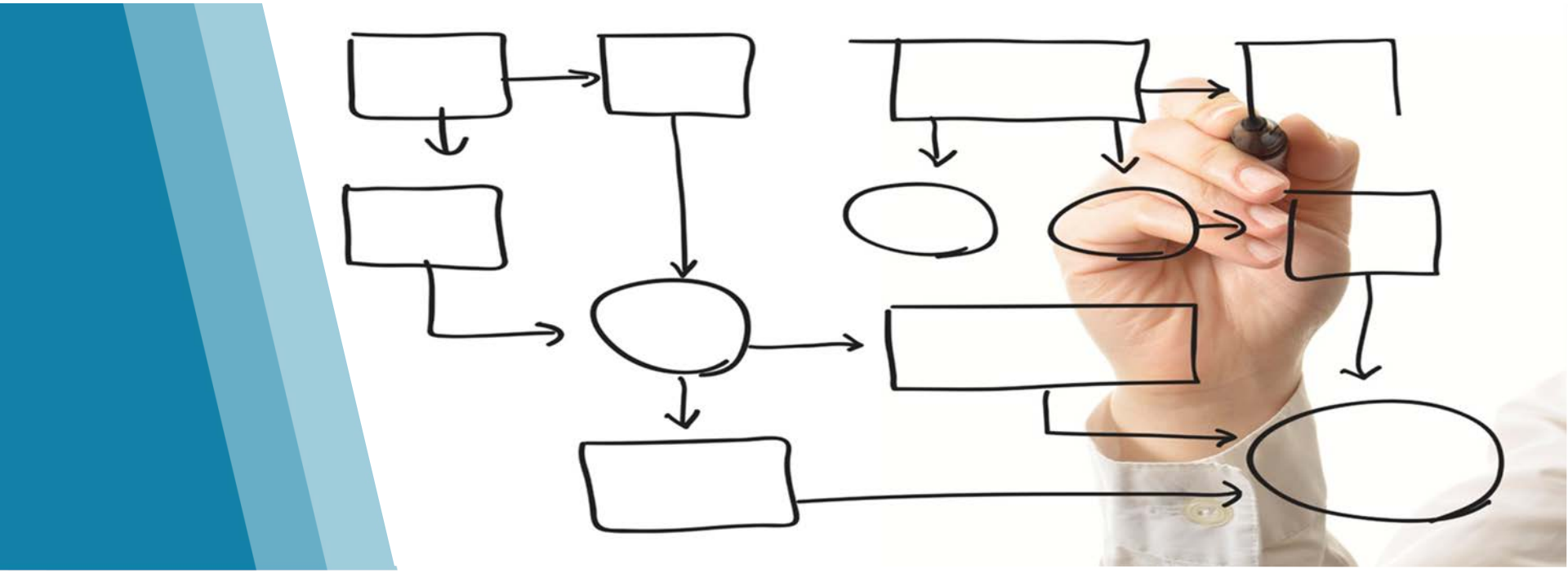
1. Understanding current context and landscape
2. Identifying problem, gap or need
3. Gathering data
4. Determining possible actions and how to proceed [4]

Key Questions

- What is the health status and incidence of diabetes in our community?[5]
- How does asthma affect youth in our community?[5]
- What are the facilitators and barriers to first-time parents attending prenatal courses?[5]
- What programs are available in this community for primary-school aged children from families with low-incomes addressing overweight and obesity?[6]
- Do family violence prevention programs have differential impacts depending on cultural and/or ethnic background?[6]

Evidence Bubble	Method	Source	Lead	Support	Time Allocated	Deadline	Budget	Other resources

Step Two: Setting program direction



What Is A Program Description?

Brief statement which includes:

- What you will be doing
- How patients' health or lives will be improved
- Goal(s) of the program [4]

What Is A Goal?

"Goals are broad statements that describe what impact you hope to achieve in the future"[4 p. 8]

Example Program Description

The “Living Well with COPD” program aims to improve patients' management of their COPD symptoms through a 6 week group educational sessions.[7]

Example Goal

To provide diagnosis, support and education for patients with COPD **to prevent hospitalizations and improve quality of life.**[7]

What Is A Target Population?

The “target population is the participants your program is designed to change.”[7 p. 9]

Example Target Audience

Patients recorded in FHT EMR with a COPD diagnosis confirmed by spirometry <1 year and recorded as either Stage 2, 3 or 4 according to Gold's COPD staging criteria.[8]

Example Program Descriptions

- The Smoking Cessation Program provides education, counselling and support to adolescent patients who want to quit smoking in order to reduce the long-term health effects of smoking.

- The mental health promotion program provides mental health group cognitive behavioural therapy (CBT) sessions. The goal of the program is to reduce symptoms of anxiety and depression and improve overall quality of life.

What Is An Outcome Objective?

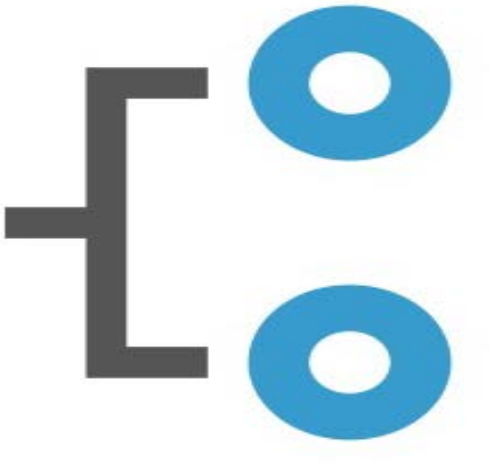
Outcome objectives "are the specific changes expected in your target populations(s) as a result of your program."[4 p. 9]

What Is An Outcome Objective?

Objectives describe:

- What will change?
- For whom?
- By how much?
- By when?[4]

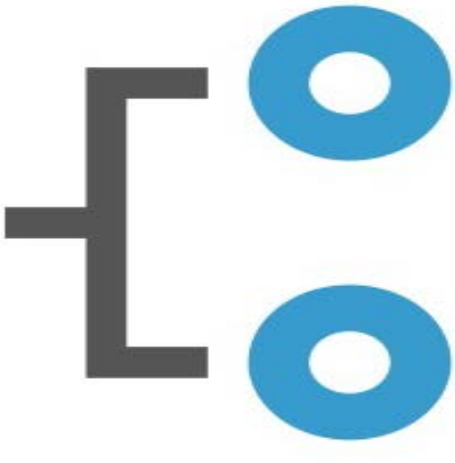
Sample Outcome Objective



Decrease the percentage of patients aged 12 and over who report smoking daily or occasionally to 16% by December 2018[8]

These are examples for teaching purposes only

Sample Outcome Objective



Decrease the **percentage** of patients aged 12 and over **who report smoking daily or occasionally** to 16% by December 2018[8]

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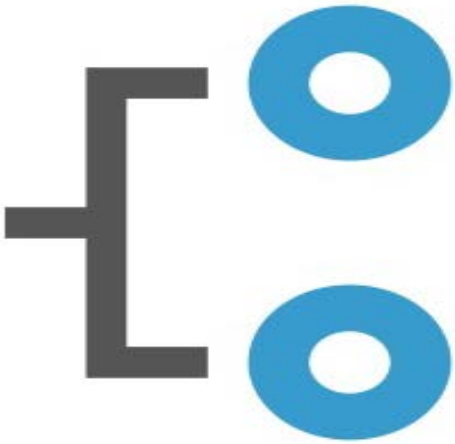

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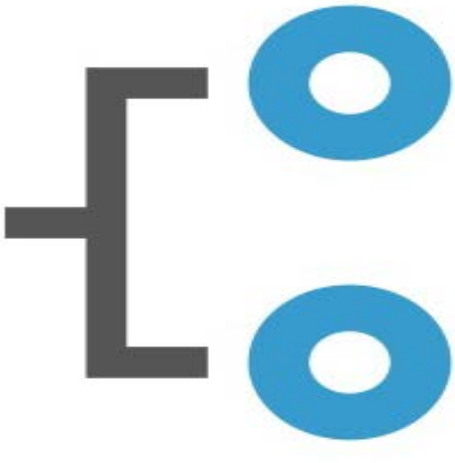

Decrease the percentage of patients aged 12 and over who report smoking daily or occasionally **to 16%** by December 2018[8]

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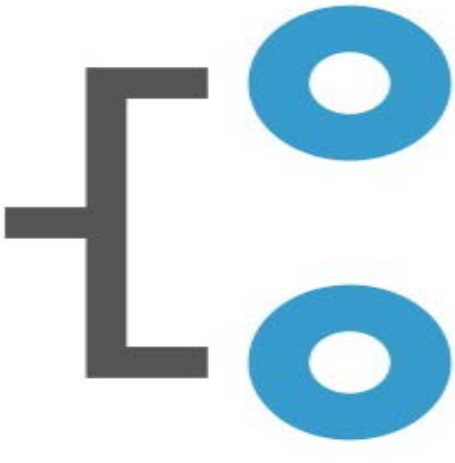

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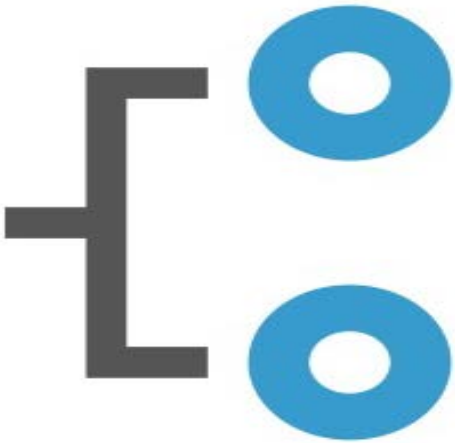

70% of all registered FHT patients will be vaccinated for influenza annually [8,9]

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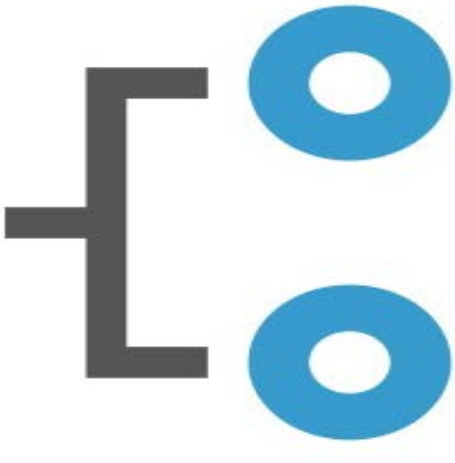
Sample Outcome Objective

70% of all registered FHT patients will be vaccinated for influenza annually[8,9]



- **What Will Change**
- **For Whom**
- **By How Much**
- **By When**

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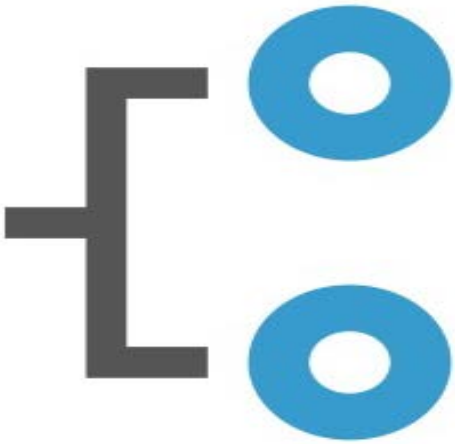
Sample Outcome Objective



- **What Will Change:** % who are vaccinated for influenza
- **For Whom:** patients of the FHT
- **By How Much:** 70% of patients
- **By When:** annually[8,9]

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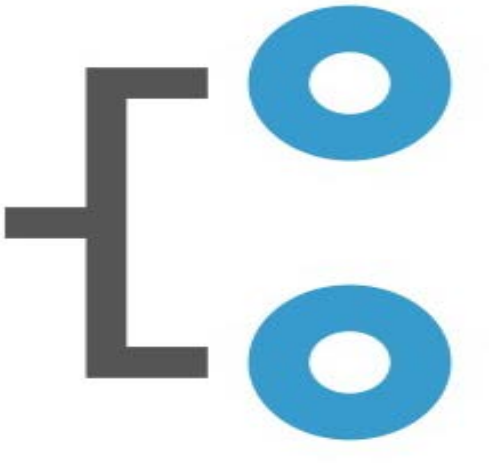
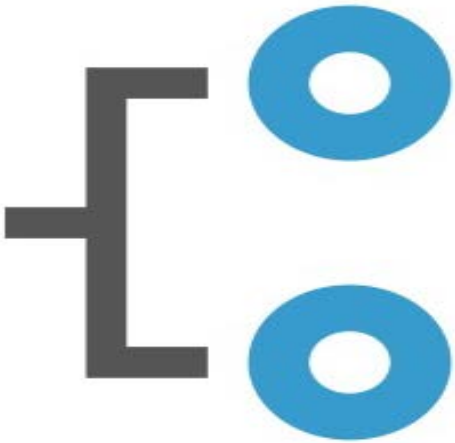
Outcome Objectives[1,4]



"Better" objectives are:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-limited[1]

Sample Outcome Objective



70% of all registered FHT patients will be vaccinated for influenza annually[8,9]

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What Is a Performance Measure?

A performance measure is “a measure of a primary care process or outcome that is useful…to support planning, management or quality improvement”[10 p. 10]

Example performance measures

- Percentage of female patients aged 50 to 74 who had a mammogram within the past two years[8]
- Percentage of recent mothers who report breastfeeding or trying to breastfeed[8]
- Percentage of patients with diabetes with two or more glycated hemoglobin (HbA1c) tests within the past 12 months[8]

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To provide diagnosis, support and education for patients with COPD to prevent hospitalizations and improve quality of life[7]

Decrease participant COPD-related visits to ED by x% in the 12 months following program completion.[9]

Decrease smoking rates in COPD patients attending the sessions by x% in the 12 months following program completion.[9]

% of patients who demonstrate correct inhaler technique after the 6 week session.[9]

% of patients with a written action plan at end of 6 week program[9]

# of participants who smoke referred to FHT smoking cessation program[9]

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Demonstration of the Program Performance Measures Indicator Catalogue

Program Area	Diabetes management			
Availability of Standard Definition	**Type of Measure**	**Measure**	**Source of Definition**	**# of tin Measure**
high	**outcome measure**	HbA1c wihin individualized target	Primary Care Performance Measurement Framework - pg 129, 136, 153 - LINK 22	
		LDL, HDL and/or Total Cholesterol within their individualized target	**Primary Care Performance Measurement Framework - pg 122, 137 - LINK 22**	
		blood pressure wihin individualized target	Primary Care Performance Measurement Framework - pg 120 - LINK 22	
		improved BMI/weight loss	**Primary Care Performance Measurement Framework: pg 184 -- % of patients in different BMI categories - LINK 22**	
		pneumovax immunization	Primary Care Performance Measurement Framework - pg 212 - LINK 22	
		flu immunization	**Primary Care Performance Measurement Framework - pg 204 - LINK 22**	
		ED visit	Primary Care Performance Measurement Framework: pg 18 -- patient reported by survey - LINK 22	
		quit smoking	**Primary Care Performance Measurement Framework pg 183 -- smoking status categories - LINK 22**	

Acknowledgements

Thank you to those participants who agreed to share their example program descriptions and objectives with all for shared learning.

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