



Going Beyond Good Intentions: Needs Assessment for Student-Led Health Outreach in Northern Ontario

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Abstract

Background: The pervasiveness of healthcare needs in the context of economic scarcity demands stewardship of healthcare resources. Despite evidence demonstrating the value of student-run clinics (SRCs), those interested in establishing or preserving SRCs are increasingly requested to conduct needs assessments. To our knowledge, no literature has described a needs assessment conducted by a developing SRC, nor how the results might inform the services offered by a SRC. This paper will explore the process, findings, and implications of a needs assessment conducted by an interprofessional team of students in Thunder Bay, Ontario, Canada.

Methods: A total of 19 semi-structured interviews were conducted. Informants included: sector representatives, potential consumers, and educators. With the use of a comprehensive regional database, a local healthcare center aided with participant selection. Interviews were audio-recorded, transcribed, and qualitatively analyzed for thematic content by multiple researchers. While sector representatives and potential consumers are the subject of this paper, analysis of education interviews will be the subject of another publication.

Results: The main themes encompassed existing services, primary health concerns, barriers to services, and gaps in services. The most cited health problem was drug and alcohol use. Diabetes, cardiovascular disease and mental illness were also frequently noted. Lack of basic necessities were felt to contribute to poor health. Gaps in services related to system navigation and coordination, mental health and addictions services, and preventative health services, which were felt to be more prominent for women, youth, seniors, First Nations, and LGBT populations. All participants identified opportunities for a SRC. Recommended SRC focus areas included: disease prevention, system navigation, walk-in/urgent care, counseling, safe social space, and mobile services. Some participants commented on the importance of supervision and sustainability.

Conclusions: Extensive community healthcare needs were revealed which could be addressed by a SRC, while continued research exploring the effectiveness of a SRC response to a priori identified needs is warranted.

Introduction

The World Health Organization (WHO) urges stewardship of healthcare resources.¹ Further, contemporary economic and political climates require that funding of health services be justified through identified needs and demonstrated success in addressing them.²

Student-run clinics (SRCs), are organizations in which students from various disciplines collaboratively plan and deliver healthcare and health promotion services, typically to underserved populations, under the supervision of licensed professionals.³ While evidence supports their clinical and educational value, there is increasing pressure for SRCs to conduct a community needs assessment

in order to justify their establishment and continued support.⁴⁻⁶

A needs assessment is a “systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way”.² This is a difficult task for these volunteer-based student groups with often minimal faculty involvement. There are two examples in the literature of established SRCs that have conducted a needs assessment for evaluation and quality improvement purposes.^{5,7} However, no literature has described a needs assessment conducted by a developing SRC, or how the results might inform the services offered by a SRC.

This paper will explore the findings from a needs assessment conducted by a group of nursing, social work, and medical students and faculty from Lakehead University and the Northern Ontario School of Medicine. This group is working to develop a SRC in Thunder Bay, Ontario, Canada. The task of examining the need for a SRC in Thunder Bay was assigned by the academic institutions as a component of the approval process. The goals of the needs assessment were to: 1) examine the healthcare needs, gaps, and services of Thunder Bay, and 2) discuss opportunities for a SRC to address these needs. Current interprofessional education (IPE) needs and gaps were also explored, but are beyond the scope of this paper.

Thunder Bay, a city of 108,359 located in North-western Ontario, serves as the hub for health and social services in the region.⁸ Northwestern Ontario residents are found to have high rates of hospitalizations and emergency department visits chronic conditions such as mental health concerns, conditions related to substance use, diabetes, and ischemic heart disease. These chronic conditions are better addressed in a consistent clinical setting rather than an emergency room or walk-in clinic.⁹ The region is also facing an aging demographic¹⁰ and a declining population of physicians and other healthcare workers. This suggests that residents will experience increased difficulty accessing appropriate health and social services in the future. Finding ways to better address the current and future needs of the region will require creativity and innovation within the local healthcare system. It was hypothesized there are needs in Thunder Bay that a SRC could address.

Methods

The project was approved by the Research Ethics Board of Lakehead University. The study was

conducted by a group of 11 student researchers and supervised by two faculty members.

Participants

The perspectives of 10 sector representatives, three consumers, and six educators were collected. The perspectives of the educators do not fit within the scope of this paper and will thus not be included.

Representatives were sought for the following sectors: primary care, social services, chronic care, mental health, and homeless services. These sector representatives were deliberately selected from a list of all possible agencies from the 211 Ontario North database. Deliberate selection was used in preference to random selection due to feasibility and to ensure a diverse sampling of agencies. The number of interviews per sector were selected to reflect the needs of the city as revealed by existing data. Interviews included three representatives from primary care, three representatives from homelessness, two representatives from mental health and addictions, one representative from chronic and elderly care, and one from social and legal services, resulting in a total of 10 interviews with sector representatives. In order to ensure consistency in the data collection, one researcher was assigned to each of the sections and conducted all of the interviews within their sector.

Three healthcare consumers were recommended as participants by a local community health center. A healthcare consumer is an individual who accesses healthcare services. In line with the mandate of SRCs, consumers living with social and economic disadvantages were identified. The researcher responsible for these interviews received extra training to mitigate potential risks.

Design

Participants were sent a question guide and information regarding the project three business days prior to the interview. At the beginning of each interview, written consent was obtained. Semi-structured interviews were implemented to facilitate consistency between interviews while allowing the researchers to pursue the conversation beyond the question set and elicit the unique, unanticipated insights of each participant. The researchers were encouraged to be mindful of their own assumptions and how this might influence the interview and analysis process. The interviews were audio-recorded and transcribed by an independent organization. Participants were invited to

review a summary of their interview and offer feedback or revisions to be incorporated.

Each researcher analyzed the interview they conducted, and developed codes to elicit the main themes running throughout the interview. All analyzed interviews were reviewed by three additional researchers in order to seek out overlapping themes and compile the results.

Results

Results from the interviews with sector representatives and consumers fell into 4 categories: specific health concerns, existing services, barriers to services, and gaps in services. Findings are summarized in Figure 1.

Specific Health Concerns

The most commonly cited health concerns were drug and alcohol use. Other health problems mentioned frequently were diabetes, cardiovascular disease, and mental illness.

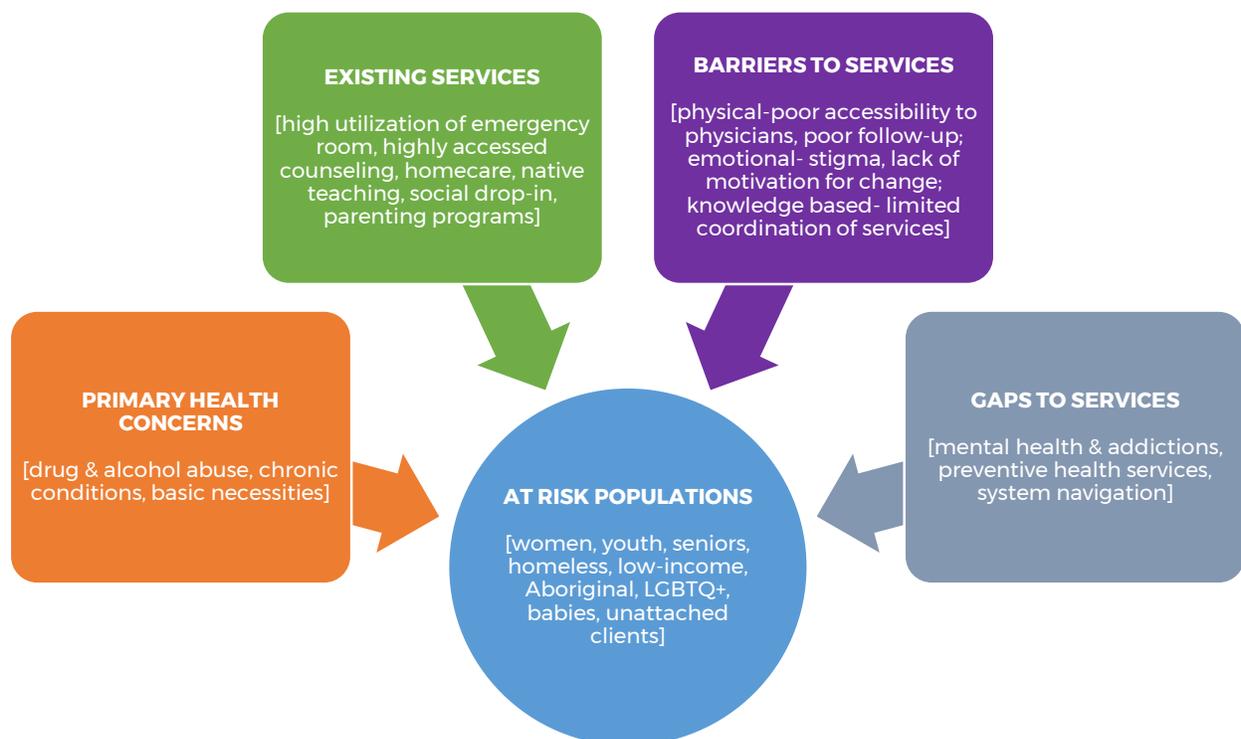
Existing Services

Consumers mentioned a number of healthcare services they currently utilize including: emergency services, community health centers, parenting programs, child care at their healthcare provider's agency, counseling, healthcare access centers, anger management, Aboriginal teaching, and social drop-in services. One consumer referred to a community health center as her second home. All the consumers spoke highly of safe, welcoming social drop-in spaces where they could relax and connect with people.

Barriers to Services

All participants described how barriers to accessing basic necessities, such as income, transportation, housing, and food, contributed to poor health. One social service provider explained, "It's Maslow's Theory, right. If we're not taking care of the basic needs of [the] individual, we're not going to be able to take care of their healthcare needs. We're not going to be able to stabilize

Figure 1. Summary of needs assessment findings



them and we're certainly not going to be able to have conversations about life goals and recovery."

Accessibility to healthcare was addressed frequently, especially from the homeless sector representatives. Some of the reasons for poor accessibility of services for vulnerable people included poor follow-up, poor coordination of services, wait times, and lack of access to primary care physicians. Another social service provider spoke about lack of access to primary care for people living homeless, resulting in increased emergency room visits. Furthermore, life for vulnerable people was described as chaotic and unpredictable, making the timing of service access more difficult. Interestingly, a client's lack of motivation was mentioned as an added barrier to accessing services, *"If somebody is in our shelter, [and] they don't seem to be working towards anything or there's nothing we can do to help them, eventually there comes a point...where we do reach cut off."*

Lack of trust with healthcare providers was a significant barrier mentioned for consumers, especially those living homeless. Consumers described experiencing discrimination when accessing health services. One consumer described their experience of being treated as a drug user in the emergency department, *"I went to the hospital [and] I was berated by the emergency doctor. He said I had jaundice and hepatitis C, because of [my] binge drinking. And I'm not a binge drinker. I drink, yes, but I'm not a binge drinker...Yes, there are intoxicated people that come to emergency and this is one frustrated doctor. But he's stereotyping me. How dare he think that every one of us is like that."*

Another significant barrier for consumers was inclusion criteria for accessing services. One consumer gave two examples of this: first, being required to take part in a shelter's anger management program to be allowed to live there. Second, they reported being refused at a shelter because of not having the proper identification to access publicly funded healthcare.

Gaps in Services

Gaps in system navigation, mental health and addictions services, and preventative services were identified by participants as contributing to poor health. Gaps were felt to be more prominent for marginalized populations, such as women, youth, seniors, First Nations, and the LGBTQ populations. As noted by one social service provider, *"There's no*

doubt in my mind that the [First Nations] population in this community has the greatest need for access to primary care."

Two main aspects of system navigation were emphasized: lack of system coordination and lack of consumer knowledge of the system. Another clinical and social service provider described how time constraints limit the ability of their staff to coordinate services: *"[We] don't have the capacity to do case management. We can manage the primary healthcare piece, but my nurse practitioners don't have time to be aligning [patients] with every other organization and advocating for them."* A social service provider, felt the lack of coordination was more of a problem at the agency level: *"[Each agency] just does their own thing and operates within their own little bubble. There's not a lot of communication."*

Another service provider explained how important it is for consumers with complex medical problems, such as in the elderly, to have a knowledgeable person who can help them navigate the system: *"If you're an elderly person you better have somebody with you. The system is so complicated that you really need a younger person who is more literate and able to advocate for you."* Similarly, a clinician suggested that clients would benefit from having a "buddy" or a "health coach" who could guide them through the system.

Sector representatives identified further voids in mental health and addictions services. One service provider identified a lack of therapists and counselors to meet the needs of those suffering from poor mental health and addictions. The representatives for the homeless sector felt that their clients lacked knowledge of the available services for addictions and mental health, and that providers do not want to work with them. One homeless sector representative felt that the lack of grief care for vulnerable populations was one reason for the high rates of drug use and mental illness: *"There probably could be something in between [the hospital and the street], because the hospital is scary [for people living homeless]."*

The sector representatives described some preventative services that they felt were lacking, including harm reduction programs; healthy eating programs; and health education, such as on disease management. One service provider explained this in relation to her clientele with concurrent mental health and addictions issues: *"They should be getting their blood pressure monitored more regularly, having their blood sugar checked,*

getting education around diabetes and harm reduction services about if you're going to drink, use this, not this."

While not the focus on this paper, interviews with educators focused on needs relating to IPE, the academic mechanism for developing an understanding of the competencies required for interprofessional care, as well as logistical factors relating to supervision and sustainability.

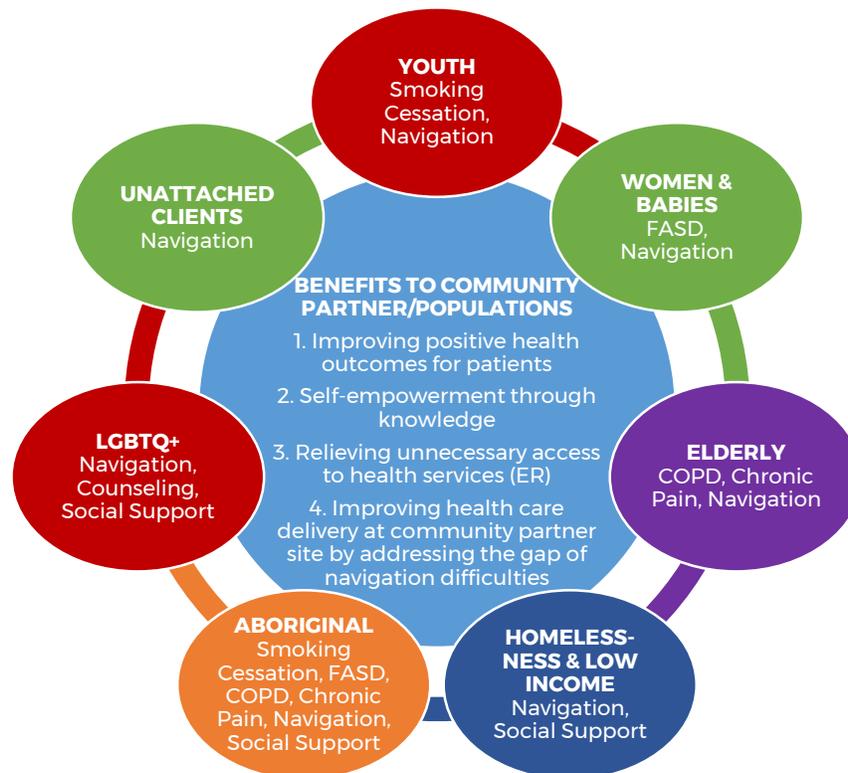
Discussion

Needs assessments are becoming a necessary requirement for SRCs wishing to become established, continue their work, or expand their services. This needs assessment focused on the perspectives of 10 sector representatives from the areas of primary care, social services, chronic care, mental health, and homeless services, and 3 consumers. The findings revealed numerous specific health concerns, trends in use of existing services,

barriers to accessing services, and gaps in services. These findings are consistent with and build on pre-existing local data and will inform the development of a SRC in Thunder Bay, Ontario Canada.

Based on the information gathered, it is difficult to identify which needs are the most important. Rather, there are numerous needs that could be realistically addressed. Practical factors such as our partner agency's priorities, available funding and space, and insurance may be more influential in shaping our SRC's response to the identified needs. Since the services offered by a SRC are diverse, there are many ways of responding to these needs. It is unclear if the traditional "clinic" model is preferred. A SRC that offers assistance with system navigation and coordination, is mobile, and focuses on prevention were among the suggestions given. Possible workshops that could address the population-specific needs are illustrated in Figure 2.

Figure 2. Sample of workshops



FASD: fetal alcohol spectrum disorders; COPD: chronic obstructive pulmonary disease; ER: emergency room

One implication of these findings is that they informed the process of securing a partner agency. Based on relevance to the needs identified, potential partner organizations were interviewed. The committee then debated the suitability of partnering with each agency, using a scored suitability criteria as a guide, which culminated in a ranking of the partner agencies. Criteria included for example clientele, identified needs, enthusiasm and logistical constraints.

The needs assessment process exposed researchers to community needs and to individuals and organizations working to meet them. It was also an opportunity to gauge general interest to the idea of a SRC. The positive response has served as motivation for the committee.

Several limitations of this study should be considered. Non-random selection of participants, and small sample size of this study, may limit the generalizability of the findings. Since SRCs are as much educational endeavours as they are clinical, the full interpretation of the needs assessment is incomplete without consideration of the educator perspectives. This will be the subject of a future publication. There was a lack of representation in the legal sector as well as student perspectives. Finally, the researchers assigned with the task of conducting a needs assessment are also members of the group working to establish a SRC, therefore confirmation bias may have inadvertently influenced the collection and interpretation of findings, despite efforts to mitigate this bias. While inherent to qualitative research, confirmation bias is a significant limitation for any SRC tasked with conducting a needs assessment. It should be noted that some degree of personal interest is unavoidable in research of any form, but especially needs assessments which are typically undertaken by health professionals in examining their local population.³

Conclusions

Few studies have examined a needs assessment conducted by a SRC, and none have described the process, findings, and implications of a needs assessment conducted by a developing SRC. This needs assessment aimed to explore, in a systematic manner, the health and social care needs of Thunder Bay, in order to provide our academic institutions with evidence ascertaining the need for a SRC. Given the significant healthcare needs and gaps in services of Thunder Bay, there are many ways for a SRC to contribute within the confines of

a student organization. At the time of writing this paper, discussions continue between our SRC, partner agency, and academic institutions. The needs assessment has proved to be valuable in these negotiations, and in other areas of the development process.

Future research should examine how the findings of such needs assessments impact the implementation and effectiveness of SRC services. While this evidence is forthcoming, the political leverage afforded by a well-conducted needs assessment should not be overlooked.

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Disclosures

The authors have no conflicts of interest to disclose.

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