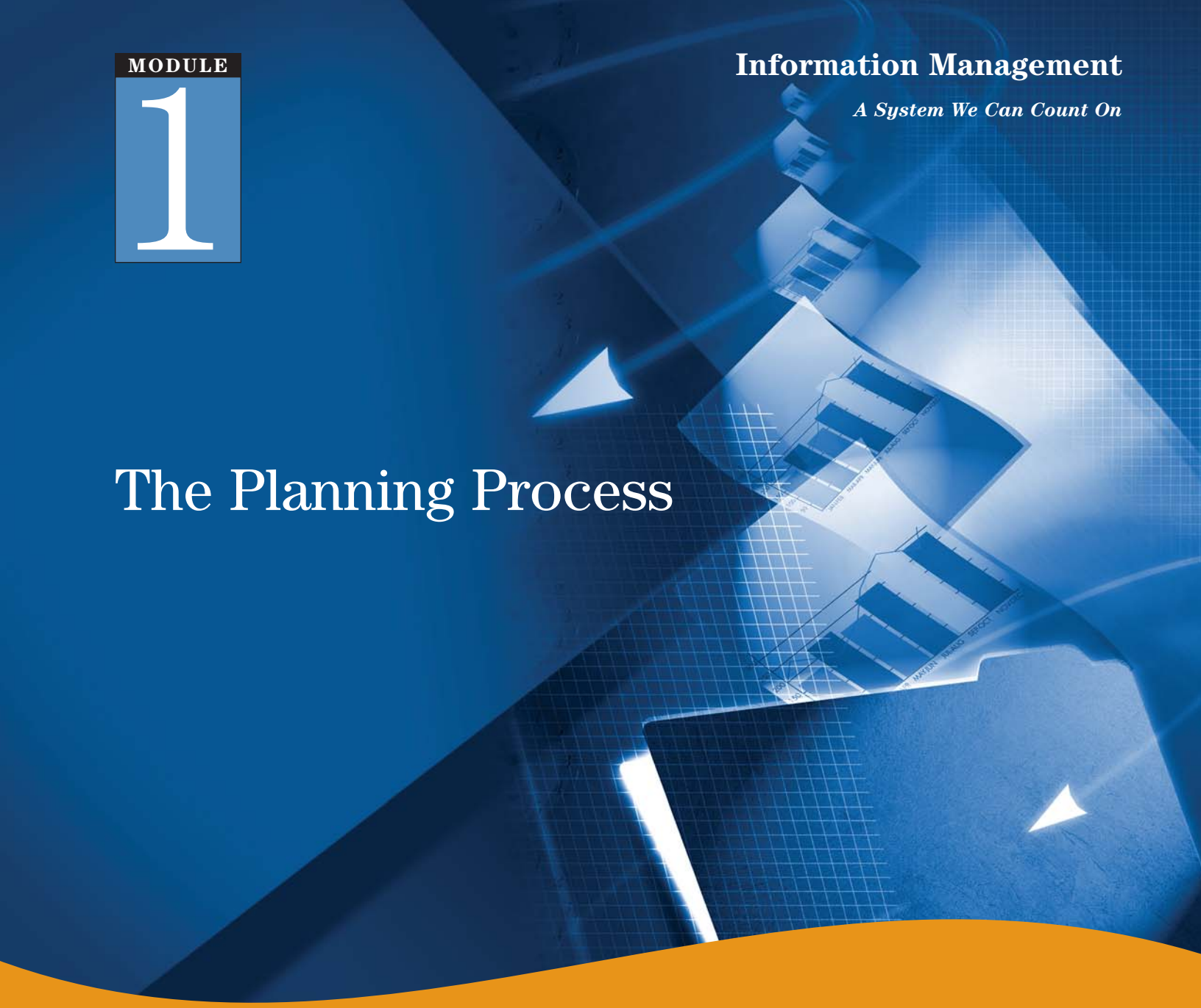
MODULE 1

Information Management

A System We Can Count On



The Planning Process

The Health Planner's Toolkit

Health System Intelligence Project – 2006

Ontario

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About HSIP

Health System Intelligence Project (HSIP)

The Health Planning Toolkit is produced by the Health System Intelligence Project. HSIP consists of a team of health system experts retained by the Ministry of Health and Long-Term Care's Health Results Team for Information Management (HRT-IM) to provide the Local Health Integration Networks (LHINs) with:

- Sophisticated data analysis
- Interpretation of results
- Orientation of new staff to health system data analysis issues
- Training on new techniques and technologies pertaining to health system analysis and planning.

The Health Results Team for Information Management created the Health System Intelligence Project to complement and augment the existing analytical and planning capacity within the Ministry of Health and Long-Term Care. The project team is working in concert with Ministry analysts to ensure that the LHINs are provided with analytic supports they need for their local health system planning activities.

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Acknowledgements

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Which Way To Go?

Maria is a health planner. Her agency has decided that it's time to re-evaluate its role within the health system.

The organisation's board and CEO support an examination of the environment within which the organisation operates and an assessment of its own future within that environment. The outcome will be a plan for the organisation.

They have turned to Maria for advice. What kind of planning makes the most sense, given a tight time frame for looking into the future? Should the agency conduct its planning within a broader framework? Does this framework exist? If not, should the organisation delay its own planning until a broader plan is in place? What values will drive the planning? What should be the role of its partner agencies and its funders in the organisation's planning? What should be the role of its clients? What information is available as raw material for planning? What data doesn't exist but needs to be generated? How should the planning project be managed?

This module is meant to provide a starter kit for Maria as she works with the CEO and the board to turn the general idea of planning into a specific actionable planning process.

> "Common sense is the knack of seeing things as they are, and doing things as they ought to be done."
>
> *– Harriet Beecher Stowe*

This Module's Purpose And Summary

Health planning comprises a range of activities that share the goal of improving health outcomes, or improving the efficiency of health services provision, or both.

Health planning occurs within the pressured environment of political direction, changing public expectation, new information and evidence about outcomes, and on occasion, media headlines. A solid and well-designed health planning process will be resilient enough to accommodate these pressures and to use them as levers to go forward to dialogue and solutions for improved health care provision and health outcomes in the population.

This module lays out the four types of health planning:

- health system planning
- health services planning
- health goals planning
- and population health planning.

It also describes characteristics and uses of strategic and operational planning as well as the differences between them.

There are critical success factors for every planning activity. How these weigh in will be different for each process. A list of critical success factors such as defining the question, planning within an ethical framework and establishing effective project management are included in this module. Other factors such as engaging stakeholders and use of information are dealt with here and in separate modules to provide a greater depth of information and advice.

This module's ideas and recommendations are designed to provide insights into the health planning challenges, processes and outcomes, and to help those who lead or participate in health planning activities to select the appropriate framework for their work.

> "If you don't know where you are going, any road will get you there."
>
> – Lewis Carroll,
> *Alice's Adventures in Wonderland*

What Is Planning?

A plan is defined as a map, as preparation, as an arrangement. Planning defines where one wants to go, how to get there and the timetable for the journey. Planning can also identify the journey's milestones. Complete planning sets out indicators for tracking progress and ways to measure if the trip was worth the investment.

Charting a course, navigating and keeping a travel log are all parts of a good planning process. Broad elements of planning are therefore:

- identifying a vision and goals
- undertaking strategic planning
- and evaluation.

Section 1

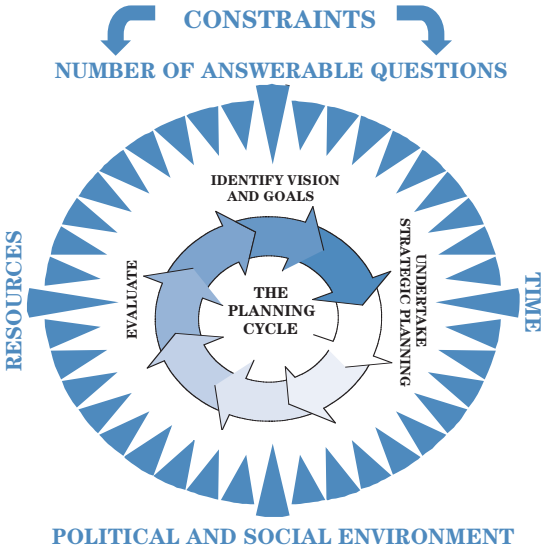
What Is Health Planning?

Health planning is a process to produce health. It does this by creating an actionable link between needs and resources. Its nature and scope will depend upon:

- the **time allowable**
- the **number of answerable questions** to be addressed within the process "answerable questions" comprise questions that are worth asking and for which there is evidence to allow them to be answered (see Module 2, **Assessing Need** and Module 3, **Evidence-Based Planning**, for insights into approaches and tools used in answering questions)
- the **resources available** to support the process
- the **broader political and social environmen**t.

There are three broad elements in a planning process; identifying the vision and goals, undertaking the strategic plan, and evaluation. Planning occurs within four potential constraints, creating a tension in many planning processes – a tension between what **ought to be** done and what **can be** done.

Figure 1: Constraints and Opportunities in Planning



The health planning process itself can be a deliverable.

1.1 Who Does Health Planning?

The health planning process occurs within the health service sector, usually initiated by government or bodies delegated by government to manage health resources in an area, such as a Regional Health Authority (see Module 2, **Assessing Need**, for an exploration of the "social model" for health that underlies government involvement in planning). Local Health Integration Networks (LHINs) in Ontario are designated to manage local health planning efforts.

A health planning process may also be led by service providers such as mental health agencies, hospitals, public health agencies and other service providers to help them define future roles or immediate service goals. Toronto teaching hospitals are a good example of a group that has undertaken member planning on key delivery areas such as neurosurgery and vascular surgery.

Professional associations (nurses' or physicians' organizations for instance) may also establish planning processes to address areas of interest to them. An example is the Canadian Medical Forum's work on physician supply. As well consumers, through advocacy groups, forums or other processes, promote their needs to the government and thereby seek to increase or influence allocation of health resources.

This module is primarily focused on the first group cited above – governmental and local health authority management group planning.

1.2 What Is Health Planning's Main Deliverable?

The outcome of an effective health planning process should be an actionable link between needs and resources.

The health planning process itself can be a deliverable. A good planning process reflects necessary perspectives and engages key stakeholders in the development of strategies. Through that process, some of the initial marketing of the changes required will be accomplished.

1.3 What Are The Steps In A Health Planning Process?

At its core, health planning follows the same basic steps that any planning process follows. In health planning these steps constitute a cycle that is normally repeated in terms of planning for programs, systems, populations or health goals. Repetition of the cycle is usually necessary because any or all of the following conditions prevail:

- Definitions of what constitutes "health" will change, necessitating planning to take into account the effect of the new definition on society's health goals.

- New techniques and technologies to create, restore or support health emerge continually, so planning must be cyclical to integrate these emerging innovations into the planning process.

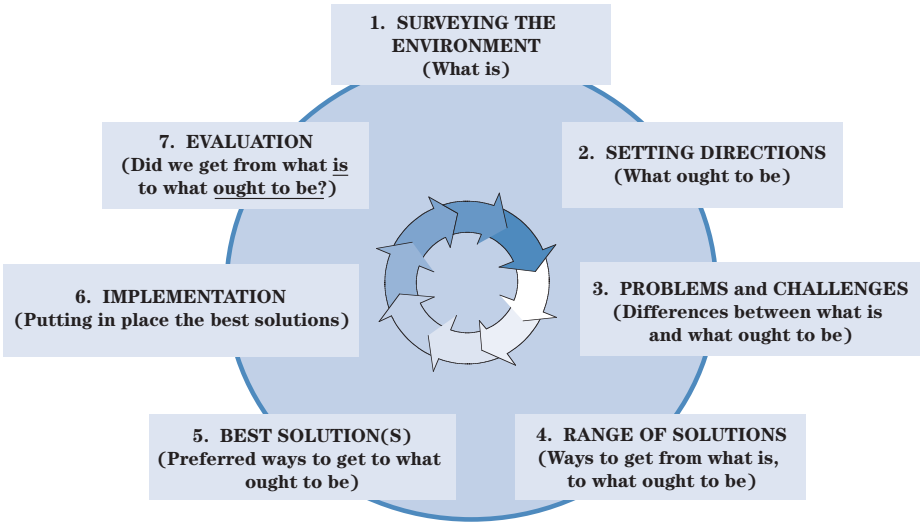
- Unforeseen health conditions emerge (a rapidly spreading infectious disease for example), requiring a new planning cycle to factor in these conditions. Similarly, emerging social conditions (an increase in child poverty for example) can have implications that require a new planning cycle to deal with the health effects of the change.

- Changed economic conditions may necessitate a new cycle of planning. If a major economic downturn occurs, for instance, a population's health may decline at the same time as governments constrain their spending on health – making a new "lean times" planning cycle necessary.

- Evaluation of the results of a planning cycle will often show weak spots in the initial planning, necessitating new cycles to correct for past oversights and miscalculations.

Most planning cycles (health or non-health) comprise seven basic steps that can be shown graphically. See figure 2

Figure 2: The Planning Cycle



Step One – Surveying the Environment:
This often involves extensive information gathering to determine the health or illness profiles and experiences of the population of interest. It is meant to identify the **current state** of the issue under consideration.

Step Two – Setting Directions:
This involves setting goals and objectives, and it also involves establishing the standards against which current health/illness profiles, or current organisational or system performance, will be compared. This step is meant to identify the **desirable future state** (expressed as outcomes if possible) for the issue under consideration.

Step Three – Problems and Challenges:
This involves identifying and quantifying the shortfalls (if any) between what is and what ought to be.

Step Four – Range of Solutions:
This involves identifying the range of solutions to each identified problem or challenge. This step should also include assessing each possible solution in terms of its feasibility, cost and effectiveness so alternate solutions can be compared with each other.

This step often requires significant creativity, since no off-the-shelf solutions may be available for some problems and challenges.

Step Five – Best Solution(s):
This step involves a choice of the solution, or set of solutions, that should be implemented to address the problems or challenges identified in step three. The choice may need to take into account fiscal, political and other limitations.

Step Six – Implementation:
This step involves implementation of the chosen solutions, and often begins with development of an implementation plan.

Step Seven – Evaluation:
This step involves evaluation of the results of implementation to determine whether the implemented solutions are effective in achieving their goals. It also involves evaluating the environment to see if it has changed, thereby rendering the solutions less effective, more effective or irrelevant. This step may begin with development of an evaluation plan well before evaluation actually takes place. It may also involve development of ongoing monitoring methods to be used to continuously identify and assess the intended and unintended consequences of implementation actions.

> Planning steps may seem linear, but feedback loops must be created between and among the steps so planning can deal with the real world's complexities.

These steps are listed as if they were purely linear steps, but feedback loops must be created between and among them; the complexities of the real world mean that what seems to make sense at one step may make less sense when seen from the perspective of a later step.

For instance, during step two (setting directions), planners may set a target for health improvement, only to find in step four (range of solutions) that none of the solutions comes anywhere near achieving the target without a change in provincial policy about how a service can be provided. The planner may therefore need to set a lower target (i.e., a target achievable within current policy), while also recommending that provincial policy be changed and that the target be changed if and when policy change takes place.

1.4 Turning Plans Into Actions

Some might argue that planners are only involved in the first five steps:

1. surveying the environment
2. setting directions
3. identifying problems and challenges
4. identifying the range of solutions to problems and challenges
5. identifying the preferred solution(s).

However, planners have a stake in understanding and helping to shape implementation and evaluation, and they may be called upon to lend a hand in both these activities.

Organisational analyst Henry Mintzberg suggests that planning (particularly strategic planning) often fails because it is not allied with or embedded within the strategic centre of an organisation (he argues that planning is about analysis, while strategy is about synthesis).[1]

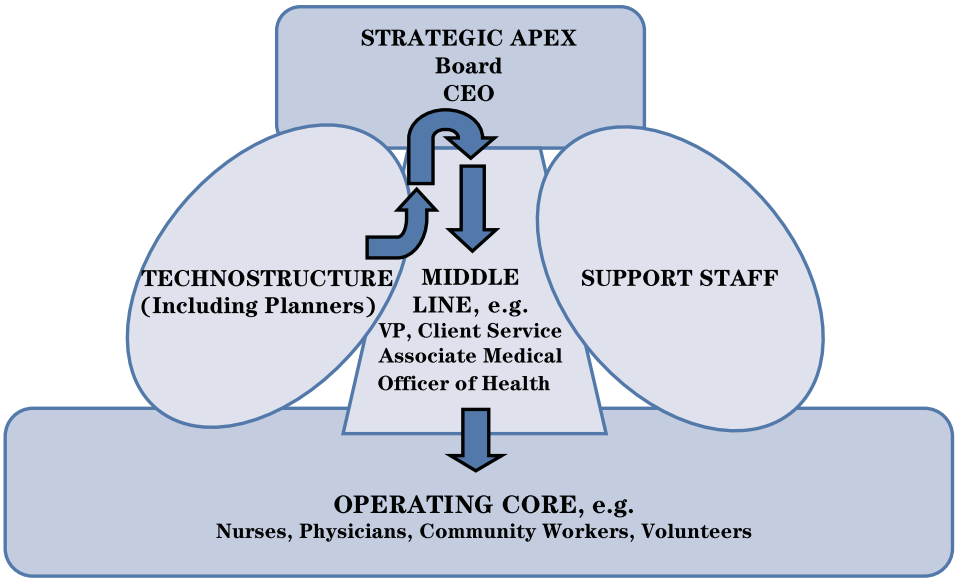
At the very least the planner should be aware that within his/her organisation or system, planners are often off to the side and that:

- decisions made on the basis of planning will be made not by planners but by what Mintzberg calls the strategic apex of the organisation or system

- the results of the planning will need to be embedded within the operating core of the organisation or system.

Mintzberg's schematic depicting organisational subunits can be used to show the usual relationship between planners and decision-makers in terms of making planning effective. This schematic is organisation-focused but a similar schematic could be created for system-level activity. See figure 3.

Figure 3: The Plan-to-Action Path



NOTE:

- **The arrows show the typical flow of findings and advice from planners, through the middle line, board and management, to the organisation's operating core.**
- **If the findings and advice are not embedded as action in the core, then planning has been largely ineffective.**
- **In most instances the findings and advice must also be embedded in all other subunits (strategic apex, middle line, technostructure and support staff subunits).**
- **If the planning project has worked well, then representatives from the strategic apex, the technostructure, the support staff, and the operating core have all been involved in the planning and "own" its outcome.**

Section 2

What Are The Types Of Health Planning?

Health planning includes several specific, often connected, types of planning:

- **health system planning.**
- **health goals planning**
- **health services planning.**
- **population health planning.**

The connections among the types of planning can be shown graphically (see figure 4).

Each planning type includes both strategic and operational planning methods and approaches. The decision as to what planning methodology to follow depends upon the issue at hand. Data and information are a key element to any type of planning, as are stakeholder input and consensus building (See Module 2, **Assessing Needs**, and Module 3, **Evidence-Based Planning**, for concepts related to information as raw material for planning).

The following sections of this module describe the four types of planning outlined above.

2.1 Health System Planning

In Canada, a recognised goal of government is to fund an efficient and well-organised *health system*. The system itself is usually planned at the provincial government level, and by provincial agents such as regional health boards. Health "system" implies:

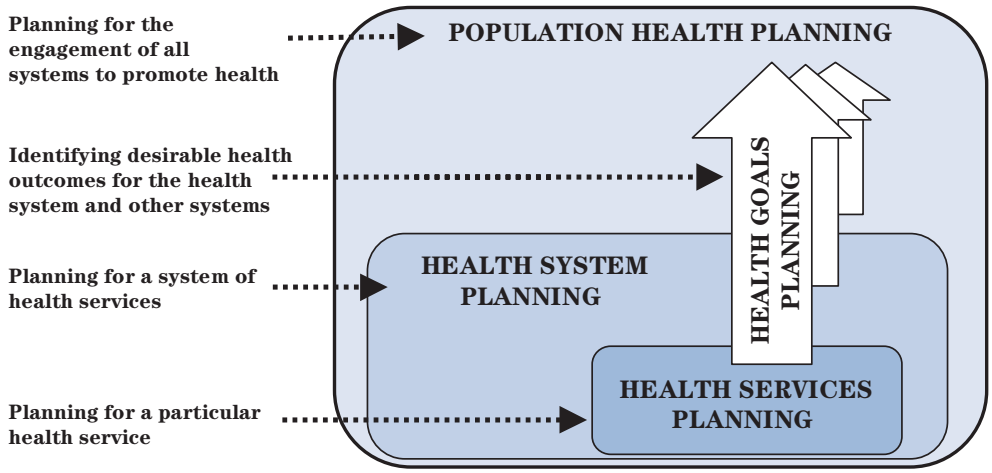
- client access to a range of appropriate, and appropriately connected/integrated, services
- operational efficiency and a sustainable operation.

A well-organised and functioning system of health services is like the connectivity of the human body system. Both require:

- command centres
- a supportive contextual infrastructure
- and a series of linked and inter-supporting activities.

An excellent example of how one area connects and manages its population health goals with health services is the integration planning carried out by the Vancouver

Figure 4: Connections Among Planning Types



Island Health authority (VIHA), show schematically in Figure 5.

There are two essential phases of health systems planning:

- the design and system development phase
- implementation of the system management and operations components.

> Health systems planning has the most potential for payoff in improved health as it can include both health services and population health within its strategic directions.

A health system cannot be achieved via a one-time organisation of providers. It is necessary to establish mechanisms for the ongoing running and adjustments of the system, just as the brain continues to regulate the functions of the body.

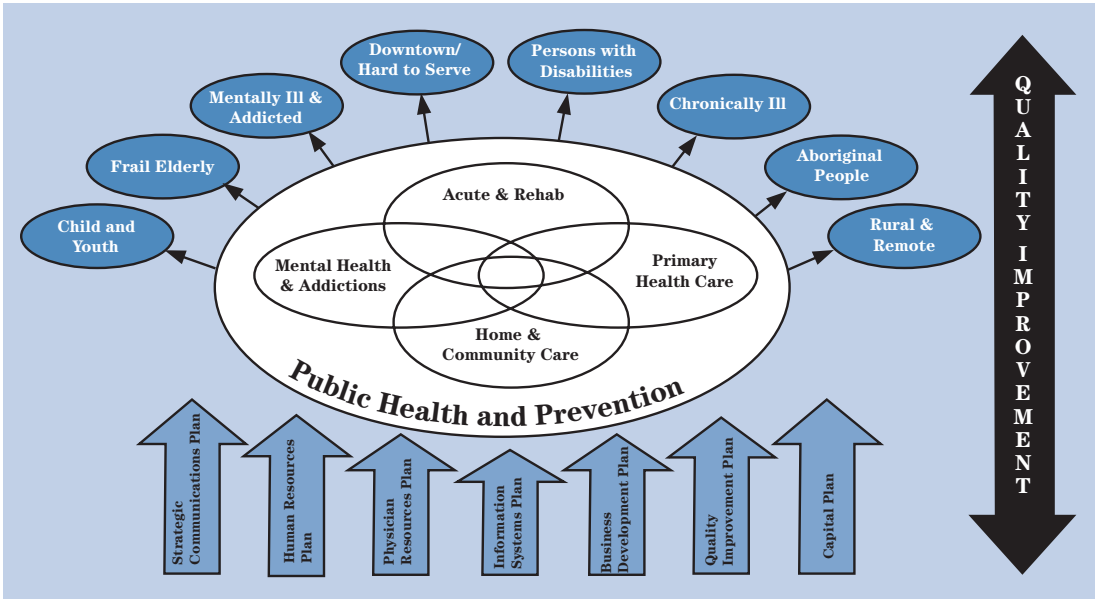
Health system or systems planning is the most complex type of health planning. It requires a clear and politically supported vision for the delivery model and the support of service providers to make it happen. Health systems planning has the most potential for payoff in improved health because it can include both **health services** and **population health** within its strategic directions.

Alberta attempts to link these by including public health within the regional health authority structure. The province of Alberta Health and Wellness states that the mandate of regional health authorities is to *"promote and protect the health of the population within the region, and to work to prevent disease and injury."* [2] It further notes that the Province's health authorities must meet provincial public health targets.

2.2 Health Services Planning

Health services planning relates to a specific type of service or sector – mental health service delivery for example. This type of planning can be undertaken by government or devolved to providers. The Mental

Figure 5: Integration Planning, Vancouver Island Health Authority



Adapted from Vancouver Island Health Authority, Integration Plan 2007.

Health Implementation Task Forces convened across Ontario in 2002/03 are a good example of taking a specific sectoral approach to service planning. It represented a combined planning effort on the part of government, providers and client advocacy groups. The Task Forces' work was a strategic planning exercise that produced several options for system design and implementation approaches.

At a different level (i.e. providers rather than funders) some providers such as community health centres and hospitals undertake health services planning related to their particular piece of the delivery pie. In some cases they do it with other organizations in the same field, but in many cases they do it within the context of their own overall budget and organisational priorities (that is, separate from a system-wide priority or role setting exercise). This planning may be an output of the strategic directions of the organisation, but is usually considered as program or operational planning.

2.3 Health Goals Planning

Ontario's health goals exercises in the seventies and eighties focused on several broad health goals and were often reflected in such initiatives as Healthy Communities and Healthy Cities initiatives. These had varying levels of success but were important in engaging municipal government and provider groups, as well as citizens, in discussion of the broader determinants of health.

Beginning in 2004 the federal government introduced a Canada-wide consultation process to identify health goals for the country, which presumably will be addressed locally reflecting local needs and opportunities. These goals can be considered part of any local health system planning exercise and will offer a macro framework for health goals and how to establish and report on them. Appendix A provides more information on this process and its initial findings.

In the United States, healthy community activities have evolved into a national umbrella focus on empowering local areas to work on health goals and priorities. An excellent resource for health goals and priority setting and for health planning in general, can be found in the Healthy People 2010 Tool Kit produced by the Public Health Foundation, Healthy People Initiative. See Appendix B for the initiative's seven action areas and for the short form of the health priorities checklist developed by the initiative.

More recent groundbreaking work has been initiated in the area of health impact assessment. A relatively new concept in North America, it is gaining momentum as a way to assess the relationship between plans for co-ordinating cities' growth and economic strategies with opportunities to create health among citizens.

Health impact assessment is a promising but challenging form of health planning because it requires the co-operation of people and institutions beyond the formal health system in determining what problems need to be addressed and how these problems can be addressed, as well as implementing preferred solutions.

Appendix C provides an overview of methodology and potential Ontario approaches in health impact assessment.

2.4 Population Health Planning

The World Health Organization's definition of health is relevant to all health planning, but particularly underlines the population health approach.

Ottawa Charter[3] – In the wake of the Charter's adoption, a new approach to improving and promoting public health was developed: *Settings for Health*. This approach emphasises practical networks and projects to create healthy environments such as healthy schools, health-promoting hospitals, healthy workplaces and healthy cities[4]. *Settings for Health* builds on the premise that there is health development potential in practically every organisation and community. This message again relates to healthy communities initiatives and enlarges the circle of partners working to improve health status among the overall population of a given area. Tackling broader determinants of health and moving away from the idea that health services alone can produce the desired improvement in health of the population is key to understanding health goals and population health processes.

World Health Organization Definition Of Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The above definition has not been amended since 1948 but was expanded in the Ottawa Charter in 1986.

The Ottawa Charter defined health promotion as *"the process of enabling people to increase control over and to improve their health."*

The Charter identified five priority action areas:

1. build healthy public policy
2. create supportive environments
3. strengthen community action
4. develop personal skills
5. reorient health services.

The population health concept is commonly used as a tool for public health (whose focus in Ontario has shifted away from one-on-one care to more broad education and health surveillance activities) and for others interested in health promotion activities. Population health starts from the premise of understanding and then improving the health status of a particular population or the population of a community as a whole.

Strategic planning for population health usually focuses on macro issue identification and related strategy development. The federal government uses health status information to prioritise and target interventions (e.g. teenage smokers) and to develop strategies for broad proactive public awareness (e.g. social marketing campaigns about lifestyle).

Local public health units do operational planning to implement specific programs such as increased TB screening centres.

As noted above, the federal initiative around health goals will presumably impact decisions locally about target population health improvement areas.

An evidence-based approach to population health planning can be found in the needs/impact based planning model. This model outlines a comprehensive method to plan based on the needs of the population. The approach comprises even steps and can be used at provincial, regional/district and community service levels.[5] Appendix D provides a diagram of this model.

Population health planning has its genetic roots in groundbreaking work done in Canada in the 1970s that resulted in the publication by the federal government of the report *A New Perspective on the Health of Canadians* (1974), commonly known as the Lalonde Report after Marc Lalonde, who was at that time Canada's Minister of National Health and Welfare. This report first put forward the **health field concept**. As the report describes it:

"…the health field can be broken up into four broad elements: human biology, environment, lifestyle and health care organization. These four elements were identified through an examination of the causes and underlying factors of sickness and death in Canada, and from an assessment of the parts the elements play in affecting the level of health in Canada."

The Lalonde Report is found at http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/perspective.pdf.

Section 3

What Are Critical Success Factors In A Health Planning Process?

3.1 Defining the Right Question

The foremost critical success factor in a health planning process is to ensure that the question being addressed is the "right" question. What is meant by the "right" question?

The planning question should:

- be specific to the actual advice required
- be posed in terms that are easy to understand (e.g. free of unnecessary adjectives and acronyms)
- be at the correct altitude, to ensure the issue is expressed in the way that will elicit the maximum relevant advice.

> Hospital X operates two sites in two different small communities. Along with hospital Y, who operates a small hospital in a third community, they have proposed to pool assets and build a new site in the most economically advantaged of the communities, where a large donation to the foundation can be expected from a local industry.

Consider the following scenario and three potential questions for a health planning body:

- **Question 1:** What would be the impact of this move on the three communities?
- **Question 2:** What are the health needs of persons in the area currently being served by the three hospitals?
- **Question 3:** What would be the optimal configuration of hospital and community services to meet the current and projected future needs?

In this case it is reasonably predictable that access patterns would change, and that people in at least two communities would fear loss of service and claim bias related to economic status. Thus the first question, while important, will be stalled in the politics of the communities and the ethical considerations of any perceived reduction of access to service change. By proactively addressing the larger second question, the planning process would provide a more useful framework for looking at overall resource allocation in that area from a population perspective. Based on answers to the second question, the third question can then be properly answered, leading to identification of gaps and duplications, and helping to create service plans for both hospital and community services.

> "Alice said very gently, 'I should like to look all round me first, if I might.'
>
> 'You may look in front of you, and on both sides, if you like,' said the Sheep; 'but you can't look all round you – unless you've got eyes at the back of your head.'"
>
> Lewis Carroll, *Through the Looking-Glass*

3.2 Choosing the Process Relevant to the Task

The second critical success factor is to decide what type of process is to be undertaken – usually a decision between strategic and operational planning. The outcome desired will define the planning focus – that is, whether it is a systems level task or service/program level task.

> The desired outcome will define the planning focus.

Regardless of which type of planning process is established, the discussions and strategies proposed must be based on best available data, usually a combination of health status, demographic and utilisation data used in tandem with qualitative data obtained from activities such as surveys and key informant interviews. These are then aligned with knowledge about best practices as identified in evidenced-based literature or based on successful local initiatives.

3.3 Engaging Stakeholders

The third key success factor is to decide who needs to be engaged in the planning and how the engagement will occur. The stakeholders who participate in the planning process are key to its success. Generally a range of perspectives should be at the table. When engaged in broad system planning at a strategic level, the goal will be to have experienced and recognised leaders and thinkers from the health sector, challenged and augmented by representatives from areas such as consumers, academia and the private sector.

There are several advantages to bringing together a diverse group:

- a broad range and depth of issues are explored
- the intended and unintended consequences of system change are considered
- the broader group will itself represent integrative thinking
- champions will emerge from a successful planning process.

Shorter term planning processes are often necessary when dollars become available toward the end of a fiscal period or when new funding announcements are made, requiring a quick plan for use of these resources. In these instances it is expeditious to have the issue experts and current service providers (hospital clinical leaders, physicians) help develop the response. The plan will thus be driven primarily by provider realities and existing implementation opportunities.

3.4 Establishing Effective Project Management

A fourth critical success factor for health planning is effective project management. Process design and implementation, a key aspect of project management, should stimulate useful discussion and debate among key participants, who will be persons with knowledge relevant to the issue at hand. These persons may all be within the governmental or funder area (such as a tri-ministry committee), or may be multi-sector stakeholders brought together as part of a local systems process. In either case, dialogue may have to be coaxed out, or strictly managed to a tight time frame. The methods used to facilitate and build consensus within the discussion process will make or break the dynamics of the planning process.

Some of these tools are noted within Section 7 and within this module's appendices. Module 5, **Community Engagement and Communication**, provides more material on building consensus in the context of community engagement.

3.5 Planning Within an Ethical Framework

An overlooked but important success factor in any planning project is transparent presentation of the project's ethics. Ethics in health planning is assumed, but not necessarily appropriately so. It is essential that the assumptions underlying decision-making processes be clearly stated. And as Module 2 (**Assessing Need**) points out, choosing amongst values is inevitable when determining measurement tools.

> "'Tut, tut, child!' said the Duchess. 'Everything's got a moral, if only you can find it.'"
>
> – Lewis Carroll, *Alice's Adventures in Wonderland*

Assuming the right people are at the table, the right questions and information are addressed and the outputs are responsibly handled, the process will usually seem to have been done in an honest and ethical manner. Within this consideration, it will be easier to promote the ethics of a broad-based open input planning process than one that is done entirely behind the closed doors of the funder. However, even in the latter case, the results can be seen as sufficient as long as they are accompanied by explanation of data and evidence to support directions that have been determined.

Within the new LHINs in Ontario (given their stated commitment to involve local areas in health priority-

setting and funding activities) challenges will likely arise related to funding decisions. Therefore an ethical and consistent decision-making approach will be important. Dealing with resource decisions in a tight health care funding environment implies that some may gain while others may appear to lose from planning outcomes. The integrity of the process will be in question if the process is, or seems to be, poorly balanced in terms of its participants or founded on inadequate information.

Perhaps the most broadly debated health priority setting exercise was undertaken in Oregon in the early 1990s. As two authors who examined the Oregon experience put it, *"The Oregon Plan has been widely heralded as an innovation in health policy as the first public insurance program to ration medical care explicitly, systematically, and openly by denying coverage for health care services."*[6]

In the Oregon initiative the state government undertook a consultative process to determine what the public thought was most important to be covered by the state's Medicaid budget. Advocates for groups such as people living in poverty and people with HIV/AIDS challenged the appropriateness of this process and what they saw as rationing of health services to the most disadvantaged. However, according to some studies the Oregon experiment successfully engaged Oregonians in thinking about hard decisions and efficacy of health care interventions, and it resulted in higher funding levels for health services in the state rather than cost savings. Nonetheless the whole dispute has been characterised as advocates of transparency pitted against advocates for the most disadvantaged.

It is essential that the assumptions about decision-making processes be clearly stated.

For more about the Oregon experience and its relevance for other jurisdictions, see Appendix E.

3.6 Accessing and Applying Relevant Information

A taxonomy of human service planning information would include the following types of information.

"Hard data":

These data include many kinds of information used in both traditional and newer planning methodologies. Hard data include:

- **Demographic data** (what are the characteristics of a population?)
- **Epidemiological and social indicator data** (what are the characteristics of social problems and health disorders within a population?)
- **Inventory data** (what are the numbers, types and characteristics of human service resources for a population – including the cost of these resources and the linkages among the resources?)
- **Utilisation data** (how does a population use those resources?)
- **Outcome data** (what changes in social and health status do these resources produce for populations?)

Attitudinal and behavioural information:

This is information on the beliefs and attitudes of consumers and of providers concerning human service systems - it is the "sociology of well-being". For instance, a consumer may believe that physicians are better helpers than other human service professionals, and may behave on the basis of this belief by seeking out a physician rather than another professional, even in the face of hard outcome data suggesting that another professional (a nutritionist for example) may yield a better outcome for that consumer.

Ignoring attitudinal and behavioural information may produce a plan that makes logical sense based on hard data, but which is impossible to implement because:

- it flies in the face of what people believe and how they act
- or because it does not build in provisions for changing outmoded attitudes and behaviours.

Expert opinion:

Both consumers and providers can be experts - a consumer may well be the expert on what it is like to be a consumer – and the provider may be an expert on specific approaches to improving social well-being and health.

Often these kinds of expertise are not easily codifiable as hard data, but they are still valuable sources of information. If one were planning an improvement in respiratory health, for instance, consumers might provide expertise on the emotional burdens of chronic lung disease. Similarly, a renowned environmental specialist might have great expertise in helping disadvantaged populations experiencing high rates of asthma.

Political process information:

Human service issues are often political, in terms of formal electoral politics as well as the politics of powerful stakeholders, particularly in formal human service systems. Knowledge of formal positions taken by political, bureaucratic or other social groupings may make the difference between a plan that will be implemented and a plan that will remain on a shelf.

In short, each of the information types can be characterised as follows:

- Hard data – the **facts** of human services
- Attitudinal and behavioural information – the **sociology** of human services
- Expert opinion – the **wisdom** of human services
- Political process information – the **politics** of human services.

Using a Taxonomy:

Whether an information taxonomy uses the categories of information outlined above – or any other set of categories – it can prove useful in helping planners make informed decisions about what kind of information to gather at each stage in the planning process.

Figure 6: Relative Volumes of Information Matrix

Information Type / Planning Stage [7]	Hard Data by Type					Attitudinal & Behavioural Information	Expert Opinion	Political Process Information
	Demographic	Epidemiologgical	Inventory	Utilisation	Outcome			
1. What ought to be?								
2. What is?								
3. Problems/ challenges (#1 minus #2)								
4. Range of solutions								
5. Best solution(s)								
6. Implement								
7. Evaluate								

Often a simple matrix can help a planner or planning group decide what kinds and relative volumes of information should be gathered at each planning stage. See figure 6.

3.7 A Commitment to Monitoring and Evaluation

Planning is often cyclical, in the sense that one cycle of planning leads into the next cycle, so that planning is a continuous and iterative process that takes into account:

- changed circumstances
- the effects of implementation of previous planning.

> "'I see nobody on the road,' said Alice.
>
> 'I only wish I had such eyes,' the King remarked in a fretful tone. 'To be able to see Nobody! And at that distance too! Why, it's as much as I can do to see real people, by this light.'"
>
> – Lewis Carroll, *Through the Looking-Glass*

However, one cycle of planning cannot learn from previous cycles unless monitoring and evaluation processes are put in place to determine the effects of previous planning cycles.

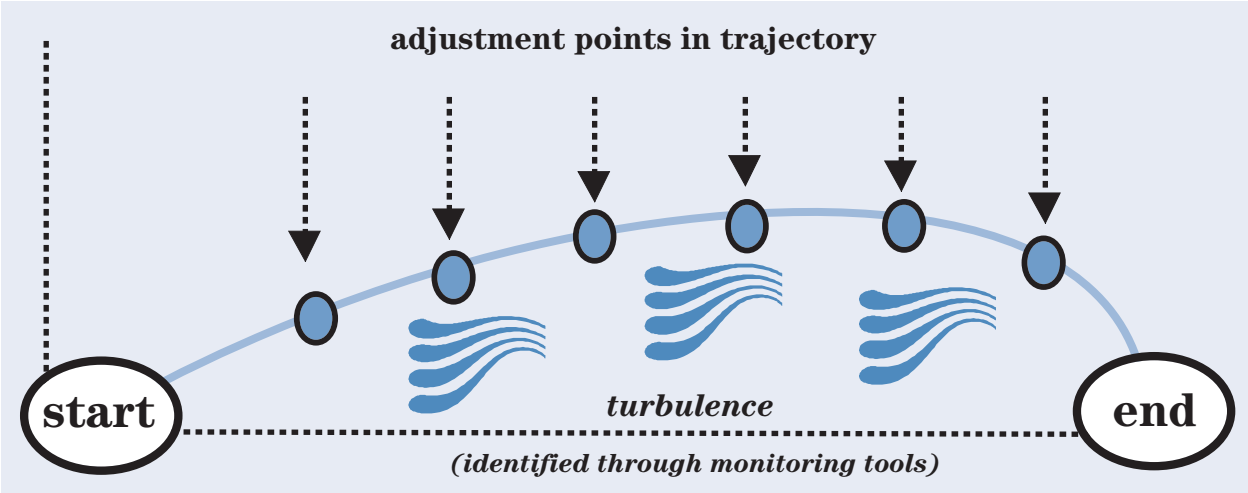
Many planning processes make it part and parcel of the process to identify the monitoring and evaluation processes and tools that are needed and to exert influence to ensure these processes and tools are developed and used.

One interesting variation on the use of monitoring and evaluation is "trajectory planning". This way of thinking assumes that the implementation of any planning may encounter **turbulence** – much like the headwinds or tailwinds that aircraft experience during their trajectory from take-off point to landing point. See figure 7.

Trajectory planning uses monitoring tools to:

- identify turbulence
- determine whether that turbulence will aid or impede achievement of the plan's goals
- provide the basis for "mid-flight corrections" to help ensure that the plan achieves its goals.

Figure 7: Trajectory Planning



Section 4

What Is Strategic Planning Versus Operational Planning?

4.1 Strategic Planning

A strategic planning process is used when there is a broad and open question to be answered, and many paths are on the table - for example, identifying the desired model for delivery of children's mental health services in rural settings and determining how to move to that model.

> … a vision should be renewed every three to five years.

Usually a strategic planning process assumes a new look at an issue, and an outcome that will take time to put in place but will exist for a period longer than one funding cycle. Generally speaking it is assumed that a strategic plan will need to be revised or redone when the context in which the service exists changes markedly. A change in context could relate to challenges to sustainability, opportunities to expand, or newly identified best practices that should be incorporated into the plan. An example would be the opportunity to design locally relevant multi-agency centres for children's mental health services within the context of the new LHIN areas.

A basic guideline for planning is that a vision should be renewed every three to five years and the strategic directions emanating from that vision also re-evaluated, perhaps yearly. A strategic planning exercise will include strategic goals and directions, and in some cases may also include specific implementation or operational planning components. For example in establishing a new local system of children's mental health services, specific budgets, service expectations, timetables and human resource models may be designed by the strategic planning group, for hand-off to providers.

The Vancouver Island Health Authority (VIHA) Health Services Plan is an excellent resource document that can be found in its entirety on the VIHA web site at www.viha.ca. The figure below illustrates VIHA's strategic planning approach, which calls for initial priority action areas, then yearly establishment of strategic directions within an umbrella framework.

Figure 8: Vancouver Island Health Authority Strategic Plan Model

Adapted from Vancouver Island Health Authority, Integration 2005.[8]

The VIHA Five-Year Strategic Plan sets the overall direction for future service delivery to 2010. It charts the move toward enhanced integration, responsiveness and innovation for all health services across the region. In particular it outlines:

- priority issues in the health authority
- critical challenges to population health and service delivery in the VIHA region
- goals and strategic themes that will guide service delivery
- strategic directions by sector and by geographic area.

The Plan advances strategic thinking to include organisational restructuring, new and innovative service delivery models, and future capacity forecasts. It is aligned with the strategic direction of the Ministry of Health, recognises the significant differences in demographics and health status throughout the health authority, and reflects clinical input and practical experience.[9]

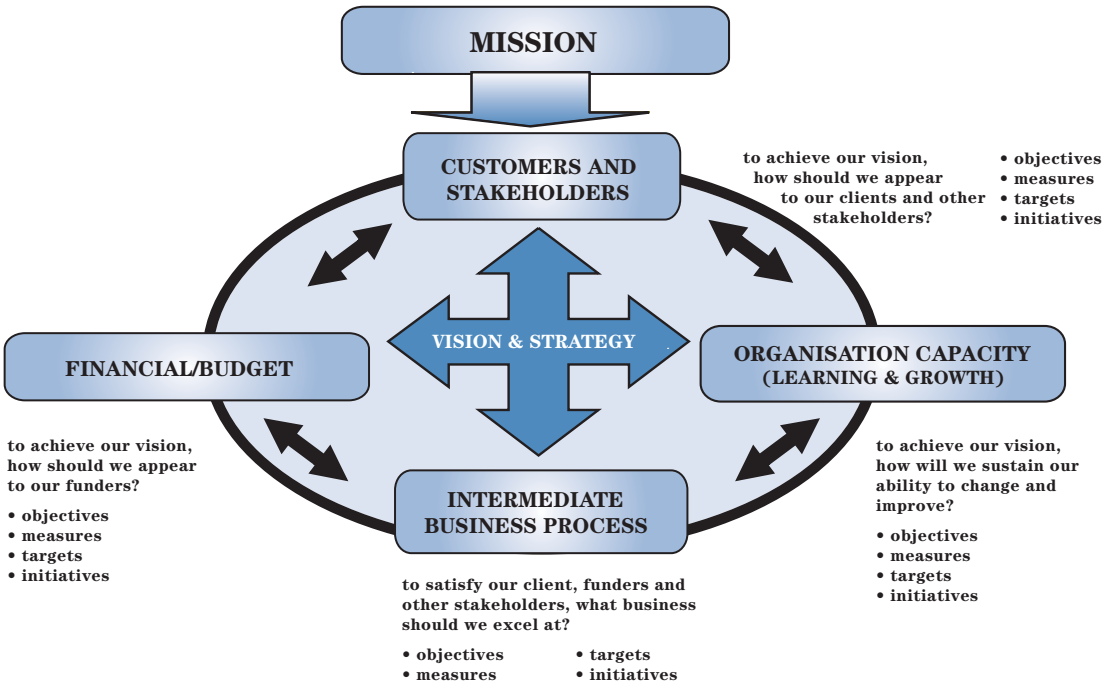
4.1.1 Strategic Planning Process Components

Within any strategic planning exercise the following activities will occur:

- a visioning exercise
- creating mission and goals
- establishing objectives
- establishing strategic directions
- developing a framework to establish and monitor success – a balanced scorecard approach for instance (see figure below)
- creating an implementation plan/timetable.

Although originally developed for the corporate sector, the balanced scorecard has become popular within the health sector as a tool for both planning and monitoring. The balanced scorecard suggests that an organization be viewed from four perspectives, and that data collection and analysis be carried out relative to each of these perspectives. See Figure 9. In some instances it has taken

Figure 9: Public Sector Balanced Scorecard: The Four Perspectives



Adapted from H. Rohm, Balanced Scorecard Institute[10]

the place of a more formalised and longer-term evaluation exercise. For more on the application of a balanced scorecard see Appendix F.

Strategic planning processes should be supported by:

- use of data, both quantitative and qualitative
- consultation with stakeholders (related to all parts of the process, from visioning to data interpretation and crafting recommendations)
- application of project management and facilitation tools, which may include activities such as SWOT (strengths, weaknesses, opportunities and threats) analysis, mind-mapping and strategic alignment models
- monitoring and evaluation protocols.

Appendix G provides a sampling of these strategic planning tools.

4.2 Operational Planning

An operational planning process starts from a point of a specific objective, for example to increase the number of clients served through a primary care clinic at a Community Health Centre, and focuses on the range of opportunities within that delivery framework.

Operational planning will include:

- statement of purpose/deliverables/target to be achieved/success indicators
- use of available and relevant data and information
- stakeholder engagement (who needs to fund, deliver expanded services?)
- selection of priority action approach (new program design)
- developing an implementation timetable and budget.

Evaluation goals – process or outcome, quantitative or qualitative, must be considered at the front end of any new initiative.

Operational planning processes may be supported by activities or tools similar to those for strategic planning but with a tighter question applied to these activities. Included in operational planning could be use of an activity hierarchy model and a program logic model.

Evaluation goals – process or outcome, quantitative or qualitative – must be considered at the front end of any new initiative.

Appendix H provides information on operational planning tools. Appendix I offers information on evaluation relevant to both strategic and operational planning.

Section 5

Other Useful Information

Planning is an art as well as a science. Keeping in mind the science/art duality will keep planning processes balanced and realistic. Project management courses are widely available but health planning is not as well understood. In reality the two disciplines must be successfully combined.

In both areas there is seldom a straight-ahead road with no bumps or diversions along the way. The challenge of adaptability will always exist and meeting that challenge is critical to successful planning. The following subsections cite examples of adaptability issues.

5.1 Comprehensive Planning Process Versus Hurry Up and Go!

In establishing a process to address a need or opportunity, there may not always be time for a pure, comprehensive and linear planning process. Decisions may have to be made to emphasise one or two elements of the planning process and short circuit the rest.

> "If we are facing in the right direction, all we have to do is keep on walking."
>
> Buddhist Proverb

For example if strategic directions are required in three months time, there may not be time for comprehensive community engagement or broad discussions about best practices. An effective way to address the tight timeline issue is to establish parallel activity processes through working groups. The key to successfully using this approach is to have built-in relationships between the primary strategic planning group and the working groups, best achieved by crossover membership to ensure continuous information flow.

Other techniques may be employed such as substituting key informant meetings and presentations by experts in the field in place of more comprehensive and time-consuming community and stakeholder consultations.

5.2 Use of Advocacy Groups

As noted earlier in this module, consumer and advocacy groups may have already identified their wish list in a certain area. Existing reports or background papers created by advocacy groups can be used to advance planning by bringing into the planning process consumer or provider views that have already been articulated (although these are not necessarily the only views to be considered). Acknowledging and incorporating this consensus into planning will strengthen the information and best practice element, and reduce consultation time.

5.3 Planning Versus Action – Selling the Process

A hospital CEO once described planning as a substitute for action. While this comment was exaggerated for effect, it expressed frustration felt by many within the health field about:

- the lack of overall health system direction
- the constantly changing landscape of funding and priority setting.

Health planning will be most effective and most saleable when it flows from a clearly defined framework for health and health services at the senior level of government. Funding to follow strategic directions will make it real for those required to make the changes at the line level. Marketing change to large organizations and smaller agencies alike requires a plan that speaks to the challenges and opportunities each will face.

Summary: Keep The Goal In Sight

A speech by Sir Winston Churchill in the early days of the Second World War contains one of the most articulate and memorable mission statements in modern history. The politics of appeasement had led England into a new political stance and into war with Germany, and Churchill was compelled to frame the issue in unambiguous terms. In his address and rallying cry to British citizens Churchill had only one outcome in mind, and that was for his country to prevail. His speech stated clearly that all strategies would emanate from that singular goal.

> We shall defend our island whatever the cost may be.
> We shall fight on the beaches
> We shall fight on the landing grounds
> We shall fight in the fields and in the streets
> We shall fight in the hills
> We shall never surrender.
>
> Winston Churchill, June 4th 1940

Health planning in Ontario will not bear the harshness of war, nor include the risk of loss of statehood. Nonetheless such examples help us to understand how political developments lead to decisions, which lead to a mission, which is inevitably translated into a plan of action, which in turn affects citizens - sometimes profoundly.

Reality dictates that political drivers both lead to, and are derived from, more deliberate policy development. Both are key aspects of health planning.

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8. Vancouver Island Health Authority. Strategic Plan to 2010, 2005. Available from: http://www.viha.ca

9. Vancouver Island Health Authority. Strategic Plan to 2010, 2005 Available from: http://www.viha.ca

10. Improve Public Sector Results with a Balanced Scorecard: Nine Steps to Success, H Rohm, Balanced Scorecard Institute, 2002. Available from: http://www.balancedscorecard.org/files/Improve_

'In that case,' said the Dodo solemnly, rising to its feet, 'I move that the meeting adjourn, for the immediate adoption of more energetic remedies.'

Lewis Carroll, *Alice's Adventures in Wonderland*

Appendix A

Public Health Goals For Canada

At the First Ministers' meeting in September 2004, the Prime Minister and the Premiers signed a ten-year action plan to pursue better health care for all Canadians. The plan included a commitment to establish health goals to improve the health of Canadians and to reduce pressure on the health system. Federal, provincial and territorial governments have agreed to work together in this goal setting exercise.

The federal government initiated a cross-country consultation process to identify how health goals for Canada should be established. Roundtables were held with experts and citizens across the country. The information from the roundtables will be synthesised through a reference group appointed by the provincial and territorial health ministers.

The goals will build on public health goals that may have already been established in some jurisdictions, and will be incorporated into a broad framework to help align public health efforts across the country.

Once released the public health goals will be published on the Public Health Goals web site at www.healthycanadians.ca.

As part of this exercise the government has defined public health as different from health care services. They have stated that it encompasses every aspect of people's lives, from homes, to workplaces, to communities and schools. They have further stated that, as the greatest share of health problems are attributable to broad social conditions, it is essential to intervene in these areas to promote health.

> "Public health is often described as the science and art of promoting health, preventing disease, prolonging life and improving quality of life through the organized efforts of society."
>
> Learning from SARS,
> Renewal of Public Health in Canada, 2003

One strategy that has been announced is the integrated chronic disease prevention strategy. Scientific evidence demonstrates that healthy eating and physical activity, and healthy weights protect against many chronic diseases, including cancer, heart disease and stroke as well as diabetes. This initiative is based on the finding that major chronic diseases share common risk factors, thereby making an integrated approach the most effective and practical way to advance health promotion.

Appendix B

Healthy People 2010 Toolkit

Explanation and Overview of the Toolkit

Welcome to the Healthy People Toolkit! The Toolkit provides guidance, technical tools, and resources to help states, territories, and tribes develop and promote successful state-specific Healthy People 2010 plans[1]. It can also serve as a resource for communities and other entities embarking on similar health planning endeavors.

This Toolkit is organized around seven major "action areas," which were derived from national and state Healthy People initiatives[2]. With the assistance and guidance of the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS), the Public Health Foundation (PHF) reviewed both year 2000 and year 2010 initiatives and identified these seven areas as common elements of most health planning and improvement efforts. The seven action areas are:

- Building the Foundation: Leadership and Structure
- Identifying and Securing Resources
- Identifying and Engaging Community Partners
- Setting Health Priorities and Establishing Objectives
- Obtaining Baseline Measures, Setting Targets, and Measuring Progress
- Managing and Sustaining the Process
- Communicating Health Goals and Objectives

Each action area includes:

- a brief explanation and rationale
- a checklist of major activities, which are taken from the comprehensive planning checklist tool in "Managing and Sustaining the Process"
- tips for success
- national and state examples to illustrate Healthy People processes in action
- recommended "hot picks" of resources for further information, designated by a star (icon)
- planning tools that can be easily adapted to state or local needs, designated by a tool (icon)

The suggested processes, tools, and resources in the seven action areas can help states build on past successes and round out their approaches to planning and developing year 2010 objectives. An effective planning initiative should reflect the state's unique needs, resources, and buy-in from a broad constituency.

Attached as appendices are comprehensive listings of resources; State, Territorial, and Tribal Action Contacts; and state and national Healthy People web sites[3].

A web-based version of the Toolkit offers users enhanced access, navigation, and search capabilities and is available at:
http://www.health.gov/healthypeople/state/toolkit.

The web version contains direct links to state Healthy People web pages, up-to-date listings of state Healthy People action contacts, Healthy People 2010 lead agency content experts, and HHS Regional Health Administrators.

Because this Toolkit is in the public domain, we encourage you to copy the Toolkit to share with your state and local partners.

The Public Health Foundation would like to hear about your year 2010 initiative, how you are using the Toolkit, and what additional resources or examples would be helpful to you. Please contact us at:

Public Health Foundation . . . . . 202-898-5600 (T)
Healthy People Initiative . . . . . 202-898-5609 (F)
1220 L Street, NW, Suite 350 . . . . . hp2010@phf.org
Washington, DC 20005

1 The term "state plan" will be used throughout the Toolkit to indicate "state-, territory-, or tribal-specific Healthy People 2010 plan."

2 The hundreds of local health planning initiatives could fill a separate volume and were not reviewed for inclusion in the Toolkit. However, a small selection of local resources is included for local Toolkit users.

3 The Public Health Foundation made every reasonable effort to confirm the accuracy of all web site addresses, resource listings, and contact information as of February 2002. PHF apologizes for any inconvenience caused by inaccurate listings.

Action Checklist: Setting Health Priorities and Establishing Objectives

(See page 113 of the U.S. Healthy People toolkit for a complete planning and development checklist.)

- ❑ Evaluate input from community partners and experts
- ❑ Collect and review previous health needs and assets assessments
- ❑ Conduct assessments of health needs and assets, if necessary
- ❑ Plan for transitions from year 2000 to year 2010 health objectives
- ❑ Decide where changes from year 2000 are needed and what should be retained
- ❑ Define the scope of the state plan
- ❑ Set criteria for establishing potential priority or focus areas
- ❑ Establish a process for final determination of priorities
- ❑ Identify and obtain information to evaluate areas according to criteria
- ❑ Select final priority or focus areas
- ❑ Determine types of objectives desired and establish criteria for adopting them
- ❑ Outline standard information to include with all priority areas and objectives
- ❑ Specify intervention points; identify potential topics and indicators for objectives
- ❑ Develop draft objectives

Tips

Perception is reality for many people

- Learn what the community and key partners see as important health issues (see action area, "Communicating Health Goals and Objectives," within the tool kit for ideas on learning from target audiences)
- Review comments your state residents submitted on the draft Healthy People 2010 focal areas and objectives (see page 54 of the tool kit)
- Obtain qualitative data, where possible, to assess and describe community perceptions
- Build on perceptions to gain broader support for priorities

Define the "rules of the game" up front – before trying to establish priorities and objectives

- Make sure everyone understands and accepts the process for recommending and adopting final priorities
- Set a cut off date for proposing changes to the "rules"
- Determine what other plans and objectives should be explicitly considered or incorporated into the state plan (e.g., national Healthy People 2010 draft objectives, state performance plans, existing tobacco or HIV/AIDS plans)
- Determine how priority areas should be related to the agreed vision and scope of your plan

Be clear about your criteria for determining priorities and establishing objectives

- Communicate important characteristics of objectives (e.g., feasibility, effectiveness, short-term/long-term, measurability) to work groups
- Make simple worksheets or checklists to help planning group members consistently consider criteria and see relevant information at a glance
- Strive for measurable objectives, but don't neglect important health areas where measures need to be developed and objectives may drive new data sources

You're not starting from scratch – build on your assets, not just your needs

- Align priorities, objectives and strategies with your state's strengths, assets, and opportunities where possible
- Look to other sources for information such as leading causes of death, Basic Priority Rating or other ranking systems, surveillance systems, or outcomes from your state's Healthy People 2000 plan
- Show respect for what has already been accomplished to address priorities

Appendix C

Health Impact Assessment

Health impact assessments look at the effect on health of policies implemented outside the health care sector (see module 2, **Assessing Need**, for further discussion of health impact assessment).

Information in this appendix includes excerpts from the following sources:

- Mindell et al. A Glossary for Health Impact Assessment, Journal of Epidemiology and Community Health 2003; 57(9): 647-651, BMJ Publishing Group Ltd. 2003

- Blau G and Mahoney M. The Positioning of Health Impact Assessment in Local Government in Victoria, Health Impact Assessment Unit, Deakin University, Australia, October 2005.

Health impact assessment has its roots in environmental impact assessment. However, the scope of health impact assessment has broadened from this traditional risk/environmental/health protection model to public health/health promotion applications that can be applied to all activities that may have an impact on human health.

It has long been recognised that health and its determinants are strongly influenced by policies outside the health care sector, for example, transport, regeneration projects and housing. In recent years several countries have introduced health impact assessment to ensure that potential effects on health are taken into account. It involves identifying disbenefits and benefits to health, interpreting health risk and potential health gain, and presenting this information to aid decision-making.

Health impact assessment is a multidisciplinary activity that a consensus paper published by the WHO Regional Office for Europe describes as *"a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population"*.

The Aim of Health Impact Assessment

All definitions of health impact assessment agree that the aim is to maximise the health gain (and minimise the loss) that might result from a proposal, even when the proposal does not have health improvement as its aim:

- Health impact assessment should be multidisciplinary, intersectoral and participatory, and should include a focus on health inequalities.

- Both quantitative and qualitative evidence should be used.

- The main values underlying the conduct of health impact assessment are:
  - sustainability
  - the promotion of health
  - participation
  - democracy
  - equity
  - equality (of all stakeholders in the process, but in particular of the community affected)
  - the ethical use of evidence.

Health Inequalities Impact Assessment (HIIA)

This form of health impact assessment used in the UK aims at assessing impacts of a proposal on the health and well-being of people in the community who experience health and other inequalities in relation to age, sex, ethnic background or socioeconomic status, to identify whether there is a differential distribution of impacts.

The current consensus is that all health impact assessments should consider inequalities and/or the distribution of potential health effects.

Levels of Application

Health impact assessment can be applied to three main levels of proposal: a *policy*, a *programme*, or a *project*:

- A **policy** represents the way in which government or an organisation seeks to achieve the objectives it has set. Health impact assessment at this level can be strategic, enabling health concerns to be incorporated early on and a global view to be taken. In some cases (taxation for example) there is no lower level at which health impact assessment could be applied.

- A **programme** is a series of related activities that give effect to *policy*.

- A **project** is a component of a *programme*, and is a discrete activity often undertaken at a specific location.

Health impact assessment at the programme and project levels allows health impacts to be assessed that are specific to a particular locality or community. It is more tactical, with aims relating to proposal modification and implementation.

Comparison of Policy Options

Ideally a health impact assessment will compare all possible options that could be under consideration. This gives policy makers the most explicit information on the health consequences of their actions and increases the possibility of integrated assessment.

Stages

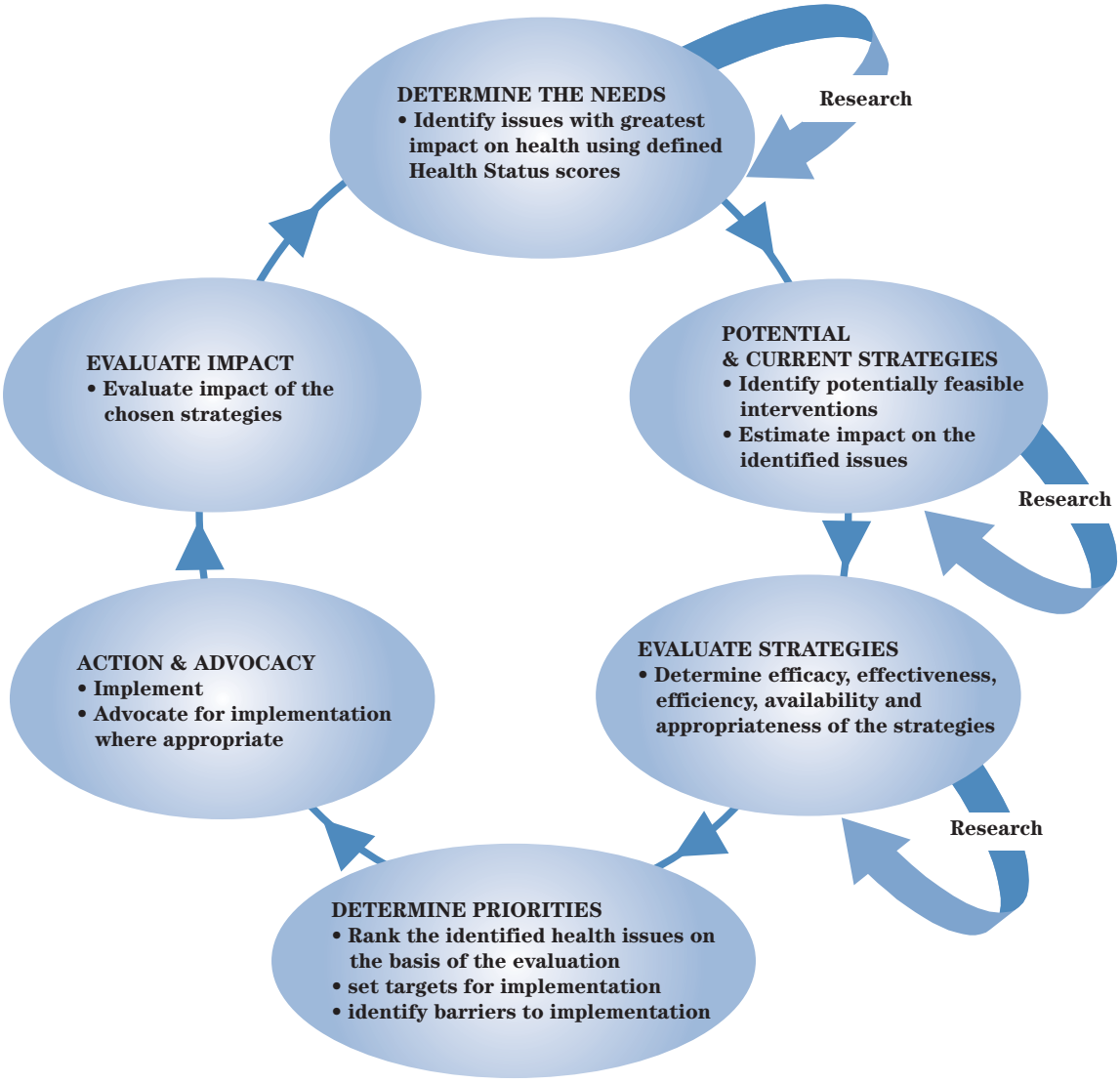
Health impact assessment comprises six stages:

1. screening
2. scoping
3. appraisal or risk assessment
4. preparation of report and recommendations
5. submission of report and recommendations to decision makers
6. monitoring and evaluation.

Appendix D

Needs Impact Based Planning Model

Figure D1: Needs Impact Based Planning Model



Source: Needs/Impact Based Planning Committee. A Guide to Needs/Impact Based Planning: Final Report to Ministry of Health. 1996.

Appendix E

The Oregon Experience

Since its inception in 1994 the Oregon Health Plan has garnered much attention. It has been heralded as an innovation in medical care policy and rationing. At the same time the process undertaken and the criticisms around the process captured the attention of many concerned about equity of access to health care.

According to Oberlander et al the Oregon Health Plan was the first public insurance program to ration medical care explicitly, systematically and openly by denying coverage for health care services. Other jurisdictions wrestling with how to prioritise within competing health demands and increasing health care costs have looked to this approach and its outcomes for possible approaches or lessons. At the same time considerable concern has been expressed about the ethics of this rationing process, especially as it could affect persons with non-mainstream health issues such as HIV/AIDS, tuberculosis and addictions.

While financial imperatives were behind the original experiment is has evolved into a more participatory health care goal-setting exercise. Moreover, according to Oberlander et al it has not resulted in saving any health care dollars.

Oberlander states that despite the Oregon Health Plan's status as a celebrated US policy innovation, no US state or other nation has emulated the Oregon model. In part this is because what other jurisdictions presumed was the key to Oregon's ability to expand coverage – the list and a formulaic system for rationing – turned out to be illusory. It is also the case that the furor over the Oregon plan has dissuaded others from similar efforts. The political controversy that comes with the decision to terminate coverage for medical services explicitly and publicly is baggage that no other US state has been willing to take on.

The real innovations in Oregon have been the use of public participation to build public support, and raising revenues for expanding coverage for the poor.

According to Oberlander the most important lesson for Canada is that explicit delisting of services is unlikely to produce substantial savings. The political paradox of rationing is that the more public the decisions are about priority setting and rationing, the harder it is to ration services to control costs.

Information for this appendix was taken from:

- Rationing medical care: rhetoric and reality in the Oregon Health Plan, Oberlander et al, Canadian Medical Association Journal, May 29, 2001: 164 (11)
- http://www.oregon.gov/DHS/healthplan/index.shtml
- http://www.oregon.gov/DAS/OHPPR/HPC/docs/HVS2004Report.pdf

Appendix F

The Balanced Scorecard

The balanced scorecard was developed in the early 1990s by Robert S. Kaplan and David P. Norton of the Harvard Business School. This new approach to strategic management was named the balanced scorecard to reflect the importance of measuring other factors to balance traditional financial measurement. The balanced scorecard suggests that an organisation be viewed from four perspectives:

- learning and growth
- business process
- customer
- financial

Under the balanced scorecard approach, metrics, data and analysis should be developed and applied relative to each of these four perspectives.

Howard Rohm, Principal and Director of the Balanced Scorecard Institute, has adapted the balanced scorecard for public sector (See Figure 9 on page 16) in away which uses slightly different concepts from the private sector approach (e.g. organisational capacity is substituted for learning and growth).

The balanced scorecard is not just a measurement approach. It is also an effective management tool to enable organisations to:

- clarify their vision and strategy
- translate them into action.

It provides feedback around both the internal business processes and the external outcomes in order to continuously improve strategic performance and results.

Kaplan and Norton describe the innovation of the balanced scorecard as follows:

"The balanced scorecard retains traditional financial measures. But financial measures tell the story of past events, an adequate story for industrial age companies for which investments in long term capabilities and customer relationships were not critical for success. Those financial measures are inadequate, however, for guiding and evaluating the journey that information age companies must take to create future value through investment in customers, suppliers, employees, processes, technology, and innovation."

Regardless of which terms are used, the balanced scorecard has been adopted by many health care organizations for planning and monitoring purposes.

Information related to this appendix can be found at:

- www.balancedscorecard.org

- Rohm, H. Improve Public Sector Results with a Balanced Scorecard: Nine Steps to Success, found as a Shockwave file at: http://www.balancedscorecard.org/files/Improve_Public_Sector_Perf_w_BSC_0203.swf

Appendix G

Strategic Planning Concepts and Tools

The development of a strategic plan for a whole health system is a large and potentially daunting task. However, there are excellent examples of its use in several jurisdictions, including some in Canada. Earlier in this module the Vancouver Island Health Authority strategic plan was noted. Both the Strategic Plan to the Year 2010 and the earlier document entitled Integration Plan 2007 are useful resources. Information on the Vancouver Island Health Authority and its planning is at: www.viha.ca.

As well, for strategic planning some organizations have incorporated the balanced scorecard approach (see Appendix F).

The best tools for strategic planning are often the ones that the person leading the planning is most familiar with and has used successfully in previous initiatives. However, there are commonly accepted tools that bring rigour and consistency to strategic planning. Some of these are described below.

SWOT Analysis:

This is an outline of strengths, weaknesses, opportunities of, and threats to, the organisation. It is usually done at the start of a strategic planning exercise in a group setting, to identify all factors in each area. The factors are usually organised in a table of four quadrants so participants in the planning exercise can visually (and easily) see the context for the planning.

- **strengths** include factors like staff capabilities, effective management processes, competitive advantage and unique programs or products.
- **weaknesses** include factors like gaps in staff skills, financial problems and inadequate information systems.
- **opportunities** include factors like global influences, new policy developments, partnerships and research.
- **threats** include factors like market demand, loss of key staff and political effects.

For more information on SWOT analysis see http://www.mindtools.com/pages/article/newTMC_05.htm

Affinity Diagrams:

An affinity diagram is a creative process used by a group to gather and organise ideas. It can be particularly powerful in a priority setting exercise.

The fundamentals of affinity exercises or diagrams is that:

- a problem or question is stated
- participants write down their thoughts or answers
- all the ideas are posted and then grouped by likeness of ideas or themes

Usually this results in a clear visual demonstration of areas of consensus on issues and responses.

For more information see:
http://www.sytsma.com/tqmtools/affin.html

Mind-Mapping:

A new way of visioning and planning, mind-mapping has made its way into both the standard flip chart based discussions, as well as computer based exercises.

It is a way of capturing ideas and organising information. It relies on pictorial representations of the flow and synthesis of ideas.

For more information see:
http://thinksmart.com/mission/workout/mindmapping_intro.html.

Mission Statement:

Key to any strategic planning exercise is the development of a vision and a clear mission statement. The mission statement may be more difficult because it must express to all – employees, clients and other stakeholders – what the organisation's current purpose is. It should be expressed at a high level, yet be rich in portraying purpose, values and business.

The mission statement should:

- express an organisation's purpose in a way that inspires support and ongoing commitment
- motivate those who are connected to the organisation
- be articulated in a way that is convincing and easy to grasp
- use proactive verbs to describe what the organisation does
- be free of jargon
- be short enough so that anyone connected to the organisation can easily repeat it.

For more information on mission statements see: http://www.businessplans.org/Mission.html.

Appendix H

Operational Planning Concepts and Tools

Program Logic Model:

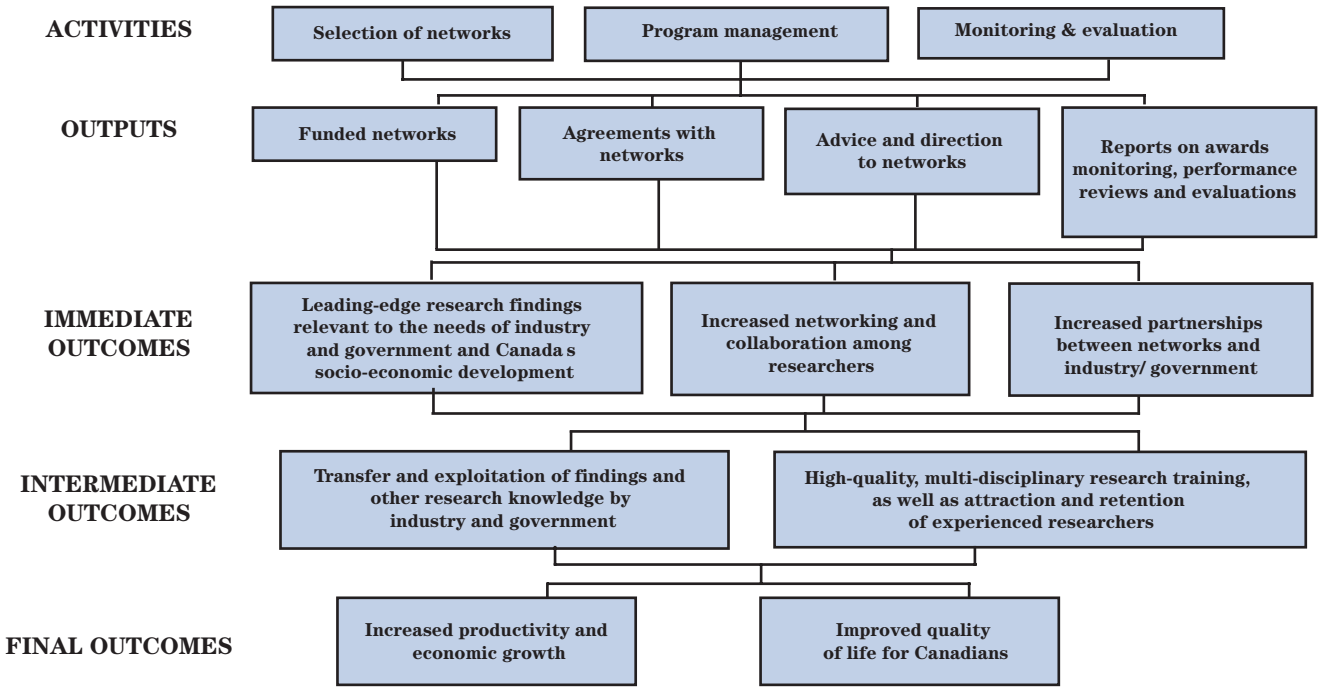
This model creates a diagram of the program and allows the effects of a proposed change to be determined. It is very helpful for program planning and implementation monitoring. A logic model depicts action by describing what the program is and what it will do – the sequence of events that links program investments to results. The model as adapted by the University of Missouri has six components:

- **Situation**: Problem or issue that the program is to address sits within a setting or situation from which priorities are set
- **Inputs**: resources, contributions and investments that are made in response to the situation. Inputs lead to
- **Outputs**: activities, services, events, and products that reach people and users. Outputs lead to
- **Outcomes**: results or changes for individuals, groups, agencies, communities or systems
- **Assumptions**: beliefs we have about the program, the people, the environment and the way we think the program is going to work
- **External factors**: environment in which the program exists includes a variety of external factors that interact with and influence the program action.

More information is at:
http://outreach.missouri.edu/fcrp/evaluation/plms.htm
and
http://www.charityvillage.com/cv/research/rstrat3.html.

Below is a sample logic model using the Government of Canada's logic model framework.

Figure H1: Logic Model: Networks of Centres of Excellence



Context Diagram:

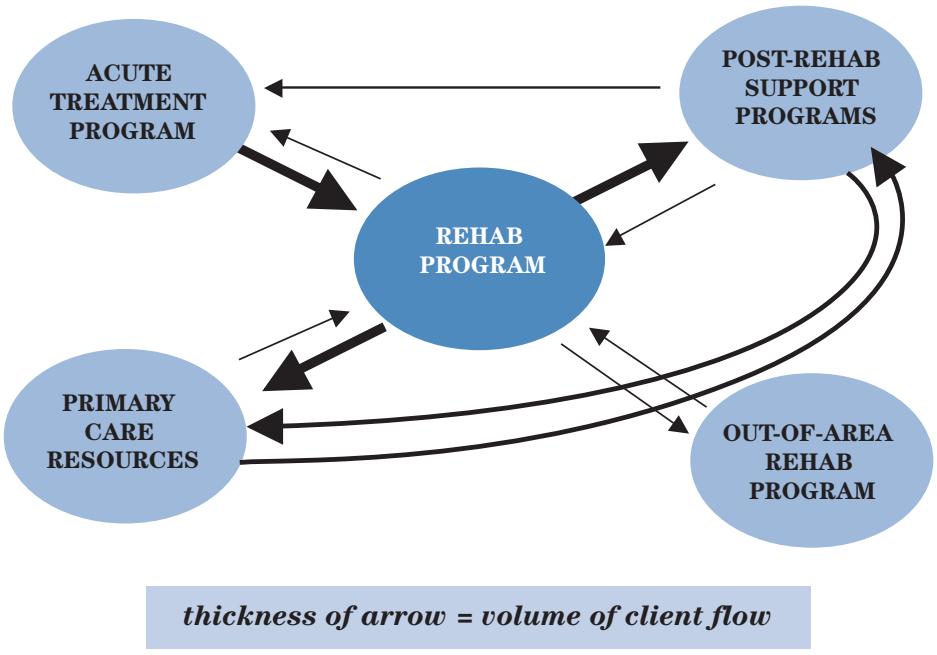
Linked to SWOT analysis is the context diagram. This diagram is best developed by a group of persons familiar with the organisation and vetted by the whole group engaged in the strategic planning process. Often those outside an organisation or system will see the context in a broader way than those inside, and both internal and external perspectives should be captured.

A context diagram is a picture of the organisation or system and the other groups with which it shares relationships and information. It can show information flow and how well the flow is working. It can therefore highlight areas for improvement and identify opportunities for solidifying alliances and partnerships.

It is common to see either a diagrammatic or written outline of relationships for large multi-agency administrations such as Canada's Department of National Defence (see http://www.vcds.forces.gc.ca/dgsp/pubs/dp_m/intro_e.asp)

A simple context diagram might look like this:

Figure H2: A Simplified Context Diagram



Activity Hierarchy:

This tool is used to visually show the activities of an organisation, sector or system. At each level within the hierarchy, activities should be broken down into more detailed, discrete elements that are part of the larger activity described in the level above.

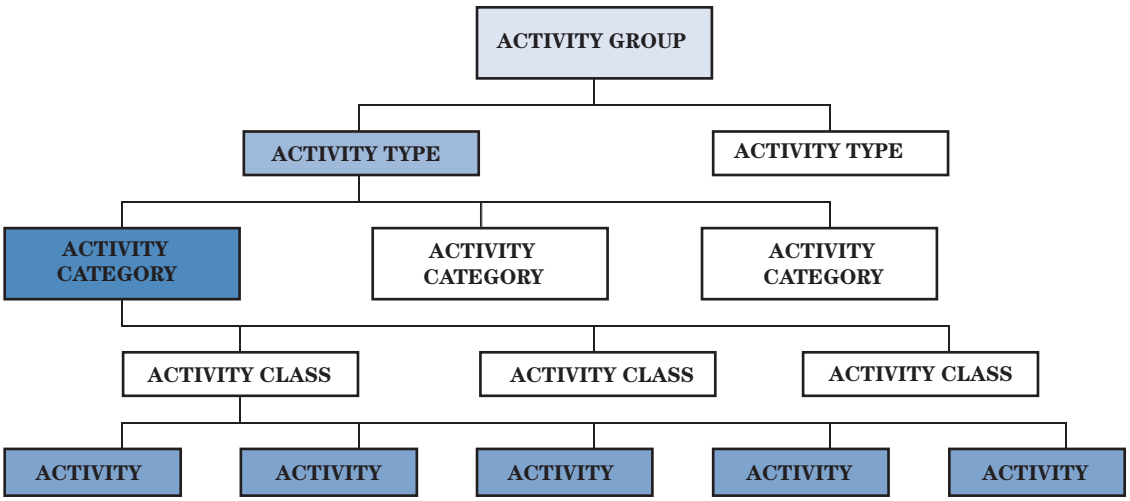
Activity hierarchies are useful for planning because they help create a clear picture of what a group does, or is accountable for doing, as part of its mandate. They can also show the impact of change in an organisation's activities or help in the development of new areas of business.

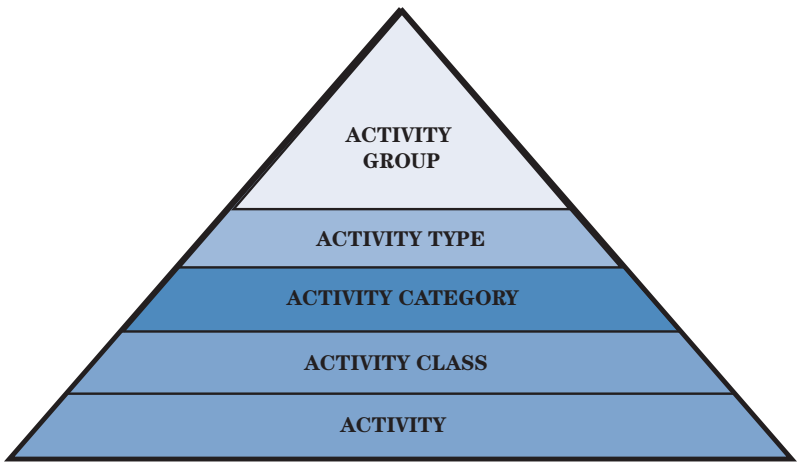
The core elements of an activity hierarchy diagram are:

- description of the organisation/sector/system
- the principal areas of activity
- the more elementary or sub activities that comprise those primary functions.

A hierarchy diagram can be organised in flow-chart format or in pyramidal form.

Figure H3: Ways to Present an Activity Hierarchy





Appendix I

Evaluation

Evaluation is a key component of planning. However as a separate module (Module 7, **Assessment and Evaluation**) will deal with this area, only basic information is included in this appendix.

A key for success with any planning effort is to agree at the beginning on what will be tracked and evaluated. Process evaluation can be particularly useful when piloting new programs. Outcome evaluation is key in understanding if investments are yielding the expected results. Both can also identify unintended consequences.

Types of evaluation are not primarily distinguished by the techniques involved (for example the difference between questionnaires and interviews) but by their purpose. In the article *Dimensions of Evaluation* (Oxford Centre for Staff and Learning Development, Brookes University) David Jacques presents a number of facets of evaluations as they relate to teaching and learning. For example it describes quantitative vs. qualitative evaluation:

- **Quantitative evaluation** attempts to measure or obtain a quantitative fix on what is going on. For example it counts instances and uses numbers as its baseline for comparison.

- **Qualitative evaluation** attempts to describe what is going on through observations, interviews and stories.

Other excellent sources of information on evaluation are:

- Canadian Evaluation Society publications and workshops: www.evaluationcanada.ca

- resources found at: http://www.managementhelp.org/evaluatn/evaluatn.htm

Notes

Ontario