

Background

In 2006, the Board of Health passed a motion for the Health Unit to undertake a comprehensive programs and services review in order to justify enhancement requests to meet mandated programs and services. At the time of the motion, the Mandatory Health Programs and Services Guidelines (MHPSG) were undergoing a technical review at the provincial level, and management recommended that a local programs and services review be conducted when the MHPSG were revised.

Subsequently, the new Ontario Public Health Standards (OPHS) were released in October 2008 with additional requirements and protocols, but without a subsequent increase in provincial funding. The Health Unit was not able to achieve full compliance to the former MHPSG with existing levels of financial and human resources. The release of the OPHS required modification, to varying degrees, of existing programs and services and in certain cases, development of new programs and services.

Therefore, a sound decision making and priority-setting method, based on multiple sources of evidence was required in order to ensure that decisions made regarding the OPHS implementation had a strong and documented rationale and scarce resources were allocated in the most effective and efficient manner.

“If you do what you’ve always done, you’ll get what you’ve always gotten”

— ANTHONY “TONY” ROBBINS

Purpose

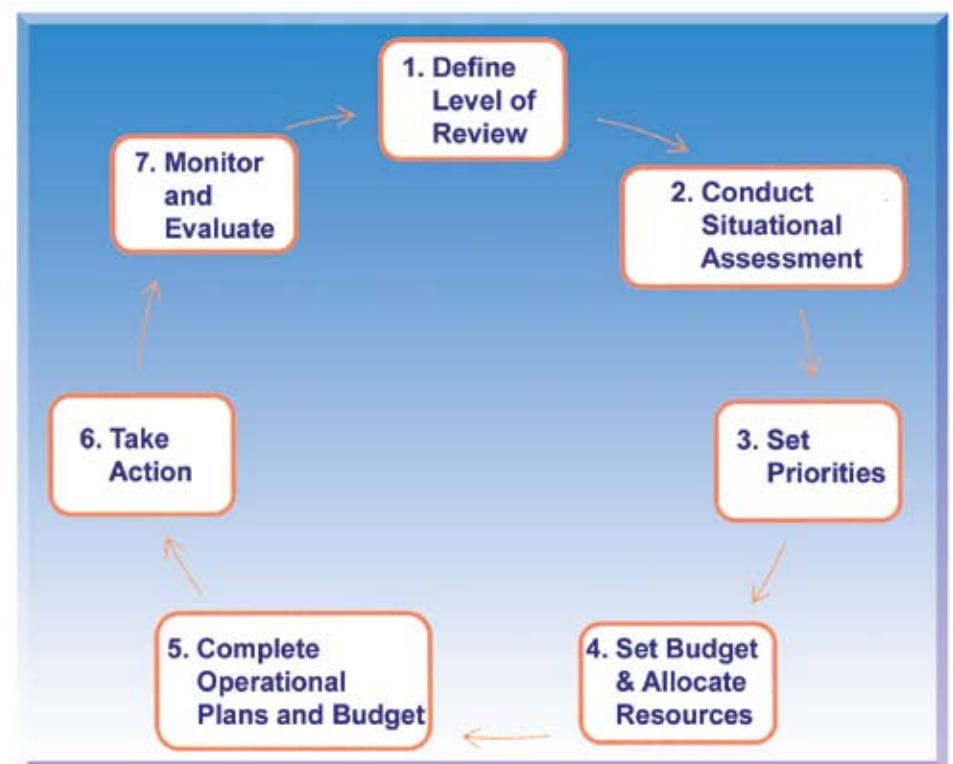
The goal of program review was to ensure the effective and efficient delivery of programs and services to meet requirements in the OPHS. The objectives were as follows:

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

The program review methodology was based on the 4 foundational principles in the OPHS document: need, impact, capacity, and partnerships/collaboration. The *Needs-Impact Based Planning Model*, developed by the Ontario Ministry of Health and Long-Term Care informed the priority-setting step; whereas a process called *Program-Budgeting & Marginal Analysis* informed the resource allocation step.

Figure 1: Program Review Cycle

Figure 1 outlines the major steps taken in the program review cycle, which received Board of Health approval in February 2009. The remainder of this report provides a brief overview of the progress to date on each of these steps.



Step 1: Define Level of Review

Early in 2009, the level of review was determined as the requirements in the OPHS program standards. Due to the iterative nature of the process, the scope was constantly reviewed and modified as appropriate. Excluded from the entire review were certain 100% provincially funded programs, as well as the Land Control program. In order to facilitate the completion of the review internally, implementation of the strategic plan and non-essential committees were postponed.

Development of the methods was initiated and the roles and responsibilities of various stakeholders were defined.

Step 2: Conduct Situational Assessment

A Program Review Team, in collaboration with management staff, conducted 4 situational assessments; one for each of the 4 OPHS foundational principles:

- 1. NEED:** measured the burden of illness in Leeds, Grenville and Lanark based on indicators for each OPHS program standard. Local and provincial data on morbidity, mortality, risk factor prevalence, economic burden of illness and long-term impact was gathered and analyzed.
- 2. IMPACT:** examined research and grey literature on the effectiveness, cost-effectiveness, appropriateness, and exclusiveness of an intervention in addressing the local burden of illness. The data from the need and impact assessments were documented in situational assessment questionnaires (SAQs), which were subsequently utilized in the prioritization step.
- 3. CAPACITY:** completed capacity documents that estimated the human resources required to fully implement the OPHS requirements. This data will inform a long range human resource plan. Departments also completed capacity documents that outlined the minimum level of service required to meet the OPHS requirements and the resources (type of staff and number of hours) required for implementation.
- 4. PARTNERSHIP:** conducted a survey with community partners from the municipal, education, health, and social services sectors, to determine the capacity of community partners to work with the Health Unit to implement OPHS requirements, the effectiveness of existing partnerships and areas of potential duplication of services. The information from the partner survey was compiled into a final report, and will be used to inform OPHS implementation and resource allocation.

Situational assessment began in February, 2009 and was conducted throughout the entire program review process, often in parallel with other steps in the process. The occurrence of the 2 waves of the H1N1 pandemic in the spring and fall of 2009 played a major role in extending the completion of the situational assessment, which was critical to the completion of the program review. In addition to H1N1, the volume of evidence, in the form of research literature and data, required for the assessments extended completion until mid-2010.

Figure 2: Prioritization Criteria

Need

- Morbidity
- Mortality
- Risk Factors
- Economic Burden of Illness
- Potential Consequences

Impact

- Effectiveness
- Cost-effectiveness
- Appropriateness
- Exclusiveness

Step 3: Set Priorities

In this step, the evidence in the need and impact SAQs were scored against a set of 5 need criteria and 4 impact criteria (see Figure 2), using defined rating scales between 1 and 5. The 9 criteria were weighted based on their relative value in the process, using a collaborative approach with key stakeholders. The intent of the criteria were to rate the degree of local need for a requirement and the impact of a potential intervention to address that need.

From February to April 2010, a Prioritization Committee, consisting of 11 staff and management members, scored the evidence in the SAQs according to the prioritization criteria. As scoring was completed individually for each member, consistency testing was conducted and the results indicated very strong or strong levels of agreement between raters for most programs, which provided confidence in the validity of the process. From the individual scores, a total weighted score was calculated for each SAQ. The total weighted score represented the level of local need for the OPHS requirement and the potential impact of the interventions.

Total weighted scores were then sorted to form ranked lists of requirements, overall, by program and by department. The ranked lists of requirements were presented to the Board of Health and staff in May 2010. The ranked list of requirements was used to inform the resource allocation step (setting the minimums and generating ideas for business cases). In addition to the ranked list, need-impact based matrices were produced for each OPHS program, based on a separate need and impact score.

Step 4: Allocate Resources

In May 2010, the Board of Health approved the use of an external consultant to design the resource allocation process and provided funding for such a consultant. Craig Mitton and associates, a team of researchers based out of the University of British Columbia and the University of Toronto, were contracted in June 2010. The consultants customized their Program Budgeting & Marginal Analysis (PBMA) process for the Health Unit and delivered the final report in early August 2010.

In the first step, departments completed capacity documents that outlined the minimum level of service required to meet the OPHS requirements and the resources (type of staff and number of hours) required to implement the minimum level of service. An analysis was then completed to calculate the cost of implementing the minimum level of service, overall and by department. The cost of implementing the minimums was then compared to the dollars available in 2011, to calculate the “gap” (i.e. - difference between the available and the minimum). Initially the overall “gap” was quite large (i.e. 35%). As recommended by the resource allocation consultants, the overall “gap” was eventually reduced to less than 10% in the 3rd version of the minimums submitted at the end of November 2010.

Departments developed business case proposals for disinvestments and investments in late 2010. The nature of these proposals was left to the discretion of the department Director, in consultation with Managers and staff. However, the disinvestments and investments had to be based on the final submission of the minimums and meet targets based on the department specific gap. The business case proposals were marginal in nature, i.e. address marginal increases or decreases to existing programs or the stepwise introduction of new activities. Final proposals were submitted to the Resource Allocation Committee (RAC) for review in February 2011.

The RAC used a set of resource allocation criteria in order to evaluate large service reductions and the investment proposals. There were 12 criteria, within 3 domains

Figure 3: Resource Allocation Criteria

Strategic Alignment Domain

- Duplication of service
- Effectiveness, Efficiency, and Appropriateness
- Access
- Downstream impact on service utilization

Health Impact Domain

- Numbers affected
- Equity
- Population health promotion
- Health protection and disease prevention
- Participant satisfaction

Organizational Impact Domain

- Workplace Environment
- Implementation support or resistance
- Liability

(see Figure 3). The criteria were all defined and a rating scale was developed based on the definition. The rating scale went from -3 to 0 (for service reductions) and from 0 to +3 (for investments). The intent/purpose of the criteria was to rate and score the degree of the IMPACT of the service reduction (negative impact) or investment (positive impact). When developing the proposals, the Director provided an initial score for each criteria. Then the RAC discussed the score and determined if there was agreement on the Director’s initial scoring. The final score was arrived at by consensus in all cases. The criteria were all weighted, to reflect their relative value in the process. The criteria and weights were decided based on input from the RAC and the program review team. A total weighted score was calculated for each proposal: negative

scores for the large service reductions and positive scores for the investments.

To facilitate the decision making process, a ranked list of all the service reductions was produced (Health Unit wide), which sorted the proposals in order of the lowest negative score (lowest negative impact) to the highest negative score (highest negative impact). A similar ranked list of all investments was produced, sorting the proposals in order of the highest positive score (highest positive impact) to the lowest positive score (lowest positive impact).

Once all the proposals were discussed and scored, then the actual resource allocation decisions could be made. The primary objective that had to be achieved was to eliminate the gap between the \$ available and the \$ in the minimums. Once the gap was eliminated, then the next step involved deciding whether to take more large service reductions in order to accept investment proposals. The decision to take further disinvestments was made if the positive score of the investment was higher than the negative score of the service reduction. It was necessary to make the actual resource allocation decisions by position (i.e. – PHI, PHN, etc), because it was agreed that no staff person would lose their job. Therefore, the gap between the \$ available and the \$ required for the minimums had to be eliminated for each type of position, before any investments pertaining to a position were considered.

The next step of the process was to communicate the results to staff and then hold a formal decision review/appeal process. As described by the resource allocation consultants, a formal decision review process is a key mechanism for engaging stakeholders constructively around making difficult allocation decisions and resolving disputes. The overall purpose of the decision review process is to improve the quality of the resource allocation decisions. Staff received communication about the results at the end of February, 2011 and the deadline for submitting appeals was mid-March, 2011. Appeals were reviewed by the Program Review Steering Committee at the end of March, 2011.

Next Steps

The information in the minimums, disinvestments and investments was used to develop 2011 operational plans and program based budget forms.

Once the appeal process is complete and the results are communicated to the appropriate stakeholders, then implementation of programs and services can begin.

Programs and services will be monitored and evaluated according to usual organizational processes. A comprehensive evaluation of the program review process has begun and the results will be used to inform decisions regarding the adaptation of program review tools and processes for ongoing use.

Key Messages

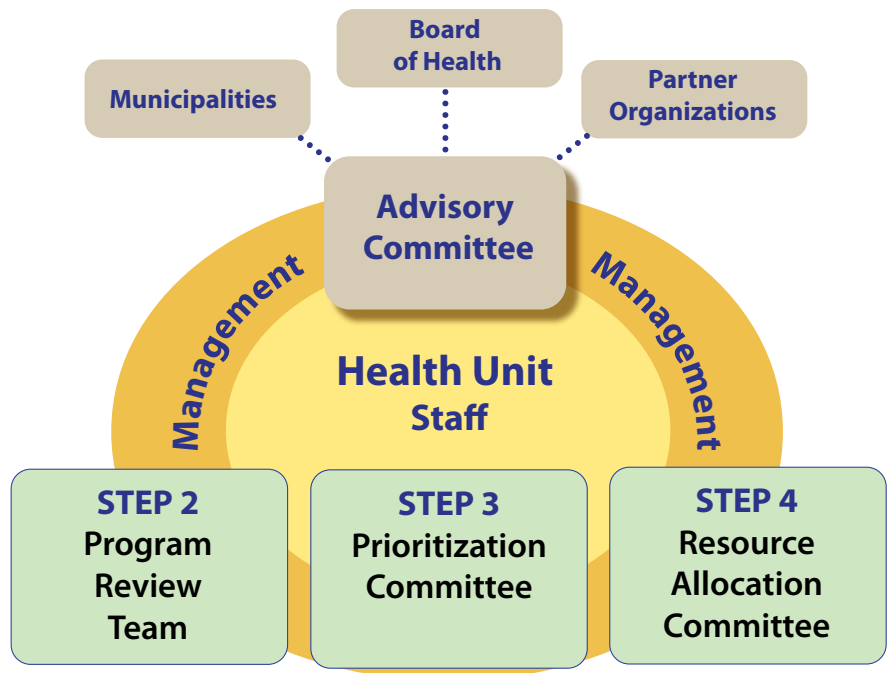
- A ranked list of requirements/activities has little meaning or value in and of itself. Meaning is attached through the allocation of resources. However, the link between prioritization and resource allocation is not straightforward.
- Priority setting is inherently threatening and requires a culture of trust, participation and engagement.
- Both the prioritization process (using a Needs-Impact Based planning approach) and the resource allocation process (using Program Budgeting & Marginal Analysis) are value-added tools for public health in Ontario.



Stakeholder Engagement:

- The program review process utilized a collaborative and participatory process, grounded in continuous quality improvement principles and involving numerous stakeholder groups (see Figure 4).
- Representatives from the Board of Health, municipal government and partner organizations, as well as staff and management representatives, participated in an Advisory Committee, which provided guidance throughout the process and served as an appeal body.
- Numerous health unit staff were involved in various teams and committees, in order to complete the work required for the review. The Program Review Team, consisting of staff representatives from each department, completed the situational assessment (step 2); while different staff representatives participated on the Prioritization Committee (step 3). The Resource Allocation Committee consisted of the management staff from all departments.
- A communication and engagement plan was developed, utilizing a variety of vehicles and channels to keep all stakeholders informed.
- A section on the Health Unit's website has been devoted to communicate key documents and steps. (www.healthunit.org/program_review)

Figure 4: Program Review Stakeholder Map



For more information about the Program Review process at the health unit, contact:

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Leeds, Grenville and Lanark District Health Unit Program Review Objectives, Activities and Outcomes

The program review process consisted of several steps, each step designed to meet a particular objective(s) and outcomes as outlined in the Table below.

Board Objectives	Key Players & Timeline	Activities	Key Outcomes	How this information was/ will be used
1. To systematically assess OPHS requirements based on the foundational principles of need, impact, capacity and partnerships/ collaboration.	<p>Program Review Team, Health Intelligence Team, Steering Committee, Partner agencies</p> <p>January 2009 to May 2010</p>	<ul style="list-style-type: none"> • Program Review Team reviewed OPHS requirements and grouped requirements together or separated them – ended up with 82 requirements • Health Intelligence Team gathered data on need (e.g. morbidity, mortality and risk factors) • Program Review Team gathered information on impact of interventions (i.e., effectiveness, cost-effectiveness) • Program Review Team completed a capacity assessment, to determine the interventions and staff resources required to fully implement the OPHS • Program Review Team conducted survey with community partners to assess the effectiveness of partnerships and areas for potential collaboration 	<p>Increased knowledge about health needs in the community. Increased knowledge about effective programs and services to address the OPHS standards and community health needs. Increased staff skills in evidence based research. Increased knowledge about the resources required to implement the OPHS. Increased knowledge about partnership capacity, effectiveness and potential areas of duplication/collaboration.</p>	<p>Provided evidence to establish minimum level of service and operational plans for each OPHS.</p>
2. To set priorities for the delivery of OPHS requirements.	<p>Program Review Team, Prioritization Committee, Steering Committee</p> <p>January 2009 to May 2010</p>	<ul style="list-style-type: none"> • Developed a priority list of OPHS requirements: <ul style="list-style-type: none"> ○ 9 need and impact criteria were developed to score the evidence provided in the need and impact Situational Assessment Questionnaires (SAQs) ○ A Prioritization Committee scored each SAQ using the criteria ○ A final list ranking all SAQs from #1 to #82 was developed, as well as priority lists by department and OPHS program • Developed a Need/Impact Matrix for each OPHS program standard that grouped health issues and programs into high need/high or medium impact, medium need/high or medium impact which have higher priority for implementation. 	<p>Increased knowledge about priority OPHS requirements that have higher need in LGL, and more effective programs to potentially address that need.</p>	<p>Ranked lists and Need/Impact Matrices were used by Departments when developing minimum service levels for OPHS and business cases for disinvestments and investments.</p>

Program Review Objectives	Key Players & Timeline	Activities	Key Outcomes	How this information was/will be used
3.To determine the levels and types of human and other resources required for OPHS implementation.	Consultants (designed Program Budgeting & Marginal Analysis process), Program Review Team as well as other staff, Directors, Resource Allocation Committee May 2010 to November 2010	<ul style="list-style-type: none"> • Identify what resources would be needed for full implementation of the OPHS requirements: For each OPHS requirement and protocol, Departments reviewed current programs and their impact along with information on community need and evidence on the effectiveness of programs to identify the level of resources required for full implementation of the OPHS requirements. • Established minimum levels of service and the cost of program delivery: Given full implementation was not achievable within the current level of resources, a more realistic measure of the resources required were calculated based on the minimum level of interventions and staff resources required to meet the OPHS requirements and protocols . • 	Increased knowledge about the human resources required to fully implement the OPHS. <ul style="list-style-type: none"> • HU would need 35% more program staff resources to provide the highest level of minimum service to meet OPHS requirements and protocols. The largest gaps from our current resources were for the Chronic Disease and Injury Prevention, and Environmental Health Programs. 	Used to inform 2011 operational plans and budget Will be used to inform long term HR plan Will be useful for strategic plan development
4.To allocate current human and financial resources to OPHS requirements.	Consultants (designed PBMA process), Program Review Team as well as other staff, Directors, Resource Allocation Committee May 2010 to present	<ul style="list-style-type: none"> • Financial summaries were prepared, comparing resources available to resource required for minimums, overall and by department. • Departments had to reduce their proposed minimum level of service to a version which was less than 10% over the available budget to do resource allocation exercise • Disinvestment proposals developed by departments to close gap between minimal level of service suggested and actual 2011 budget. There were 3 types of disinvestments: efficiencies, revenue generation and service reductions. Target for \$ amount of disinvestments was determined for each department. • 12 Criteria were developed to rate proposals to close the gap based on 3 domains of strategic alignment, health impact and organizational impact. • Revenue generation, efficiency proposals, and small service reductions (<\$6500) discussed and accepted. 	Increased knowledge about potential areas for efficiencies, generation of revenue and service reductions with minimal impact on the community and the workplace. 48 Disinvestment proposals completed to close gap from 8.5% over budget to 2011 budget, as follows: <ul style="list-style-type: none"> • Efficiencies (n=20) \$335,685 • Revenue generation (n=3) \$65,843 • Small service reductions (n=7) \$27,809 • Large service reductions (n=16 of 18 accepted) 	Revised minimums with accepted disinvestment and investment proposals will be incorporated into operational plans and implemented beginning in May 2011. Experience with the Program Review process will be used to guide the annual review of programs.

		<ul style="list-style-type: none"> • Large service reductions (>\$6500) rated by the Resource Allocation Committee for negative impact according to criteria. • Investment proposals developed by departments. Target for \$ amount of investments was determined for each department. • Proposals were rated for positive impact according to the criteria. • Made resource allocation decisions, by dividing proposals into 4 separate groupings according to health professionals (public health nurses, nutritionists, public health inspectors, program assistants). • Made resource allocation decisions by accepting enough disinvestments to eliminate the gap and then accepting investment proposals if the positive impact outweighed the negative impact of the service reduction. 	<p>\$379,380.91</p> <p>Increased knowledge about potential areas for enhancing service delivery with maximum impact on the criteria.</p> <p>9 Investment proposals submitted</p> <ul style="list-style-type: none"> • 7 of 9 Investment proposals were accepted \$203,893 	
		<ul style="list-style-type: none"> • Appeals process: The resource allocation decisions were communicated to staff, who then had opportunity to submit appeals for investment proposals and service reductions that were accepted. • 3 criteria for appeals: new data, correction of errors in original decision, procedural inconsistencies • Program Review Steering Committee reviewed one appeal and prepared written response 	<p>Increased engagement of staff regarding the resource allocation decisions and enhanced quality of decisions.</p> <ul style="list-style-type: none"> • One appeal received and heard by Steering Committee. No change to decisions of the Resource Allocation Committee. 	<p>Questions about the process raised in the appeal will be included in the evaluation of the Program Review.</p>

Next Steps

Next Steps	Key Players & Timeline	Activities	Key Outcomes	How this information was/will be used
Implementation	<p>All staff, Directors, Senior Management Team</p> <p>April 2011 onwards</p>	<ul style="list-style-type: none"> • Staff have been working towards completing operational plans, using the revised minimums to inform the plans. • Information from the minimums was used to inform the program based budget submission to the Ministry of Health and Long-Term Care. • Attention is being paid to critical elements of effective change management. • Staff will begin implementing activities in the operational plans • Senior Management Committee will decide if any shifts in staff are required between departments. • Communication plan being developed to communicate to those impacted by changes (positive and negative) – community partners, Municipalities, public, MOHLTC, MOHPS. • Presentation made to Ontario Public Health Convention on April 8, 2011. • Developing checklist to use when considering interventions not in the minimum level of service. 	<p>Provision of effective and efficient programs that meet the health needs in LGL to meet the OPHS programs.</p> <p>Increased comfort levels among staff with transition and changes in departments.</p> <p>Increased knowledge among stakeholders of the results of the Program Review exercise.</p>	<p>Operational Plans are living documents used to outline annual activities to meet community needs with effective and efficient programs.</p> <p>Learnings from change management process will be used with any future change.</p>
Monitor & Evaluate	<p>All staff, Planning & Evaluation Consultant, QI Department</p> <p>March 2011 onwards</p>	<ul style="list-style-type: none"> • Process is being evaluated with feedback from staff, management and the Board. An evaluation framework and staff focus groups have been completed. A staff survey is currently being implemented. • Changes in programs and services will be evaluated to assess the impact on clients and staff. 	<p>Increased knowledge and understanding of program review strengths and areas for improvement. Recommendations for revisions to process for the future.</p>	<p>Information will be used to make improvements to the process for the future</p>