



Leeds, Grenville and Lanark District Health Unit

Program Review Guidelines

Description of an Evidence-Based Planning and Prioritization Process

Created by: Quality Improvement Department
6/16/2009

Table of Contents

1. Background.....	3
1.1 Rationale for Program Review and Prioritization.....	3
1.2 Purpose and Objectives.....	4
2. Methodology.....	5
2.1 Program Review Cycle and Overview of Steps.....	7
• Step 1.....	7
• Step 2.....	8
• Step 3.....	14
• Step 4.....	15
• Step 5.....	15
• Step 6.....	16
• Step 7.....	16
3. Stakeholder Involvement	16
4. Timelines	19
5. Prioritization Criteria	21

Appendices *(under separate cover)*

1. Situational Assessment Questionnaires
2. Description of Prioritization Criteria
3. Stakeholder Map
4. Committees Terms of Reference

1. BACKGROUND

1.1 Rationale for Program Review and Prioritization

In 2006, the Board of Health passed a motion for the Health Unit undertake a comprehensive programs and services review in order to justify annual enhancement requests to meet mandated programs and services. At the time of the motion, senior management was aware that the Mandatory Health Programs and Services Guidelines were undergoing a technical review at the provincial level, and recommended that that a local programs and services review be postponed until the guidelines were revised.

Subsequently, the new Ontario Public Health Standards (OPHS) were released in October 2008 with additional requirements and protocols, but without an increase in provincial funding. The new OPHS will require the modification, to varying degrees, of existing programs and services and in certain cases, the development of new programs and services. The Health Unit was never able to achieve full compliance to the Mandatory Health Programs and Services with existing levels of financial and human resources. Therefore, a sound decision making and priority-setting method, based on multiple sources of evidence and proper documentation of the process, is required in order to ensure that decisions made have a strong and documented rationale and resources are allocated in the most effective and efficient manner.

As described in the OPHS, effective public health programs and services take into account communities' needs, which are influenced by the determinants of health. As well, understanding of local public health capacity and the resources required, including collaboration with partners to achieve outcomes, is essential for the effective management of programs and services.¹ To ensure that the Health Unit assesses, plans delivers, manages and evaluates public health programs and services to meet local needs, 4 foundational principles have been included in the new OPHS: need, impact, capacity and partnership/collaboration. These principles are intended to be the lens through which Health Units examine all OPHS requirements.

As well, 2 of the Board of Health outcomes in the OPHS Foundational Standard² state that:

- The board of health identifies public health priorities, including identification of emerging public health issues
- The board of health allocates resources to reflect public health priorities and reallocates resources, as feasible, to reflect emerging public health priorities

¹ Ministry of Health and Long-Term Care. *Ontario Public Health Standards*. 2008.

² *ibid*

Using an evidence based planning process, as outlined in the OPHS, consistently throughout the organization, will help the Health Unit determine the focus for local programs and services based on our local context and allocate resources to requirements based on local need, impact, capacity and partnerships/collaboration. Such a process is strategically aligned with our Moving Upstream goals of evidence-based decision-making and an integrated planning framework.³

As well, the Health Unit has developed an agency program planning and evaluation policy and procedure (v-215-0) states that an “evidence-based approach will be utilized to plan, monitor and evaluate Health Unit programs and services. Planning and evaluation mechanisms that support and ensure effective and efficient programs and services will be in place.” However, there is not a standard method or approach that has been consistently adopted by the Health Unit. A program review process can be developed so that it can be applied on an ongoing basis, after the program review is complete.

1.2 Purpose and Objectives

Priority setting can be defined as a structured process for analyzing, in a standard fashion, all the important factors, alternatives, and problems in a given decision situation and ordering them based on a set of criteria.⁴ Two characteristics of priority setting are as follows⁵:

1. Involves establishing the priority of an item in relation to other items.
2. Priority setting is one step – but not the final step – in decision making process. A list of priorities is of little value in and of itself. Its value lies in the extent to which action is taken based on the list. That action most often involves maintenance, enhancement, reduction or removal of resources on the basis of position of items on the prioritized list.

Setting priorities is not primarily about separating good initiatives from bad ones. It is about establishing the degree of importance or urgency of items within a set of items, all of which may be good or desirable. In the case of the OPHS, all program requirements are mandated and necessary. However, our health unit has limited resources for implementation all of the requirements to the fullest extent possible. Therefore, the primary reason for a prioritization process is to allocate our limited resources to those OPHS requirements which are the most urgent for our local context. Also, pursuing this process, will meet the Board of Health requirements for a comprehensive programs and services review

³ Leeds, Grenville and Lanark District Health Unit. Moving Upstream. Health Unit Strategic Plan. 2006-2010.

⁴ Leeds, Grenville and Lanark District Health Unit. Programme Prioritization Manual. 1994

⁵ Ministry of Health and Long-Term Care. Health System Intelligence Project – 2008. The Health Planner’s Toolkit. Module 7: Priority Setting.

http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_7.pdf
(March 16, 2009)

and is an opportunity to thoroughly review and understand the implications of the new OPHS for implementation of local programs and services.

The **goal** of this process the effective and efficient delivery of programs and services to meet requirements in the new OPHS.

The **objectives** include:

1. To meet the Board of Health's requirements for a comprehensive programs and services review.
2. To systematically assess OPHS requirements based on need, impact, capacity and partnerships/collaboration.
3. To set priorities for delivery of OPHS requirements based on need and impact.
4. To determine the levels and types of human and other resources required for OPHS implementation.
5. To allocate current human and financial resources to OPHS requirements.

The **outcomes** of the process will be:

1. Completed program review
2. Documentation of need, impact, capacity and partnerships for each OPHS requirement
3. Scores for each OPHS requirement based on need and impact
4. Levels and types of staff and other resources needed to implement the OPHS
5. Recommended staffing allocations for each program requirement and standard

2. METHODOLOGY

These guidelines outline the key steps in a comprehensive *program review process*, using an evidence-based program planning and priority-setting method that will meet the above stated objectives and outcomes.

The proposed process is based on the 4 foundational principles in the OPHS document (need, impact, capacity and partnerships/collaboration) and on the Needs Impact-Based Planning Model⁶. Lessons learned from past Health Unit program planning and prioritization attempts and experiences of other health departments have been taken into account. As well, the Health Planner's Toolkit⁷ produced by the Ministry of Health and Long-Term Care will be an important reference throughout the process.

⁶ Final Report of the Needs/Impact-Based Planning Committee to the Ministry of Health Community of Health Division. A Guide to Needs/Impact-Based Planning. April 1996.

⁷ Ministry of Health and Long-Term Care. Health System Intelligence Project – 2008. The Health Planner's Toolkit. Module 7: Priority Setting.

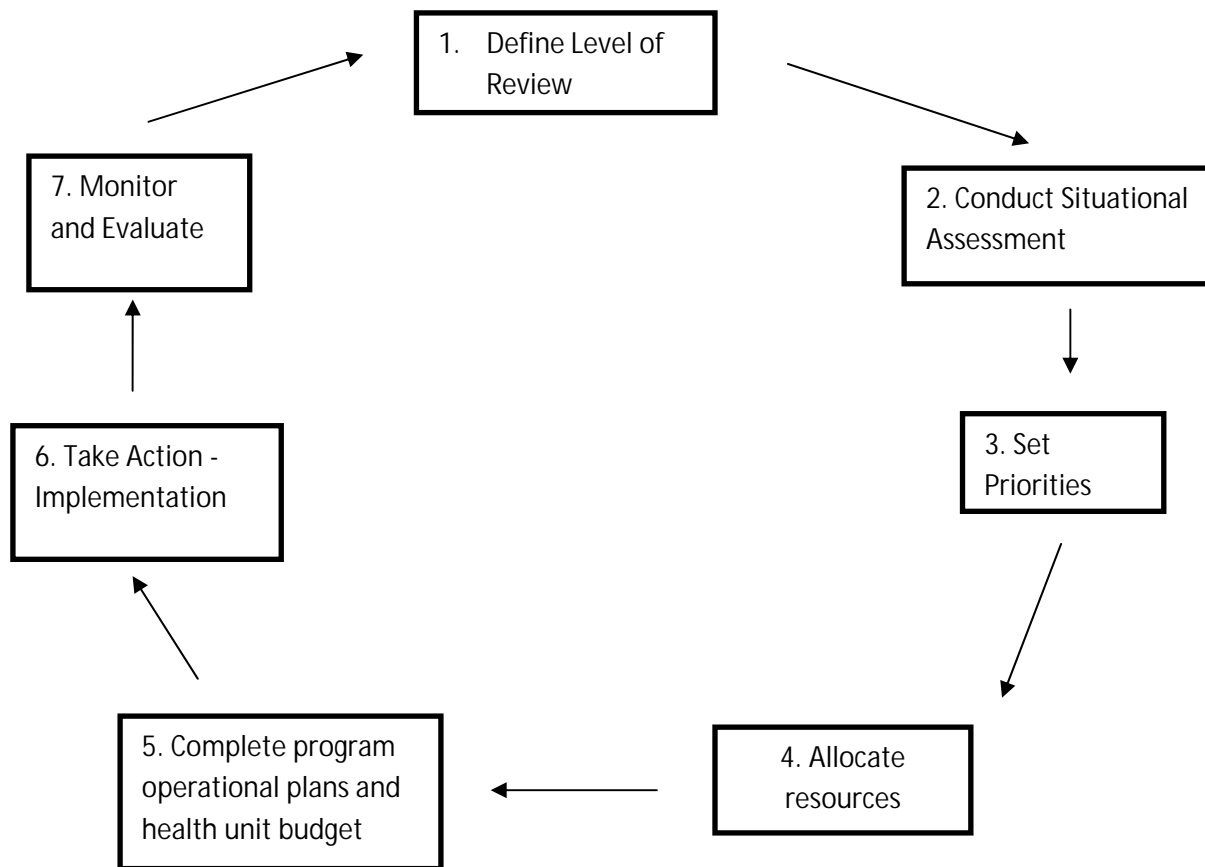
http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_7.pdf
(March 16, 2009)

While the process of prioritization is made to seem quite objective, there is subjectivity at all levels of the process. For example, we are choosing the criteria that should be used and deciding how important each criterion should be and the Program Review Committee will decide how much each requirement conforms to the each of the criteria. The process is not perfect, but is the best attempt to set some priorities for future resources and planning. Every attempt will be made to reduce bias and threats to validity in the process.

The process needs to be based on a number of principles and assumptions, which are as follows:

- The level of prioritization will be the program requirements in the OPHS document. Using program requirements will allow for the allocation of resources within each of 13 OPHS program standards. As well, the data could be analyzed to allow for prioritization between the 13 program standards.
- The Foundational Standard and the requirements for assessment and surveillance in each of the 13 program standards will be exempt from the prioritization process, as implementation of these requirements will provide the necessary data for step 2 (situational assessment) of this process. These requirements will undergo the capacity assessment
- Those requirements that speak to 100% funded programs will not be included in the prioritization process (i.e Smoke-Free Ontario, Healthy Babies Healthy Children).
- The Public Health Emergency Preparedness Standard will be excluded from the prioritization process as well, as the prioritization criteria are not congruent with the nature of the standard.
- All OPHS requirements are equally mandated and enforceable from a legal perspective. Program requirements with protocols are not assumed to be more important and will not take automatic priority over those requirements that do not have associated protocols. Protocols are the “how” of implementation and exist for the requirements where provincial consistency is necessary. However, the capacity to implement the protocols must be considered, as the prescriptive nature of the protocols reduces implementation flexibility.
- All requirements within a program standard will be systematically assessed for need, impact, capacity and partnerships and collaboration, using common questions for each principle.
- The review process is based on the principles of continuous quality improvement, in that it is:
 - Collaborative and participatory
 - Client-focused
 - Flexible and iterative
 - Evidence-based
- The entire process, including the prioritization and allocation of resources will be as transparent a process as possible, while still maintaining the integrity and confidentiality of the prioritization process.

2.1 Program Review Cycle and Overview of Steps



Step 1: Define Level of Review

This step requires reviewing the OPHS requirements (excluding the assessment and surveillance requirements) in each program standard, as well as the associated protocols and guidance documents (and getting ready to conduct the situational assessment. The set of items to be prioritized needs to be determined (i.e – the level of review).

The following steps are to be undertaken in Step 1:

- Assign a lead person to each requirement or group of requirements.
- Decide upon the “level of review” within each program standard.
 - **Combined:** For some programs, it may be logical to combine several requirements together for the purposes of the review. For example, if the requirements would always be implemented together and/or if the same data on need, impact, capacity, and partnerships will be used to assess the program requirements, then it most likely makes sense to combine them for the sake of review.

- **Separated:** On the other hand, there may be some requirements that address multiple risk factors for which there would be different interventions. In these cases it may make sense to do a separate review for the requirements based on the different risk factors.
- **Stand Alone:** Most requirements will be reviewed as one and won't be combined with others or separated out.
- Identify program stakeholders, both internally and externally, who will be consulted in the review.
- Document all information in the Excel spreadsheet that has been developed.

Step 2: Conduct a Situational Assessment

The OPHS glossary describes a situational assessment as influencing planning in significant ways by examining the legal and political environment, stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for a project. The phrase "situational assessment" is now used rather than the previous term "needs assessment". The new terminology is used as a way to avoid the common pitfall of only looking at problems and difficulties. Instead it encourages considering the strengths of and opportunities for individuals and communities. In a health promotion context, this also means looking at socio-environmental conditions and broader determinants of health.

In step 2 of the program review process, Program Review Team members (roles and responsibilities discussed in the next section) will be conducting a situational assessment for each requirement or group of requirements as determined in step one. The situational assessment will involve the collection, analysis and documentation of information on the foundational principles in the OPHS: need, impact, capacity and partnerships/ collaboration.

The situational assessment questionnaire (Appendix 4) will be used to guide the collection of data/information in a consistent and standardized manner. Data/information that is collected in this step must all be documented using the tools provided; as it will be used to inform steps 3 and 4 of the program review process.

2.1 Assess Need

The OPHS document states that public health programs and services must consider the health needs of the local population. Need is established by assessing the distribution of determinants of health, health status, and incidence of disease and injury by ongoing population health assessment and surveillance.⁸ The OPHS incorporates assessment and surveillance requirements into each program standard as a means to assess need. Completing this part of the program review will in essence be completing the assessment and surveillance requirements in the program standards.

⁸ Ministry of Health and Long-Term Care. *Ontario Public Health Standards*. 2008.

To support need, information will be used on the following: demographics; burden of disease, including mortality and morbidity rates; reproductive outcomes; risk factor prevalence; cultural and social behaviours related to health; health conditions (including injury and substance misuse); environmental conditions and hazards; health determinants; and other risks to the public's health.

As stated in the Health Planner's Toolkit, in a conventional needs assessment, choices must be made among indicators, and these choices will have implications for how health need is identified and described⁹. For the purposes of the review, the following criteria/indicators for need have been selected (described further in Appendix 2):

1. Morbidity: The requirement is directed toward a cause of morbidity.
2. Mortality: The requirement is directed toward a cause of mortality.
3. Risk Factors: The requirement is directed toward a risk factor and/or cause that are prevalent in the community.
4. Economic Burden of Illness: The requirement is directed toward a cause/problem with large costs.
5. Potential Consequences: There would be increases in morbidity, mortality and costs if the requirement were not implemented.

The Epidemiologist and Health Information Specialist will be responsible for gathering epidemiological data on morbidity, mortality, and risk factors. However, before the epidemiologist can collect and analyze the data, the following steps must occur:

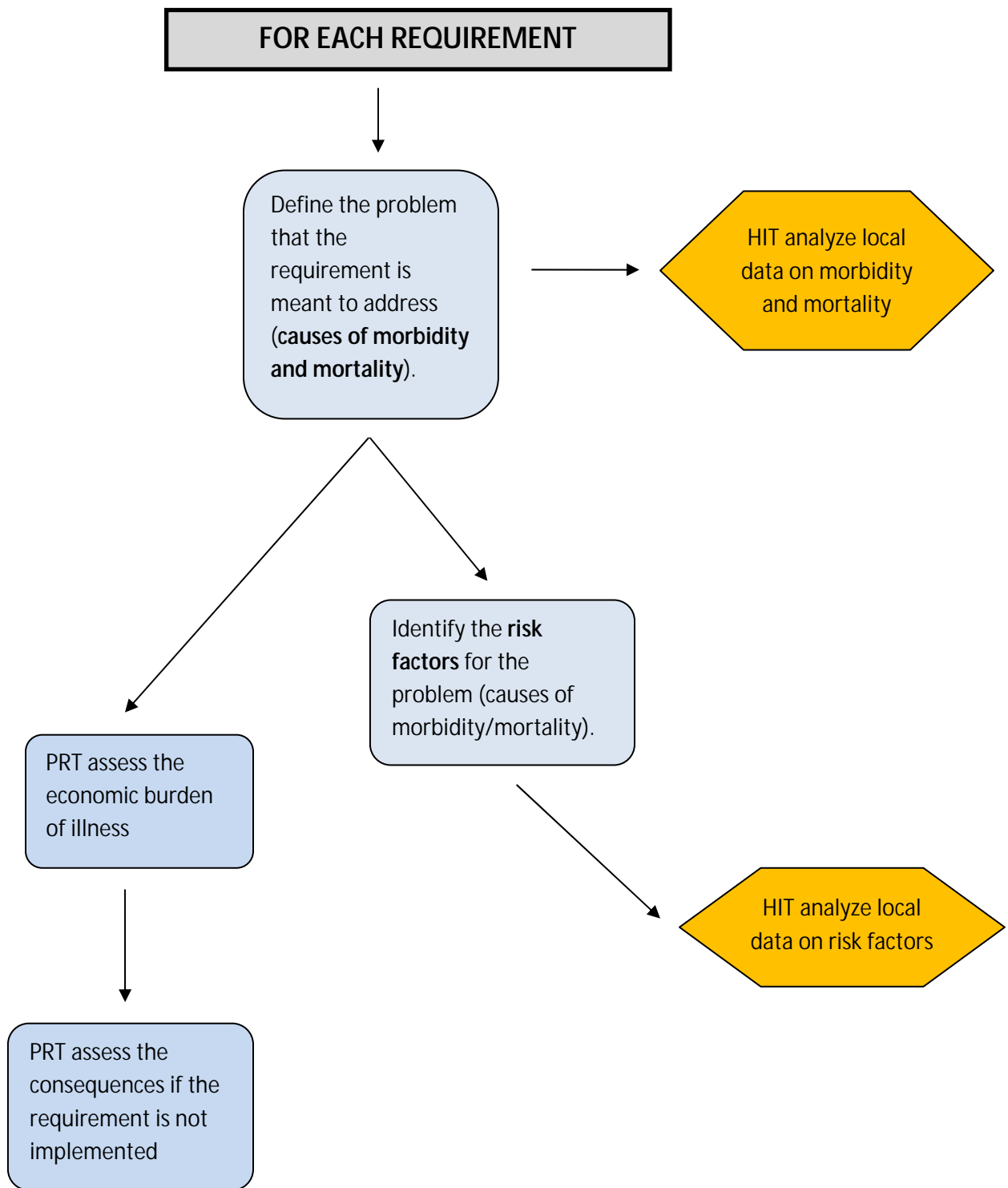
1. Clearly define the problem: i.e. the cause(s) of morbidity/mortality, the risk factors and the priority populations that each requirement is aimed at reducing or eliminating. This information should be documented on the program spreadsheets. Review the surveillance and assessment requirements in the program standard, as these often define the types of data that must be collected. Also, the goal of the program standard will indicate the problem and/or opportunity that is being addressed by each requirement in that standard.
2. Consulting with the epidemiologist, develop a data collection plan, which will include data sources and timeframe.

The figure below depicts the steps to be undertaken in the assessment of need, with the responsibilities of the Program Review Team (PRT) and the Health Intelligence Team (HIT).

⁹ Ministry of Health and Long-Term Care. Health System Intelligence Project – 2006. The Health Planner's Toolkit. Module 2: Assessing Need.

http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_2.pdf
(March 16, 2009)

Figure 1: Steps in the Assessment of Need



2.2 Assess Impact of Requirements/Interventions

This step looks at the potential of the requirement and associated interventions/protocols to make an impact on the need and the outcomes as stated in the OPHS. Therefore, it will be important to have a clear description of the intervention/protocol that will be implemented to meet the requirement. For each requirement it will be necessary to identify potentially feasible activities or “interventions” that will be implemented to meet the requirement in the program. Potential interventions could be the following:

- An OPHS protocol that is referred to in the requirement
- An activity that was previously conducted to meet the Mandatory Health Programs and Services Guidelines
- A new intervention based on evidence from the literature or best practices outlined in a guidance document.

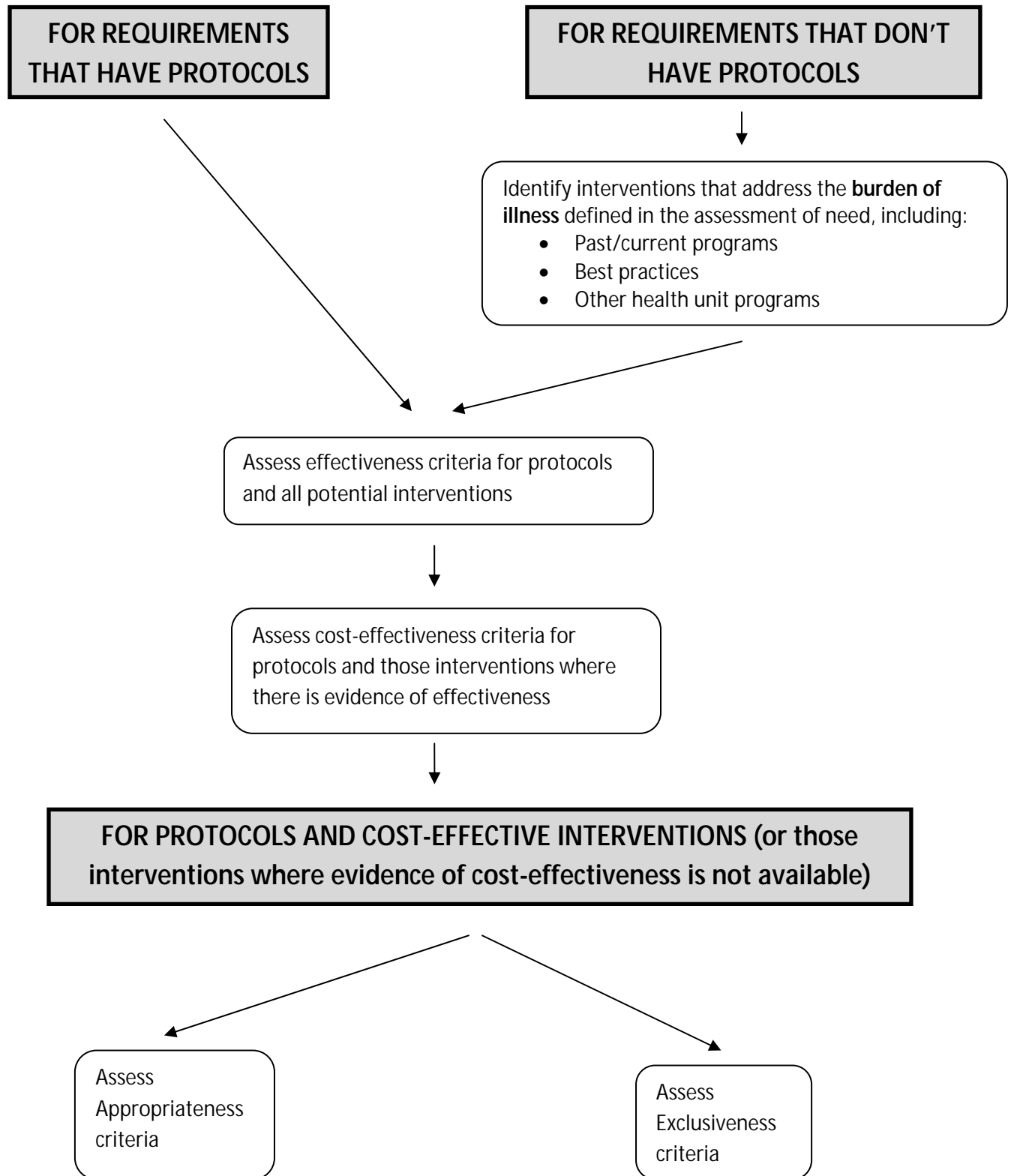
In the OPHS document, impact involves the consideration of several concepts, all of which contribute to the achievement of the best possible health outcomes for the community. Several criteria have been developed to measure these concepts (described further in Appendix 2), as follows:

1. Effectiveness: Evidence of the effectiveness of the intervention in the scientific literature or in the reviews of best practice.
2. Cost-effectiveness: Evidence that the benefits of the intervention/requirement exceed the costs which are incurred in delivering it.
3. Appropriateness: The requirement/intervention fits with the scope of public health in that it is an upstream intervention.
4. Exclusiveness: The Health Unit is the only organization who can implement the requirement/intervention due to skill, scope of practice, legislation, etc.

The data/information on impact must be collected based on the requirement and the potential intervention(s) or protocols that have been selected. The intervention selected must have a direct impact on the problem that was assessed under need. Much of the information for most of the impact criteria can be found in the research literature. Evidence used for exclusiveness would include copies of legislation, scope of practice documents and core competency documents. Collection of data for community capacity will involve some type of consultation with community partners, either through focus groups, interviews or a survey. The Planning and Evaluation Consultant is available to assist program team members in conducting literature searches, interpreting research literature and consulting with community partners.

Once the data has been collected and summarized, program review team members are to complete the related questions of the Situational Assessment Questionnaire. See figure 2 on the following page for an overview of the steps in the impact assessment.

Figure 2 - Steps in the Assessment of Impact



2.3 Assess Organizational Capacity to Implement the Requirement/Interventions

After some discussion internally, it was determined that capacity will inform the implementation of a requirement once it has been prioritized, and is not necessarily a criteria for what makes a requirement a priority. As such, capacity concepts will be considered during step 4, resource allocation, once the priorities for requirements have been set.

Data/information on capacity will still be gathered and documented as part the situational assessment. As described in the OPHS document, the following factors will guide data collection efforts on organizational capacity:

- The amount and type of human resources required (inputs)
- The potential use of volunteers
- Current skill levels of staff and identification of training needs
- Core competency development
- Other financial resources required
- Need for and availability of organizational structures and processes;
- Need for and availability of information and knowledge systems; the accessibility of relevant and timely information

In order to assess efficiency, each intervention will be assessed for potential outputs. Inputs will be combined with outputs for an intervention efficiency measure.

Data/information on capacity should be collected based on the same potential intervention(s) that guided the collection of data on impact. Program review team members will consult with appropriate internal and external stakeholders to collect data to inform capacity. Potentially, an environmental scan of other health units could be conducted, with help from the Planning and Evaluation Consultant. The level of resources required to implement the potential intervention should be estimated, using time tracking data from the past, if available and applicable.

Once the data has been collected and summarized, program review team members are to complete the related questions of the Situational Assessment Questionnaire.

2.4 Assess Partnerships/Collaboration Required for Implementation of the Intervention

The quality and scope of partnerships is important information most appropriately considered with capacity information, during step 4: resource allocation. Information to guide discussions on partnership/collaboration will be gathered during the situational assessment and will help inform the implementation of requirements.

As discussed in the OPHS, the following factors will be considered during the situational assessment of partnerships/collaboration:

- The quality and scope of partnerships within the health sector (e.g., Local Health Integration Networks and primary health care)
- The quality and scope of partnerships within other sectors e.g., education, social services, housing, workplace health and safety system, and environment, voluntary sector, non-governmental organizations, local associations, community groups, networks, coalitions, academia, governmental bodies, the private sector, and others.
- The capacity of our partner organization to continue to work with us in program delivery.

Data/information on partnerships/collaboration should be collected based on the same potential intervention(s) that guided the collection of data on impact and capacity. Program review team members will consult with appropriate internal and external stakeholders to collect data to inform partnerships. Potentially, an environmental scan of other health units and/or some primary data collection with partners could be conducted, with help from the Planning and Evaluation Consultant. The level of resources required to implement the potential intervention should be estimated, using time tracking data from the past, if available and applicable.

Once the data has been collected and summarized, program review team members are to complete the related questions of the Situational Assessment Questionnaire.

Step 3: Set Priorities

In this step, all of the requirements will be systematically reviewed and scored based on the set of 9 pre-defined criteria developed to assess need and impact. These scores will be used as one piece of information, along with capacity and partnership information, in the resource allocation step.

Having criteria in only 2 categories of need and impact, allows for the application of the Needs Impact-Based Planning Model (NIBPM) to the priority setting process. Needs/Impact Based Planning is defined as “planning based on the assessment of the ability of a population to benefit from health strategies directed towards a specific health need.”¹⁰

The matrix can be customized for use in our internal program review process. Each criterion for need and impact will be scored on a scale of 0 to 4 (described in more detail in Appendix 2). A scoring system will need to be developed in order to determine the definitions of high, medium and low need. Because the impact criteria assess more than effectiveness, there may need to be a change the definitions of estimated impact to high, medium, and low based on the scores in the criteria.

¹⁰ A Guide to Needs/Impact-Based Planning. Final Report of the Needs/Impact-Based Planning Committee to the Ministry of Health Community of Health Division. April 1996.

Needs Impact-Based Planning Matrix

		ASSESSED NEED		
		HIGH	MEDIUM	LOW
ESTIMATED IMPACT	WORKS WELL	Must Do	Must Do	Do
	WORKS	Must Do	Do	Do
	MAY WORK	Do If and Advocate for Research	Do If and Advocate for Research	Advocate for Research
	DOES NOT WORK	Stop or Don't Start	Stop or Don't Start	Stop or Don't Start

Once the data on need and impact has been collected for a requirement, the completed situational assessment questionnaire will be submitted to the Program Prioritization Committee for review. Using the prioritization criteria definitions and interpretations (Appendix 2), the requirement will be assessed for compliance to each criterion. Each member of the Committee will do their own scoring for every requirement. Scores will be documented on a scoring sheets, which will be submitted the Epidemiologist for analysis. Results will be given back to the Committee for review and discussion.

Step 4: Estimate and Allocate Resources

In this step, information on capacity and partnerships/collaboration will be reviewed by the Senior Management Committee, along with the ranking of the requirements from step three of the process in order to allocate current health unit resources (human and financial) to each requirement. This information will be given back to department staff for use in the development of 2010 program operational plans.

Step 5: Complete Program Operational Plans

Using the new OPHS operational plan template, 2010 program operational plans will be developed for each program standard. Data from the situational assessment questionnaire may be useful in completing sections of the template, and the resources allocated to each requirement in step 4 can be documented in the plan.

Step 6: Take Action

After the operational plans are complete, requirements and their associated interventions/protocols can be implemented. To support implementation, work plans and logic models can be developed, using templates that will be designed in the near future.

Step 7: Monitor and Evaluate

Program evaluation is a key responsibility in the Foundational Standard in the new OPHS. The following are the evaluation requirements from the standard:

- The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.
- The board of health shall conduct program evaluations when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes.

Staff are encouraged to consult with the Planning and Evaluation Consultant to develop evaluation plans for interventions. A performance monitoring system with associated indicators will be developed after this review in order to guide program monitoring and reporting.

3. STAKEHOLDER INVOLVEMENT

In order for the program review process to be successful, engagement of key stakeholder groups throughout the process is critical. Stakeholder groups will have differing values and needs for the process, as well as different roles and responsibilities. Appendix 3 contains a stakeholder map, which serves as a pictorial representation of the relationships among the different stakeholder groups.

Board of Health: As the process is ultimately accountable to the Board to meet their requirements for a comprehensive program review, ongoing communication with and involvement of Board members is critical. The Board of Health will have representation on a Steering Committee (described below), which will report directly to the Board. Also, the methodology has been presented to and approved by the Board, along with an overview of the costs and benefits of the process. Regular reports on the progress of the review will be shared with the Board at regular meetings. The outcomes of each step of the review process will be shared as the step ends. Other ways of involving the Board in the review process will be considered as opportunities arise.

Program Review Steering Committee: In order to involve external stakeholder groups, such as municipalities and partner organizations, in a formal manner a program review steering committee has been formed, which will be responsible for monitoring the program review methodology, advising the prioritization committee, establishing an accountability strategy (including an appeals process) and establishing a communication and engagement plan. The Steering Committee will be composed of health unit management and staff representatives, Board representatives, municipal representatives and community representatives. (Terms of Reference found in Appendix 4).

Program Review Team: Successful completion of the process will require the commitment of dedicated staff time from each department within the Health Unit for a designated period of time, working in a team environment with leadership from the Quality Improvement Department. The Program Review Team will be made up of designated staff from each department, who will be assigned the role of completing Steps 1 & 2 of the process. The Program Review Team will work with the Health Intelligence Team (Epidemiologist, Planning and Evaluation Consultant, and the Health Information Specialist), and report to the Director of Quality Improvement.

The following will be the roles and responsibilities of members of the Program Review Team:

- Provide input into the program review methodology and prioritization criteria
- Attend training/orientation session – review OPHS document and all materials in advance
- Complete Step 1 and 2 of the Program Review process, working in collaboration with QI Director, HIT Team, Dept. Director and appropriate department staff and community partners.
- Assist department staff in completion of 2010 program operational plans

Program Prioritization Committee (Terms of Reference found in Appendix 4): The Program Review Committee's purpose is to assess all OPHS requirements (excluding surveillance and assessment requirements) using the prioritization criteria and situational assessment information. The committee will consist of: Medical Officer of Health, Director, Quality Improvement Department, 4 Program Directors (Health Promotion, Family Health, Health Protection, and Clinical Services), and one staff representative from each department. The chair will act as a neutral facilitator to keep the process on track and will not rate the requirements and the Program Assistant in the QI Department will serve as the recorder.

Responsibilities of the committee include:

- Attend an orientation on prioritizing and develop skill in using prioritization tool
- Randomly select the sequence in which the programs will be reviewed
- Follow the guidelines for review of the requirements/programs
- Contact department staff for additional clarification of submitted materials as required
- Submit the completed scoring forms to Epidemiologist for calculation of total scores
- Ensure the calculated scores for all requirements are received from Epidemiologist
- Submit the rating scores for all program requirements to senior management committee for the allocation of resources

Each reviewer shares equal responsibility for the process. Responsibilities of individuals on the committee include:

- Review the OPHS, all protocols and the program review guidelines prior to the orientation
- Determine the requirement scores from the materials submitted and available background documents, rather than using their own knowledge or experience derived from health unit affiliations or experience
- Not discussing material submitted, outside the room, to maintain the confidentiality and integrity of the process

Senior Management Committee (SMC): SMC will be responsible for conducting the resource allocation step of the process. Other responsibilities of SMC members in the process include:

- Help establish the Program Review process
- Help select and define the prioritization criteria, determine the weighting and scoring of the prioritization criteria
- Approve, support and commit the time and human resources required to complete the process, as outlined in a workplan drafted by QI Director
- Approve and support the temporary suspension of some Health Unit activities during the program review process, based on recommendations from the QI Director
- Communicate the process to health unit staff, the Board of Health, Ministry of Health and Long-Term Care and other stakeholders as required
- Allocate numbers and types of resources to program standards based on the rating scores for program requirements and programs received by the Program Review Committee

Quality Improvement Department: The QI Director will provide leadership to the process with the following responsibilities:

- Provide recommendations to SMC on the Program Review and prioritization process
- draft and finalize Program Review Guidelines, situational assessment questionnaire, and other necessary documents
- Estimate time and resources involved in the process and prepare a workplan
- Provide recommendations on what activities need to be temporarily suspended for the process to proceed
- Assist with communication of the process to staff and the board of health
- Develop/delivery training/orientation session for staff involved
- Provide leadership and guidance to assigned department staff and HIT Team staff for the program review process

The Health Intelligence Team, which consists of the Epidemiologist, the Planning and Evaluation Consultant, the Health Information Specialist will have the following roles and responsibilities in the process:

- Provide input into the program review methodology and prioritization criteria
- Attend training/orientation session – review OPHS document and all materials in advance

- Work with seconded staff to support the completion Step 1 and 2 of the Program Review process:
 - Develop data collection plan, and any necessary data collection instruments
 - Gather, analyze and help interpret all relevant data
 - Assist seconded staff with completion of the Situational Assessment Questionnaire
- Assist department staff in completion of 2010 program operational plans

Department Directors: The Directors of program departments will have the following responsibilities:

- Appoint department staff to the process, in consultation with the QI Director
- Assist with communication of the process and provide leadership within department for allocation of resources
- Attend orientation/training session -review OPHS document and all materials in advance
- Assist appointed staff with the completion of Situational Assessment Questionnaires, especially for the criteria for capacity
- Authorize the completion and submission of the Situational Assessment Questionnaires completed by seconded staff to the Program Review Committee
- Allocate resources to program requirements based on rating scores for requirements and the number and types of staff allocated to each program standard

Health Unit Staff: Staff who are not directly involved in the program review will be provided with general information and updates on the review. A communication plan will be developed in the near future to include activities for communicating with staff.

4. TIMELINES

The program review process will be conducted systematically for all OPHS program requirements throughout 2009. The aim is to have 2010 program operational plans and Health Unit resources allocated based on OPHS priorities identified through this process. In general, Steps 1 and 2 will be conducted from February to mid-August 2009, while Steps 3 and 4 will be conducted from September to December. The figure below provides a general idea of when each step will be conducted and who is responsible.

Development and implementation of new programs and activities will cease for the duration of the Program Review process. Current 2008 activities that are included in the program operational plans will continue to be implemented. The initiation of new program evaluation projects or data collection requests will be dependent upon their alignment with the situational assessment phase of the program review. As well, the collection, analysis and reporting of compliance data and certain Health Unit wide committee meetings will be put on hold.

Step	Timeline	Responsibility
Step 1: Define Issue	February to April 2009	Program Review Team
Step 2: Situational Assessment	April to August 2009	Program Review Team Steering Committee
Step 3: Set Priorities	September to November 2009	Program Prioritization Committee Steering Committee
Step 4: Allocate Resources	December 2009	Senior Management Committee
Step 5: Complete Operational Plans	November to January 2009	Department Staff and Directors
Step 6: Take Action	January to December 2010	Department Staff and Directors
Step 7: Monitor and Evaluate	January to December 2010	Department Staff and Directors Quality Improvement Department

Starting in 2010 and beyond this same method would be applied for the creation of new programs or interventions and the review and significant modification of existing programs. Using the proposed model assumes a relatively comprehensive analysis and is would not be suitable for minor modifications of activities or minor program changes. However, some stages could be used for this purpose. This model is suitable for planning processes that we are responsible and accountable for. Our expectations may need to be adjusted for community-driven, multi-stakeholder initiatives. In these situations, we may advocate for the use of this model, or parts of it, including the use of some tools but may not be able to fully exercise it.

5. PRIORITIZATION CRITERIA

Process to Select Prioritization Criteria

Prioritization criteria have been established for use by the Program Prioritization Committee. A collaborative process was used to select the criteria. Initially, a list of potential criteria was drafted to measure need, impact, capacity and partnerships/collaboration. The initial list was based on the OPHS principles, the 1994 Health Unit prioritization process, and criteria from the other sources, including: the Health Unit prioritization principles in HUAM, Middlesex-London Health Unit's prioritization process, and criteria suggested by the CDC. The initial list can be found and sources can be found in Appendix 5.

This list was discussed at a meeting with members of the program review team and the program prioritization committee. Based on feedback, the list was further refined and formatted into a survey, using Survey Monkey. The survey was distributed to this same group, in order to rate the usefulness of the criteria and rank the importance of using the criteria in the process. A small working group met to review the results of the survey and narrow down the criteria into a final list, which is found in the table below.

List of Prioritization Criteria

Principle	Criteria
Need	1. Morbidity: The requirement is directed toward a cause of morbidity.
	2. Mortality: The requirement is directed toward a cause of mortality.
	3. Risk Factors: The requirement is directed toward a risk factor and/or cause that are prevalent in the community.
	4. Determinants of Health: The requirement is directed toward reducing health inequities in priority populations.
	5. Economic Burden of Illness: The requirement is directed toward a cause/problem with large costs.
Impact	6. Effectiveness: evidence of the effectiveness of the intervention in the scientific literature or in the reviews of best practice.
	7. Cost-effectiveness: Evidence that the benefits of the intervention/requirement exceed the costs which are incurred in delivering it.
	8. Appropriateness: The requirement fits with the scope of public health in that it is an upstream intervention.
	9. Exclusiveness: The Health Unit is the only organization who can implement the requirement due to skill, scope of practice, legislation, etc.

The working group discussed the principle of capacity and determined that the concepts would inform implementation of requirements and were more appropriately applied to during the resource allocation step of the process once the priorities have been set. As well, the quality and scope of partnerships is important information to be gathered during the situational assessment and will help inform the implementation of requirements, but not necessarily prioritization.

Definition and Scoring of the Prioritization Criteria

Each of the criteria will be defined and the application of the criteria to the OPHS requirements will be described (see Appendix 2). Each criterion will then be given a score from 0 to 4, which will indicate the degree of conformity or correspondence of the requirement to the criterion. Specific scoring and interpretation will be developed based on the definition of each criterion. In general, scores will be assigned as follows:

- 1= does not meet or comply with criteria at all
- 2= meets or complies with criteria a little
- 3= meets or complies with criteria somewhat
- 4= closely meets or complies with criteria
- 5= completely meets or complies with criteria

Each of the scores may then be multiplied by a weight (yet to be determined). This would be done because the criteria are not necessarily considered to be of equal importance in rating a requirement. The weights should not be considered when deciding whether or not a program meets each of the criteria.

In order to complete the needs/impact-based matrix, the categorization of the need criteria as high, medium and low and the impact criteria as works well, works, may work, or does not work will need to be customized to the scoring and interpretation of the criteria.

Further details on the interpretation and scoring will be found under separate cover in Appendix 2.

Fair Priority Setting-Processes: Accountability for Reasonableness

Priority-setting is not only a technical act, it an ethical and a social act. The challenge of any priority setting process is to balance the technical part with the people part. Therefore, people's values and assumptions will come into the process and opportunities must be given for people to express these

values and assumptions. The fairness of the priority setting process is very important, as an ethical issue, as a fair process is more likely to produce fair outcomes and be accepted by the stakeholders.¹¹

The Health Planner's Toolkit suggests an approach called Accountability for Reasonableness¹², as a model to help ensure procedural honesty and fairness in the priority-setting process. Such a strategy for the program review process will be established in the near future.

An accountability **for reasonableness strategy** is comprised of the following 5 conditions:

1. **Relevance:** Decisions should be based on reasons (evidence, principles, values, or arguments) that fair-minded people agree are relevant under the circumstances.
2. **Publicity:** Decisions and their rationales and the processes that led to the decisions should be made publicly and conveniently accessible.
3. **Revision:** There should be accessible opportunities and processes to revise decisions based on further evidence or arguments and there should be a mechanism for challenges, appeals and dispute resolution.
4. **Enforcement:** There should be either voluntary or public regulation of the process to ensure that the other four conditions are met.
5. **Empowerment:** There should be efforts to optimize effective opportunities for participation in priority-setting and to minimize power differences in the decision-making context.

¹¹ Ministry of Health and Long-Term Care. Health System Intelligence Project – 2008. The Health Planner's Toolkit. Module 7: Priority Setting.
http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_7.pdf
(March 16, 2009)

¹² *ibid*