



**Minutes of the Board of Health Special Meeting
Program Review Update**

Thursday, May 20, 2010
Board Room, Brockville Office
458 Laurier Boulevard
3:03 p.m. – 4:05 p.m.

Present: J. Butt, Chair
B. Fletcher, Vice Chair
S. Dodge
K. Giroux
K. Graham
G. Grewal
R. Haley
F. Kinsella
J. Lousley
L. Paine
L. Sowchuk
A. Warren
A. Carter, Medical Officer of Health
J. Pearce, Treasurer
H. Bruce, Recording Secretary

Absent: J. Earle

Invitees: Dr. Paula Stewart
Program Review Steering Committee
Program Review Team
Shani Gates, Director of Quality Improvement

J. Futchter – Director – Department of Clinical Services
J. Lyster – Director – Health Protection Department
J. Mays – Manager – Health Protection Department
J. Hess – Director – Family Health Department
R. Kavanagh – Director – Health Promotion Department

R. Zajac – Recorder and Times

T. Boileau, Y. Decoste, W. Goodridge, K. Jackson, C. Millard, E. Mclean, D. Oickle, D. Shewfelt

1. Call to Order:

J. Butt called the meeting to order at 3:03 p.m. He welcomed back Ron Zajac from the Recorder and Times and stated that he will introduce Dr. Paula Stewart more formerly at the regular meeting.

We set this meeting for 3:00 p.m. today to be brought up to date on our program review.

J. Butt turned the meeting over to S. Gates.

2. Introductions:

2.1. Dr. Paula Stewart:

Noted previously.

2.2. Program Review Steering Committee:

S. Gates introduced the Program Review Steering Committee. Its purpose is to develop the communication plan and we have both external and internal stakeholders on the committee. S. Gates introduced the committee members stating that our process was very participatory.

2.3. Program Review Team:

S. Gates recognized the Program Review Team. This team has worked hard over the last year on the situational assessments. There are still some to do on capacity and partnerships. S. Gates introduced the group and thanked everyone for participating. The Prioritization Committee put the questionnaires through the rating process. S. Gates introduced this group as well.

3. Presentation:

3.1. Background and Update on the Program Review Process:

Shani gave a power point presentation. (see Appendix #1) Copies of the slides have been updated and will be sent to board members with the minutes.

S. Gates handed out copies of the ranked and unranked lists of the OPHS (Ontario Public Health Standards) requirements. The OPHS were released in October 2008 and came into effect January 1, 2009. They are structured to reflect key public health functions. The OPHS are mandated by the MOHLTC and are part of the Health Protection and Promotion Act.

F. Kinsella asked what does enforceable mean? S. Gates stated enforceable means it would provide the ministry the authority to ensure that it is being done. J. Butt advised that he is part of the MOHLTC committee that is developing a new funding model for public health in Ontario. There are another 2 groups that are concerned with the accountability agreements and the performance management system. The tools to measure or contract with us to deliver on the OPHS are not in place yet. The expectation is at the beginning of next year the tools will be available.

S. Gates advised that the OPHS is structured in a logic model format with broad goals to be achieved at a societal level. The program review has been structured around the 147 requirements in the OPHS.

While the standards are provincial we need to filter them through the 4 foundational principles. This has formed the basis for our program review process. The 4 foundational standards are need, impact, capacity and partnerships/collaboration. With the release of the new OPHS we need a decision making framework and process to access what we need to deliver and allocate our resources in the most effective manner. The focus of our presentation today is to set priorities for delivery of the OPHS.

In Step 1 we looked at the level of review and had to determine within the 147 requirements whether they could be combined together or separated out by topic. Step 2 was our evidence gathering phase. The program review team has been working with the HIT team on the situational assessment questionnaires. Our capacity and situational assessments are not complete yet and the program review team is still working on those. We are now at Step 3.

Of the 147 OPHS requirements, there were 84 that were assessed for need and impact. There were 63 that we decided were not appropriate because the need and impact criteria did not fit the nature of the requirements. All 147 requirements will be assessed for capacity. In Step 3 we need to set priorities. Once the need and impact assessments were complete they went to the program prioritization committee to be scored. Each criteria has a defined rating scale between 1-5.

B. Fletcher and L. Sowchuk jointed the meeting at 3:24 p.m.

The 5 "need" criteria are morbidity, mortality, risk factors, economic burden of illness and potential consequences, i.e. if a requirement is not implemented, would there be consequences down the road? Vaccine preventable disease is a perfect example of this. We had 4 impact criteria – effectiveness, cost effectiveness, appropriateness, and exclusiveness. S. Gates reviewed the weighting criteria.

R. Haley referred to the 5 new criteria and asked were hospitalizations measured by age? S. Gates stated no, we looked at the top 10 causes of hospitalization in Leeds, Grenville and Lanark. With disease incidents we did look at age standardized rates of occurrence. G. Grewal asked what is the criteria for exclusiveness and appropriateness? S. Gates looked at the intervention and how upstream it was. We want what we do to be primary prevention. We assessed all the interventions to see how upstream they were and they got a higher score if they addressed the social determinants of health. We are looking at duplication of service delivery in our partnership assessment.

F. Kinsella referred to effectiveness and asked if this means a local data related exercise. S. Gates advised that with this criteria we did not use local evaluations on the effectiveness of the activities. We looked at research literature at a broader level.

L. Paine asked is there any benchmarking or best practices done by other health units? S. Gates advised we did not do that. Our effectiveness data was the literature. We did not consult other health units in this review. This will happen when we look at capacity and how to do things more efficiently.

Then we will look at benchmarking. There are no other health units that are undergoing a systematic assessment in this way of these standards. They are not producing a prioritized list of the requirements. S. Gates advised that we are trying to set priorities. That is why we are doing the review this way. That is the difference between what we are doing here and what other health units are doing. Dr. Carter advised that the benefit of using research literature is that research literature involves controlled trials. We can attribute the effect to the intervention.

S. Gates advised board members that everyone was blind to this weighting except for W. Goodridge and J. Cunningham. It was conducted before we did the situational assessment. The 82 SAQs were scored by the prioritization committee. We conducted a consistency review of all SAQs before they were submitted for prioritization.

All of the criteria had a strong or very strong agreement between raters. S. Gates reviewed the total rated scores for the SAQs and the ranked list of requirements.

4. Ranked List of OPHS Requirements:

The total weighted scores range from a high of 446.5 to a low of 255.0. There are 3 types of lists available, overall, from high score to lowest score – which the Board has, then by OPHS program and then by department. The total weighted score represents the level of local need for that requirement and the potential impact of the interventions on the local need.

G. Grewal stated you have healthy eating and healthy weights as 1 and for school it drops down to 19, is that because of the criteria? S. Gates stated it could be the prevalence of the risk factor. She would have to go back to the raw data and see how a certain intervention rated against the other. It is not about what is happening locally currently. The impact score is based on the research literature and the potential impact. We have to look at efficiency and feasibility and include our partner information on what services they provide.

F. Kinsella referred to the list and asked how do you control the amount of physical activity and weight of an individual? S. Gates stated it involves much more than getting individuals to change their lifestyle. Comprehensive school health is about the quality of food in the cafeteria and policies on fund raising. It also includes a skill development portion, but it is much broader. It is effective because of this broad approach. We need to try to change the environment to enable this approach.

F. Kinsella stated that in the program implementation you will create a certain environment. Do we control it or does someone else control it and if they do how do we influence them? Dr. Carter advised that the concept between health promotion in general is, it is not about control, it is about development of population and what our job is as a health unit to work with populations to help them develop their own programs. It is not about controlling anything. We work with people to change things gradually over time.

B. Fletcher stated would the answer to your question not be smoking. All of the programs we have done to educate people, it has led us to a position where we have smokeless public areas. Is that not what it is all about? That is the example he would use. Dr. Carter advised that legislation is part of it, but we cannot legislate a population. We are always working with communities to have a better environment. S. Gates stated that is one of the reasons why we have the public health professionals that we have. We have to have core competencies. Comprehensive health promotion is a very complex and difficult thing that is why we have public health professionals. Our staff do a great job. G. Grewal stated rather than calling it control, it is more like trying to influence.

5. List of Unranked OPHS Requirements:

There are many variables that we will use in addition to the priority list when we allocate our resources. We also do have the unranked list of requirements.

6. Next Steps:

S. Gates advised that the next step is to look at resource allocation. We need some external expertise for this exercise as it is quite complex. We have received expressions of interest and reviewed them and will be sending out an RFP to 2 of the candidates. We will ask them to submit an RFP and to do a presentation for us.

We hope to have a consultant in place by the end of June. S. Gates reviewed the rest of the expected timelines. We hope to implement through September and October to inform the drafting of our operational plans and our 2011 budget. We will implement in January 2011.

Kim Giroux joined the meeting at 4:02 p.m.

J. Butt stated that we are about 5 minutes behind schedule. We will take a short recess before we start the regular meeting.

J. Butt, Chair

Date

H. Bruce, Recording Secretary

Date

c: Board members
HU offices
Municipalities
Shared Drive