Capacity Review Committee

Phase II Stakeholder Consultations

Accountabilities, Funding and Governance Report

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Section I — Project Description

In June 2004, the Ontario government launched Operation Health Protection, a three-year plan to rebuild Public Health. The goal is a stronger revitalized Public Health system able to meet the population's Public Health needs. A key component of Operation Health Protection was the formation of the Capacity Review Committee (CRC) by the Chief Medical Officer of Health (CMOH). The CRC is responsible for both analyzing the existing *capacity* of the local Public Health Units (PHUs) to meet their local needs as well as *how* they deliver their services in order to come up with system wide, manageable and sustainable solutions and recommendations. The goal is not to review or assess the operations of any individual PHU, but to analyze and gather data from all PHUs to assess how they can work more effectively as part of an integrated Public Health System.

The committee will provide advice to Ontario's Chief Medical Officer of Health and the Public Health Division as to how to renew Public Health in relation to rebuilding Public Health capacity within the province; enhancing Public Health leadership and accountability; and, improving system collaboration and partnerships. The CRC is to report to the Chief Medical Officer of Health in the winter of 2006.

In relation to Public Health services, the content of that advice is to be in the following areas:

- Core capacities required at the local level to meet communities' specific needs and to effectively provide Public Health services
- Issues related to recruitment, retention, education and professional development of Public Health professionals in key disciplines
- Operational, governance and systemic issues that may impede the delivery of Public Health programs and services
- Mechanisms to improve systems and programmatic and financial accountability
- Strengthening compliance with the Health Protection and Promotion Act, associated regulations and the Mandatory Health Programs and Services Guidelines
- Organizational models for Public Health units that optimize alignment with the configuration and functions of the LHINs, primary care reform and municipal funding partners
- Staffing requirements and potential operating and transitional costs

Extensive consultations with the field have been a critical component of the committee's task. As part of this work, it has established key sub-committees that incorporate community expertise:

- Governance & Structure
- Public Health Human Resources
- Public Health Funding
- Research and Knowledge Transfer
- Public Health System Accountabilities

It has also conducted two major surveys completed by all Public Health Units as well as their staff and board members. A capacity mapping initiative has also been completed by the Ontario Public Health Association which includes selected human resource and training issues. It has received submissions and presentations from individuals and groups with important perspectives on Public Health revitalization.

The Capacity Review Committee produced and published on the internet in early November 2005 its interim report entitled "Revitalizing Ontario's Public Health Capacity: A Discussion of Issues and Options". In that report it presented its conclusions to date and some of the directions being pursued and options being considered by its subcommittees.

Starfield Consulting was engaged by the CRC in mid October to conduct the Phase II consultation with the objective of probing on specific issues identified by the CRC subcommittees given the survey results from Phase I and their other research activities. The objectives of the second phase included:

- Conducting a series of interviews and focus groups with health unit staff, managers, leaders, board members and local partners; and
- Conducting three round table discussions in the following areas: Accountabilities, Funding, and Academic and Health Human Resources.

The Starfield Consulting tasks have now been completed through site visits and roundtable events.

Section II — Multiple Reports

Because of the amount of information, Starfield Consulting has produced three reports each focused on a different set of subcommittee questions:

(1) Accountabilities, Funding and Governance,

(2) Research and Knowledge Transfer, and,

(3) Public Health Human Resources.

This report is focused on **Accountabilities, Funding and Governance.** The kinds of questions posed and the responses received are closely related in these three subcommittees.

The body of this report contains the results of the health unit interviews and focus groups related to Accountabilities, Funding and Governance subcommittees. The results of the round table discussions were submitted in separate reports to each subcommittee, and are now included in separate documents to the three main reports.

Section III — Consultation Design and Methodology Overview

Starfield has conducted a series of interviews and focus groups with health unit staff, managers, MOH, CEO, CAO(where appropriate), Board members and local partners to probe on specific issues identified by its subcommittees. The on site interviews or focus groups were conducted between November 1 and November 30, 2005. All 36 Public Health Units were included in the stakeholder consultations. The initiative began on October 13, initial telephone reports were required on December 5th, a presentation to the CRC occurred on December 15th.

Starfield Consulting put together a team of 9 consultants and a logistics coordinator. Two principal consultants oversaw all components of the project and liaised with the CRC and its representatives. The first and second levels of findings were done by the six field consultants and the final reporting of findings was prepared by the two principal consultants.

The design of the consultations was led by Starfield's two principle consultants based on the context provided by the MOHLTC staff and the brief interviews with the subcommittee chairs over a two and a half week period. The questions developed were then also reviewed by senior staff within the ministry responsible for CRC who made the final decision as to the questions to be asked.

Interview and focus group protocols were developed and approved. Focus groups were designed to maximize participation of management and staff in the short time frame available at each site. A few questions were added or modified to engage the participants and stimulate appreciation for successes and positive accomplishments. A total of 83 questions were included in the whole process. Most questions were targeted and thus only asked of one or some of the groups involved.

There were many open-ended questions leading to a substantial number of responses. Thus, the questions were coded into themes to allow for improved reflection on the data. It was not possible to "prioritize" the data and not appropriate given that we were seeking "top of mind" responses in a variety of ways.

The data analysis, based on a maximum of 10 most frequently mentioned themes, was used to support intuitive perception of the findings. Field consultants worked with assigned questions to develop an initial summary of findings. A second level of analysis provided a summary focusing more on highlights, emerging issues and polarities when appropriate. The lead consultants reviewed and edited the findings. Themes are ordered in the report based on the frequency by which respondent groups mentioned that theme.

Some limitations to our design and methodology include:

- Protocol questions were developed rapidly and the initial testing done during project implementation. The question development process did not follow rigorous research standards due the time frame available. This was not the expectation of the CRC.
- Theming or coding of the data generated by the site visits and interviews was completed quickly with limited quality control. There was, however, a general testing of assumptions and highlighting of patterns around demographic cuts.
- Demographic "cuts" of the data were conducted in the analysis. There were some differences in the demographic data provided by the province and the realities encountered in the field, but not time to change the assumptions in the analysis.
- Given that the data recording and transcription was done by six people and that a tape recorder was not used for interviews, the potential for translating the qualitative data into statistically valid quantitative data was limited.
- Because of the tight time lines, theme selection was done after data collection and transcription was completed in 27 of the 36 health unit's so that data entry could begin. Themes might have varied if we had been able to finalize them at the end of the site visits.

The conditions for a valid test for statistical significance of the data are not present.

A more detailed description of the consultation methodology and design is provided in Appendix A of this document.

Section IV — Consultation Findings

Introduction to Consultation Findings

Each health unit in the province took part in the consultation process. The following respondents or respondent groups were involved in the consultation. For a complete breakdown of the health units and respondents involved in the process see Appendix D and Appendix F.

- An interview was conducted with the MOH. In health units which had a separate CEO or Executive Director role, the CEO or executive director was also interviewed. We were successful in interviewing the MOH and/or CEO from every health unit.
- Where appropriate the CAO or City Manager of an aligned organization was interviewed. 5 CAO interviews were conducted.
- A group interview was conducted with a cross-section of Board members from each health unit. The health unit and their Boards made the selection of which Board members to include in the interview. A total of 104 Board members were interviewed. Of these Board members, 12 were provincial appointees, 87 were municipal politicians, and 6 were citizen Board members.
- Focus groups were held with both management and staff groups. Health units made the decision as to who was included in each of the meetings. Health units were asked to provide a cross section of participants. They were cautioned to refrain from including managers in staff focus groups in order to protect the confidentiality of these discussions. A total of 585 staff members and 430 managers participated in focus groups. The groups crossed a wide variety of disciplines and represented a wide range of experience. Approximately 30% of the participants had less than five years of service, and just over 25% had over 20 years of service.
- A total of 78 Partner organizations were interviewed. These organizations included 16 school Boards, 15 hospitals, 28 community care or medical companies, 4 charities and 15 other types of organizations.

There were four types of questions asked.

- Most were targeted questions designed to understand participants' views on specific areas of interest for CRC subcommittees. These questions have been synthesized to provide perspectives of the Public Health system as a whole.
- A few questions are focussed on issues experienced by only a handful of health units (e.g. Those who have undergone consolidation). These questions were asked to only the applicable Health Units.
- A few funding questions require detailed information specific to the health unit. This information was collected and submitted separately (a high level summary is included in this report).

- Two questions were included to get an overall sense of the accomplishments of the Public Health system as a whole. A summary of these questions has been included at the beginning of the findings section.

Public Health Accomplishments

Interviews and focus groups generally started with a request for participants to describe what they felt were their top accomplishments over the past year. The following are some of the highlights of these responses.

Most health units were eager to report on 'good news' when asked to cite their recent top accomplishments. Most units mentioned success in meeting the Mandatory Health Programs and Services Guidelines, (including many unique and innovative approaches to reach, influence and serve their communities), enhancing relationships and community partnerships, meeting local needs, and internal process improvements. Linked to their local successes, many also cited better recognition and profile in their communities.

In addition, those units that experienced physical or organizational restructuring such as amalgamations, internal shifts and/or hiring a new MOH or other senior staff, talked about how they had 'made it through' without major disruptions to the services they provide to the public.

The most frequently cited success was around tobacco policies and programs. A large number of units were proud of their ability to implement 'Smoke Free Ontario', by working with the local municipalities to pass smoke-free by-laws in all public places (and in some units workplaces too). These efforts included long and often painstaking discussion and debate with local municipalities, including many that were, for political or economic reasons, dead set against smoke-free policies. Through their relationships and ability to influence locally, these laws were passed with a minimum of backlash. In addition to the by-laws, many Public Health units were proud of their ability to prevent or reduce tobacco usage by developing and implementing programs in schools, educating and mobilizing parents to influence their children, and by working with corporations to provide access to smoking cessation support and education materials to their employees.

The second most cited success was progress in pandemic planning and emergency preparedness including surge capacity. Clearly this is a response to the recent national and local outbreaks and to the provincial mandate to all communities to work together to develop plans for managing such incidents. The units' partnerships and relationships within their communities were also essential to progress in this arena.

Many were proud of their ability to quickly and appropriately react to local incidents and crises. For example, they cited success with managing illegal meats, the rubella and e-coli outbreaks, arsenic poisoning in a local lake, water contamination incidents, and responding to the cosmetic use of pesticides.

Everyone commented on progress in meeting mandatory programs, including specific examples of increased utilization rates, unique approaches to providing access, enhanced partnerships to influence and reach broader segments of their population, internal programmatic process improvements and evaluation methods and results. Units were proud of their public awareness campaigns (i.e. Influenza, West Nile Virus) and increased

utilization rates (immunization, breastfeeding and STD clinics, and sexual health services). Many cited either new or ongoing results of programs including: Obesity programs (Healthy Weights and Physical activity programs), Best Start and Healthy Babies (early childhood development), Water monitoring, Eat Smart (including partnerships with farmers on "Field to Table" and "Food Basket") and "Food Check" initiatives (inspections) and "Workplace Wellness".

Public Health employees are proud of their positive relationships and recognize the importance of their liaison and connecting role. Numerous Public Health Units mentioned unique and innovative community partnerships to assess and address local issues often 'beyond the mandatory programs'. They are proud of their partnerships with local agencies to help the homeless, train maternity nurses to support and coach new mothers on breastfeeding, reduce violence in schools, prevent teenage pregnancies, help new mothers manage post partum depression, train and support drug addicts in the safe use of needles, assist youth through on-line health information, and plan for urban growth. Their pride is in the impact they are making on their community.

Public Health employees interviewed are also pleased with their work on process improvements. Most often cited accomplishments include work on Strategic Planning, followed by achieving accreditation (4 years). Also cited were quality assurance and service improvement plans, operations reviews, more evidence based planning, increased accountability measures and implementing a balanced scorecard approach.

Several units successfully reorganized either through mergers, relocations and/or internal shifts. Two that amalgamated were proud of their ability to do so 'without skipping a beat' and without layoffs. Others that faced such shifts reported on their ability to harmonize wage and union agreements. Also several units were proud of their internal structuring to cross train employees and reflect the social determinants of health model (multidisciplinary teams). They believe the new structure is changing the culture so that 'now people like to come to work'.

Many units reported that, in line with their efforts, they have increased their recognition and profile with the community. They are happy about success in this arena as evidenced by positive media attention, recognition through public service and other awards, and, in one case, the public's reaction to their new weekly radio show.

The many examples of successes emphasize the *local* role of Public Health to deal with a *wide range* of issues. Employees are proud of their connections with and their job to serve the community. They feel most successful when they see evidence that what they do does 'promote health' and 'prevent disease' - *in their local community*. This evidence comes in many forms; local population health statistics, local survey results, program usage rates, media coverage and invitations to participate in events, conferences or coalitions addressing local issues. They also noted and appreciated the recognition they receive in praise of their efforts and accomplishments. For the most part, this recognition comes from those they work with and serve.

Section V — Accountabilities

Introduction to Accountabilities

The Public Health System Accountabilities Sub-committee posed three questions for the Phase II interviews and focus groups. The questions focused on what respondents saw as being required to improve accountability processes.

We interviewed from 3-8 Board members per site. The Board members were asked what should be in place to hold units accountable. MOH/CEO and CAO's were individually interviewed and Management focus groups were asked to identify performance management tools to help monitor health units. MOH/CEO and CAO's, in interviews, and Management and Staff, in focus groups, were asked to identify indicators of effectiveness of a unit to their local communities.

Each question or group of questions and the findings related to that question or question group are presented in the same format. The questions include a brief introduction and an overview or summary of the primary findings for that question. That is followed by a more detailed description of each theme used to categorize the responses of those interviewed or in focus groups. The words in that description follow those key words stated or put on flip chart paper by those interviewed or from the focus groups at the unit site.

Findings for Accountabilities Section

The three questions in this section focus on accountability processes, performance management tools and indicators of effectiveness as seen by the community. The Board was asked about accountability process. The MOH/CEO and CAO respondents and Management focus groups were asked about performance management tools and those two plus the staff focus groups were asked the last question.

In summary, most Board respondents were convinced that new standards and outcomes based measures should be developed so that units and Boards could be held better accountable. The current measures do not work and many Boards only focus on financial measures. Some Board members strongly believe that they are not now being held accountable. They believe that the current guidelines do not hold the power of standards. Without clarity as to the outcomes sought in some standardized way across the province, the tools developed would not be useful.

When asked about tools, MOH/CEO and CAO respondents and staff reinforce the statements of the Board. As one CAO noted "I think the province should set out some very clear health standards". Again, they believe what is most needed are outcomes based measures which might be formatted in terms of scorecards and benchmarking. Both agreed a computer and web based standardized measurement would be the most efficient.

As for indicators to the community of effectiveness, the extent of the community's awareness of the unit and what it does or the public's knowledge of the unit was seen as the top indicator. In addition some community members were seen to pay attention to outcome measures and statistics relating to impact of unit programs on health. As well, communities were seen to be aware of the internal processes, positive or negative, within the unit. Their interaction with the unit would help them perceive positive morale and organizational effectiveness.

Questions and Findings for Accountabilities

50 QUESTION:

What should be put in place to better ensure your health unit is accountable for meeting its program mandate?

QUESTION CATEGORY	**Performance Management**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Accountabilities**

RESPONDENTS			
	MOH/CEO	×	**No**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Question Findings

Almost half of the Board responders, representing more than half of the units, saw the need for new and consistent, standard and outcomes based measurement to better ensure unit accountability.

A variety of processes and tools were suggested at a high level. Computer based reporting was seen to be necessary. Audits, accreditation processes, provincial report cards, quality assurance measures were mentioned among others. The tool was seen to require both common standards and the ability to incorporate local distinctions.

7 respondents (7 health units) gave interesting Board perspective. 6 were members of autonomous Boards. They saw a current lack of Board accountability to the province. The guidelines they are given (which are not standards) are not being enforced. The "province gives us money and we cut it, and it does not hold us accountable".

Some believe that developing good accountability processes will have a larger effect than system restructuring.

Description of Themes

Theme: Consistent measurement for the use of all Public Health Units

The responses of the largest number of Board members, twice that of the closest number of responses was for the need for a clear and consistent measurement process across the province. This was said in a variety of ways. The measures need to state how well the unit and Board are meeting their mandate based on clear standards, goals, objectives and benchmarks. Some Board members believe that every unit needs to use the measures and the reporting needs to go beyond the mandatory programs. Some saw this as being part of the contract with the province.

Currently Boards focus more on expenditures than on such guidelines. One saw the current measures as "ridiculous". Many believed that the province and Boards are not currently measuring the right things in order to assess the impact of what is being done.

The measurement and reporting process could involve establishing a template with key performance indicators, a menu of critical success factors, a report card, or benchmarks with comparable units. Such measures need to take into account differences in population and geography, including income levels of clients.

A couple of Board members mentioned that a global report card would help the Board to require department report cards. They saw this as a helpful part of budget deliberations. This would allow the Board to see what needs more money. Some believe that this change would be more important than restructuring the Public Health system.

Theme: Process and tools for reporting

Some Board members went further in commenting on the processes and tools that could be used for such measurement and reporting. Others acknowledged that they did not know what the current parameters or tools were.

Some wanted any new provincial tools to be provided with the computer system or software to use it. Some believe that the reporting should be not less than quarterly. Others saw the reporting going to both the province and the public.

Some Board members also saw tools being based on the following: audits based on specific set of objectives, financial statements, program efficiency, program delivery, or the unit's ongoing strategic planning process. One believed that if the MIPQ was "done right" it could work. Others saw the use of gap analysis tools, the accreditation process, or a provincial Public Health report card like the hospital report card. Others saw a quality assurance measurement like that used in long term care. For some the tool needs to include both common standards and reporting of local distinctions.

Theme: Need accountability to province

Some Board members commented on the nature of their accountability to the province. Councilors often noted that they were already locally accountable as elected officials. Some want the same type of accountability to the province as they have to their municipality or county. Currently they see nothing being enforced and that the guidelines can be ignored. One Board member stated, "The province gives money for programs that we just cut, which is not a good thing for Public Health."

One acknowledged that they have or the municipal administration has refused the MOH's requests. Some believe that the province needs to be more engaged and become accountable for the money in a way that is not punitive. The Province doesn't hold the Board accountable instead they hold the executive and senior staff responsible. Some believe the only way a higher authority can hold a lower authority responsible is to hold periodic assessments.

Because of this, some saw the need for "more of a connection between Boards and ministry". This is to be done with "some ease of implementation with limited extra work", particularly for those Boards that are already doing well. Some saw this as a quarterly report on the delivery of mandatory programs. One was clear that there had to be an

accounting for dollars intended for Public Health to be sure that they were going to Public Health and not roads when the unit is part of a municipal structure.

Theme: Measurement tool implemented by an outside agency

A few mentioned the value of measurement by a 3rd party. Accreditation was seen to be useful and one believed it should be mandatory. Another noted the difference between measuring effectiveness of a strategic plan and an accreditation process.

Theme: Change to a simpler process

Two respondents stated that the process for measurement and accountability needs to be simpler and computer based so that staff do not have to complete multiple forms.

3 QUESTION:

What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?

QUESTION CATEGORY	**Performance Management**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Accountabilities**
RESPONDENTS	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	√	**Yes**
	Staff	×	**No**

Introduction:

The focus of this question was on tools for performance management that the province should monitor. Both the MOH/CEO and the Management focus group were asked to respond and there were a substantial number of ideas and responses by the two groups.

Question Findings

The most frequent comment was not a tool per se, but what needs to be measured in order to have effective tools. New outcomes based measures of performance with mandatory programs are required according to both MOH/CEO and management respondents. Current tools were seen to require some real change to take on this focus. They need to be based on standards not guidelines. Without clarity as to the outcomes sought in some standardized way across the province, new tools would not be useful.

A key support, and the second most mentioned item, was the development of a centralized or common standard computer measurement capability. These new measures require the information of local measures and tools based on local needs and performance. Incorporating local needs and measures into those tools were also important to both the managers and the MOH/CEO and CAO. For example, one Board member stated "We would like to impress on Toronto folks that things that work down there, don't work here. In our {location} we don't have transportation – so if a {laboratory} test is recommended which requires travel to [location] people won't go. We have to have ways to bring services to these communities."

Whatever tools are developed MOH/CEO and management respondents commented on the importance of incorporating local needs and measures into the tools. The tools need to "be sensitive to small local populations". As well there was a common idea for measuring cost effectiveness of programs. Accreditation or audits were seen to be useful as were scorecards, benchmarking and partner or client satisfaction surveys. In addition, a number of MOH/CEOs and managers saw the need for measurement of Board of Health performance as well as effectiveness in community partnering.

Description of Themes

Theme: Measure against clear and balanced goals, priorities and outcomes

The largest group of MOH/CEO and management focus group respondents focused on what is to be measured. MOH/CEO respondents believe that even though mandatory programs "may not be easily measurable", it will be helpful to develop a "series of structure, process and outcome measures". Some believe the measures should also focus on "ecosystem health and the determinants of health". Some believe the indicators should focus on "change over time". Other MOH/CEOs believe there should be measures of "penetration – how many people are being reached", particularly in the North.

Managers in their focus groups also identified performance or outcome measures more often than any other topic and the need for "standards not guidelines" that are applied across the province. Some managers also believe that process measures are important, but many stated the need to go beyond them to measuring qualitative and quantitative outcome. One identified that the performance measures need to "reflect legislative compliance". Consistency and timeliness were also seen to be important characteristics of such measures. Long term indicators that can be used in long term planning were also a concern for some managers. Others mentioned developing measures of service levels, healthy behaviour, professional development and policies developed.

Theme: Centralized computer system to measure

One key performance measurement tool for both MOH/CEO and management respondents was the development of a centralized or common computer system, or at least compatible systems in each health unit that can communicate with each other. For one MOH/CEO respondent, this would allow the province to "burn the MPIQ". It would need to be developed in a way that is "complementary to day to day activities".

Some managers believed that the use of a "retooled version of the MPIQ or ISCIS" could be used. But for others, new and more effective measurement tools need to be based on provincial standards. With a common IT system, standardized collection tools of various sorts could be developed. This would be different than the current local stand-alone databases. Some see those local systems as "flawed or outdated". A new system could allow for "point of care data input" and "provincial time tracking" and better explanation of any results. Some imagine that the computer system would be able to "provide a feedback loop to the local unit" and be flexible enough to include new trends.

Theme: Incorporate local needs and measures into tools

Both MOH/CEO and management respondents commented on the incorporation of local needs to any new tools. One MOH/CEO believes that population demands -- needs assessment --need to be part of such tool development. This would allow units to know better "if they are meeting the needs." One believes that cultural diversity should be taken into account. Another believes that "RRFFS allows you to tailor questions to your own community". A MOH/CEO cautioned against using per capita costs as a measure because it "costs more to deliver in the North".

Management comments paralleled a number of those of the MOH/CEOs. One stated that like good surveillance tools new tools need to be "sensitive to small local populations". Unique community needs could then be shared with other health units which may lead to provincial standards. One person saw the possibility of incorporating RRFSS data into "normal" health unit practice.

Theme: Effectiveness of program delivery given the money provided

Again both MOH/CEOs and management focus groups commented equally related to cost effectiveness. One MOH/CEOs respondent saw the need for the province to determine the appropriate staffing for a health unit and then doing financial auditing. Another identified the need for "financial metrics to ensure we are putting the money into mandatory programs". One called for per capita costing, and one from the North said not to use it.

Managers had similar points to make. Some called for program-based budgeting, especially for mandatory programs, which are centrally monitored in relation to efficiency and effectiveness of outcomes. Another suggested such a tool would need to take into account the recognition of surge demands in relation to program cost effectiveness. The adequacy of funding for particular programs needs to be taken into account as well. One mentioned that "it could be done like cancer care with clear expectations attached to Ministry funding". Another manager suggested a capacity review process with this focus be completed every 5 years.

Theme: Accreditation/Service Delivery Audits

Again both MOH/CEO and management respondents saw the value of an accreditation process as a useful provincial tool. Some MOH/CEOs saw it as a potential mandatory requirement for health units while others saw the value of applying accreditation standards to site audits that could be annual or every few years. If accreditation standards were operating practice across all health units then Ministry site visits could audit the performance in relation to those standards. Some MOH/CEOs state that the accreditation process is costly. Others pointed to quality improvement measures and process as an alternative or complement to accreditation.

Some management staff also saw the value in mandatory accreditation. Certainly ministry site visits were also seen as a useful tool.

Theme: Scorecards/Report Cards

Both Management and MOH/CEO respondents mentioned score cards. One MOH/CEO respondent saw the need to include the "ability to deliver mandatory programs" as one component. Management focus group respondents mentioned the "balanced score card" based on both provincial and local information.

Theme: Benchmarking

Another important tool for both MOH/CEO and management respondents was the development of comparative information for benchmarking with other health units (near

and far). According to management respondents this would allow "easy provincial comparisons" and lead to "identifying best practices".

Theme: Partner and Client Satisfaction Surveys

Both MOH/CEO and management respondents believe that their "community should have a say" in how they are doing. Some managers believe that customer service surveys could be developed based on service indicators". Other see potential in using tools like "360 degree feedback" with clients and partners

Theme: Board Performance Accountability

A few MOH/CEO and management respondents saw Board of Health performance as an indicator. They saw the need "to measure and report on Board performance". One MOH/CEO stated that the "Board of Health has to be held responsible for supporting Public Health" and if they are not then the "chair has to be held accountable. Some manager respondents believe there should be penalties for not meeting the mandatory guidelines. These responses were evenly split among aligned and autonomous units.

Theme: Community Partnership Effectiveness

MOH/CEO respondents believe that if the "Public Health community and the hospitals would work better together "many of our Public Health crises would be less challenging". Managers respondents believe that such evaluation tools should be "tied to deliverables" with community partners and also "include the communities perception" of the partnerships.

2 QUESTION:

What indicators would best demonstrate the effectiveness of your health unit to the community?

QUESTION CATEGORY	**Performance Management**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Accountabilities**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	√	**Yes**
	Staff	√	**Yes**
	Partners	×	**No**

Introduction

This question was asked of three respondent groups. The MOH/CEO was interviewed and focus groups were held with volunteers from the management and the staff of all units.

Question Findings

The indicators that most demonstrate effectiveness to the community were categorized as those that indicate the perception of the unit and the amount of public knowledge. Indicators from customer surveys, partner relations, policy changes and community invitations demonstrate effectiveness to the community by these respondents. More specific statistics and measures of health outcomes and program outcomes as well as measures of unit activity were seen as being important to the community.

Respondents also believe that the internal processes of the health unit are also visible enough to the community to be taken as indicators of effectiveness. A well functioning organization with a positive culture gets known in the community as well as one that is struggling.

Description of Themes

Theme: Community Perception of Health Unit and Public Knowledge

Indicators that show the nature of the community's perception of the unit and the extent of public knowledge of the unit were grouped together in this theme, which was the most frequently mentioned by the MOH/CEOs, Management and the Staff across all sizes and regions.

Some indicators of the communities perception and knowledge appear to be more easily measured: customer service indicators through surveys or feedback, the use of a unit's website, the number of press releases and amount of media coverage for newsworthy unit items, perceptions of the annual report, the strength and number of partnerships, community attendance at an Open House and other events, the number of staff members involved in outside agencies, the number of invitations to sit on community committees, or the number of changes in public policy fostered by the unit, the amount and rapidity of response to boil water advisors or other such Public Health initiatives.

Other indicators may be more difficult to measure and may require qualitative or anecdotal information: the community's endorsement of a unit's stance on a specific topic (partly indicated by their willingness to work with the unit), visibility of our MOH and senior leaders, recognition of our health expertise, or having a respected community presence.

Some proposed indicators focused on the interaction with partner organizations like School Boards, Hospitals and the extent to which the unit's expertise is recognized by other community professionals.

Theme: Health Outcomes and Statistics

The impact on community health outcomes was also mentioned frequently as an indicator for the community of the effectiveness of a unit. Communities want to see disease rates reducing whether it is chronic or infectious disease. They want to see less lost time at work and reduced social and economic impact of disease or injury.

If Public Health programs can show reduced child related injuries and illness due to increased seat belt usage, the community would see that as positive indicator. Other programs increase the number of women who breastfeed, change the food in vending machines in schools and reduce the use of tobacco by teens. The effectiveness of a unit's response to the West Nile virus was also seen as a positive indicator. The same is certainly true for effective response to outbreaks as shown by their efficient control.

Many stated are broad long-term indicators like reduced obesity/BMI rates, cancer rates, heart disease incidence, morbidity, birth weights, and the number of teenage pregnancies.

Theme: Internal Measures (process indicators)

The third highest number of respondents suggested that a good indicator to the community of effectiveness is the internal functioning of the health unit. They suggest that the community becomes aware of the internal workings of the unit, of things like employee morale, management interactions with staff, the number of people who want to work at the unit, 'perceptions' of staff by partner agencies, whether or not it is a 'learning organization' and the active relationships with community partners.

Internal indicators that may be more easily quantifiable, include budget/financial performance, quality improvement indicators, the number of staff (per given population), response time to hazards or outbreaks, accreditation of the unit, the partnerships with universities on research and the sustainability of programs.

Theme: Activity Measures

There was a lot of similarity of the items identified in this theme with those in the top theme, indicators of community perception of Public Health. These indicators focus more on the frequency of the community's use of the unit or the frequency of contacts with the community. It complements the items in the top theme with indicators with the number of: immunizations, people attending clinics, inspections, health line calls, school children

screened by dentists, public queries, pandemic presentations, signs posted, car seat clinics, requests for service or community development initiatives.

All of the above could be used to measure the amount of activity of a unit. The relation of that kind of activity to both community perception and health outcomes was stated in earlier themes. Clearly, a substantial number of respondents at the CEO/MOH and Management level with slightly more at the Staff level believe the community sees some value in such indicators.

Theme: Community Based Programs

For a substantial number of responders, a strong indicator to the community of unit effectiveness is the ability to work with partnering agencies to develop and deliver together programs that meet community needs. These partnerships function at many levels and are also shown by the presence and leadership of unit staff in community multi-stakeholder groups or coalitions. It is also enough of a focus that all three groups of respondents equally mentioned this topic.

Theme: Regular Reporting to all Stakeholders

This theme was indicated most by the staff and includes regular reports to a variety of stakeholders such as: monthly reports to the Board or regional council, RRFFS, newsletters, community report cards and the annual report.

Theme: Provincial Measures and Standards

Some believe that provincial measures or standards would also indicate to the community the effectiveness of a health unit. This theme's existence also indicates the often stated concern of the responders that the province develops measures and standards. Few managers gave this response, but both MOH/CEO and Staff responders were equally represented. Listed in this theme are measures for provincial programs and services in relation to compliance with mandatory standards, RRFFS and benchmarking with other health units and indicators of how units compare with each other.

Some MOH/CEO respondent responses used this to emphasize that more work needs to be done on the compliance monitoring and measuring and the value of the ministry working together with the unit to come up with the appropriate parameters to measure.

Theme: Social determinants of health

Social determinants of health are those larger systemic factors that have been demonstrated to affect health outcomes. Poverty is one clear example of a social determinant. Some respondents believe a community that recognizes the evidence of links between improved health indicators and overall community well-being and economic prosperity will want to see health units to be involved in those tasks as well.

Theme: Emergency Management/Outbreak Control

Only the MOH/CEO respondent group highlighted this theme. The emphasis is on the unit's ability to minimize an outbreak and/or their timeliness and ability to react appropriately to an emergency (water contamination, bean sprouts, etc.).

Section VI — Funding

Introduction to Funding

The Public Health Funding Subcommittee had a number of fairly technical questions it wanted to ask in follow-up to the Phase I research. It was decided to ask most of those questions in a Roundtable format such as those related to the funding process and timelines, capital funding or operating reserves. It also asked MOH/CEOs and Board members as to their perceptions of the appropriate split of funding in the future between local regions or municipalities and the provincial government. During the interviews two other questions specific to Health Units were asked and that information is included at the end of this section.

The subcommittee is considering the advantages and disadvantages of either staying at a 75/25 provincial/municipal split in health unit funding or moving to 100% provincial funding. 75/25 is the current MOHLTC decision to be implemented by January 2007. Choosing 100% funding would be a change from the current commitment.

We present the findings on the advantages and disadvantages of each approach together and then the themes for all each advantage and disadvantage and their descriptions follow.

There are also two questions from the interviews and focus groups as to the governance impact of either decision. Their responses strongly parallel the perspectives found in these interviews. They are presented at the beginning of the governance section of this document.

Findings for Funding

Arguments are put forth for both the 75/25 and 100% funding approaches. The comments clearly lean toward the 75/25 funding option. There were more statements on the advantages (110) and fewer on the disadvantages (33). There were a large number of comments on the disadvantages of 100% funding (67). But there were also a substantial number of comments (84) on the advantages of 100% funding.

There were consistent comments across all sizes of units. The regions were fairly evenly spit on their comments. There were fewer comments on the down side of 75/25 and more comments on the disadvantages of 100% from those in the South West region that might be expected given the number of units.

It may seem surprising, but autonomous units did make the largest number of comments on the advantages of 75/25 (80 responses) compared to aligned units (30). Autonomous units out number the aligned by more than 2 to 1. They also made substantially more comments (61), but with not as big a difference from the aligned (24), on the advantages

of 100% funding. Both autonomous and aligned made fewer comments on the downside of 75/25 with the aligned units making very few comments (6).

More units with a split CEO and MOH role responded to the advantages of 75/25 and fewer identified advantages to 100% funding.

In relation to the content of the comments, most responses were similar between MOH/CEO's and the Boards.

Responses to 75/25

With regard to the advantages of 75/25, the theme "Funding Provides Control" focuses on the belief that with 75/25 the unit will have more say in the direction of Public Health in their community because the 25% will be used for local needs. Substantially more Board responses (20) were to that point than those of the MOH/CEO. This point was repeated by a larger group of Board responses to the top disadvantage of 100% financing, "Lack of Control".

Autonomous and aligned alike who want some freedom and budget to respond to local health issues in the ways they see appropriate to their communities – this may mean through councils or broader community organizing related to the determinants of health.

Some believe that there will be more funding for Public Health if the 75/25 funding approach is continued because it will keep the municipality in the "game". Although it is a struggle, especially in some municipalities, some believe it can be done.

More MOH/CEOs commented on a disadvantage of 75/25 being that of dealing with hassles and conflicts with municipal politicians (10) as opposed to Boards (4). But some Boards did comment on this as well.

Responses to 100%

More Board responses identified removing funding pressure from the municipalities as an advantage of 100% approach (19), but MOH/CEOs did as well (11)

Others, particularly in the North but also in rural and some smaller urban areas, do not have the tax base to provide what they see as necessary for their 25%. They believe they are not able to "leverage" the funds because they don't have the local infrastructure required.

Many Boards and some MOH/CEOs are fearful of the province taking control of Public Health as it is perceived to have done with hospitals and school boards. Some see the shift to 100% as a potential "power grab" by the province. Some do not trust the MOHLTC bureaucracy to provide appropriate leadership, guidance and standards or support or to make funding decisions in a timely manner. Trust for a number of Board members is a serious issue. Some Board members are willing to try to pull their councils out of Public Health if necessary, but this is a small number. "You pay for it you run it." Some believe that once the province loses municipal involvement, then getting it back will be extremely difficult. The trust issue is exacerbated by the legislation that required

municipalities to provide the funding to which they comment while the province "may" fund according to the HPPA.

There are advantages to 100% funding seen by the respondents. Removing the funding pressure from municipal tax bases was a clear advantage for some as was preparing and defending only one budget. Some MOH/CEOs were extremely frustrated in working with regional or municipal Boards to the extent they were ready to leave their jobs. Some described having been undercut and having road repair take priority over Public Health with underhanded maneuvering by regional executives cutting their budgets.

Increased provincial equity was a concern for some supporting 100%. The possibility of more consistent standards for reporting led some to support 100%, although, it was seen to be needed for all funding approaches. Others believe that health is a provincial matter and Public Health should be fully funded by the province.

Many stated that all mandatory programs should be funded at 100% suggesting a combination of the two funding approaches. One supporter of 100% funding suggested that Boards of Health and the Province could contract with regions to provide Public Health services, just as it does with other services. In that way, some indicated a Board of Health could have some independence from regional budget processes but council members could be on Boards of Health as they are now.

For some, the funding approach doesn't matter as much as ensuring that there is clear long term planning which goes beyond political changes at the provincial level. Although, some MOH/CEOs are also clear, as stated earlier, that this issue also exists for local units where an election may change their Board of Health into one with which they cannot work and that would make getting budget approval difficult. This also points to the relationship between perceptions of the funding approaches and the governance issues involved which will be reported in the next Governance section.

There were questions as to the meaning of either funding approach as many were not clear what would be included. Some saw the 75/25 meaning 75% of the funding would fund 100% of the mandatory programs and the other 25% would be used for local initiatives. With this definition, then they believed 75/25 would allow them to generate more total funding for the local unit than would full provincial funding. Others wondered if 100% included all costs, administrative and other, for all programs even those developed locally. When the funding approaches are more clearly outlined as to what is included, some perceptions could change.

Question and Findings for Funding

32 QUESTION:

Assuming the 75/25 level of funding with either model, what are the advantages?

QUESTION CATEGORY	**Funding**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Funding**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Description of Themes

Theme: Municipal people involved, increased buy-in, closer link to community

Keeping the municipality involved in funding as well as in governance is a strong direction for many Boards and MOH/CEO roles. With their vested interest in the community and shared local responsibility, some see their involvement as critical. It would better leverage working with municipalities, meaning that more Public Health proposals can get passed like local by-laws. It builds connections between health and other municipal services and makes healthy public policy more likely. If the perception is that 75% of money is for mandatory programs and 25% is for local needs, it is even possible to leverage even more local funding. There is also more accountability when the municipalities are involved.

Theme: More Funding

Boards in particular, believed that the 25/75 split would allow them to generate more funding than the 100% model. Some see the municipalities contributing more than their minimum share or doing a 65/75 split giving a total of 130% of funding. This would imply local programs receive more funds. Some believe all mandated funding should be at 100%. Others believed that it is easier to find a way to keep municipal players in the game with the 25% requirement. Two sources of funding are seen to be better than one. One MOH/CEO stated that they had no trouble getting their funding approved locally.

Theme: Funding Provides Control

It is believed by many that if the municipality is contributing 25% it will have "Pay for Say" or "he who pays the piper calls the tune". This funding formula will ensure that the Province's 75% will be spent on health related issues. The perception is that the 75% will be for mandated programs and 25% will be for local needs. It is assumed it will reduce the hassle and conflicts when municipal politicians have to pay for mandated programs.

Theme: Flexibility in Implementation to meet local needs

Some local communities have particular challenges. Having locally generated funds allow those to be better addressed. Another saw the real advantage of having a discretionary amount in the budget

Theme: Efficient Use of Resources

Some believe that requiring 25% from the Municipality will increase the administrative efficiency and return for the money spent. They believe they are more able to be efficient with the use of funds than is the Province.

33 **QUESTION:**

Assuming the 100% level of funding with either model, what are the advantages?

QUESTION CATEGORY	Funding			SOURCE CAPACITY REVIEW SUB-COMMITTEE:	Funding
RESPONDENTS		MOH/CEO	√	**Yes**	
		Board	√	**Yes**	
		Management	×	**No**	
		Staff	×	**No**	

Description of Themes

Theme: Remove some funding pressures from municipality property tax base

Clearly going to 100% provincial funding would put fewer burdens on municipal tax base. Some are clear they do not have the tax base to support health care locally. The funding would come from income tax rather than property tax which some believe is more aligned with values in HPPA. Some who support this perspective believe that 100% funding means 100% control. Most others would want discretionary power at local levels. Some see 100% funding as providing stable funding that is not tied to municipal processes. Others believe that municipal councils may not object as Public Health issues are sometimes difficult issues for councils.

Theme: Consistency and clarity – don't have conflict of interest

Another area of advantages was related to an often quoted statement for both approaches, "Pay for Say". Some see an important advantage being that of less hassle in getting a budget passed. It would be clear what you have to do and where the money is coming from if you do not have municipal contributions. If the province is going to set standards and rules, then it should pay for them. Putting the accountability in one place for both money and programming will allow for a consistent and equitable formula. One respondent believed that health care should be provided by the Provincial government and all of it funded in the same way.

Theme: Equity across province

Some emphasized the importance of equity and the hope that it would be better addressed if Public Health were clearly a provincial responsibility. Again the importance of the variations in the local property tax base was emphasized. The North has a declining tax base while South has increasing tax base funds. For those emphasizing equity, unless Public Health is funded 100% by the Province the distribution of services will be inequitable, particularly in any times of recession or economic downturn.

Theme: Easier to get budget approved

This category is similar to the previous one and respondents occasionally combined their responses. Only have to prepare one budget and to go through one budget approval process was important to a number of respondents. Some saw life being easier for the MOH if she or he is not continually defending their budget on multiple fronts.

Theme: Consistent standards and expectations across the province

With 100% funding, some believed the Province would set priorities and move on those priorities. It would be more able to control the operation of the system. They believe it would also be able to better enforce the criteria. If units do not meet the criteria then they shouldn't get the funds.

Theme: Some areas should be 100%

No matter what option is used, it was important to a few that some programs be funded at 100%, such as infection control, CDC or environmental issues. "If they are mandatory programs, they need to be funded by the province."

34 QUESTION: ***Assuming the 75/25 level of funding with either model, what are the disadvantages?***

QUESTION CATEGORY	**Funding**			SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Funding**
RESPONDENTS		MOH/CEO	√	**Yes**	
		Board	√	**Yes**	
		Management	×	**No**	
		Staff	×	**No**	

Description of Themes

Theme: Conflicts with municipal politicians who have to pay for mandated programs

The theme statement makes the point well, so not many additional comments were added. There is concern by some in having to deal with municipal politicians to get the 25% as is stated in the advantages of 100%. One wondered if municipalities do not contribute their 25% will they still get their 75% (an issue that relates to the following theme as well).

Theme: Cost to municipal tax base

Some believe that Public Health is a provincial issue and should not be as much burden to the local taxpayer which has to pay off its deficit at the year end. It can't carry over a deficit like the province. As one said, "We're all suffering from downloads and so are looking for opportunities to upload!"

Theme: Inequity across province

In the North and elsewhere, there are units that do not pay their 25%. They are usually in situations of declining populations and tax bases. For these groups, the disadvantage of 75/25 is that they would not be able to generate their 25% from a property tax base.

Theme: Inequitable funding base

Another theme, with few respondents just reinforces the previous two, pointing to the inequity that will emerge in relation to the different funding bases of local units.

35

QUESTION:

Assuming the 100% level of funding with either model, what are the disadvantages?

QUESTION CATEGORY	**Funding**			SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Funding**
RESPONDENTS		MOH/CEO	√	**Yes**	
		Board	√	**Yes**	
		Management	×	**No**	
		Staff	×	**No**	

Description of Themes

Theme: Lack of control

Many Boards and some CEOs believe they will lose all choice with 100% provincial funding. The Province will be in complete control and they have seen this happening with the hospitals. Some believe that the province should pay 100% if they are mandating the programs. If the funding came as a grant where health units could provide the legislated programs within their whole budget, and allocate as they see fit. Otherwise this group sees the 100% option as a control move rather than a contribution mechanism.

Based on past experience with provincial cuts, there was also concern that under the 100% funding approach, the province would start a program and then cut the funding. They see the province as more likely to cut back in tight times due to the political process.

Theme: Less Community Buy In

Some firmly believe the community will be less involved if it has less ownership. Some councilors would decide on a "hands off" approach to their local Board of health.

If municipality has no input into funding, it will lose interest in the decision making process with regard to Public Health. If the school system approach is followed, then some believe the role of the Board will become less important. They are concerned that the province will end up controlling all the dollars, as is currently the case with the school system. This would reduce two way communications and municipal engagement would be lost.

Theme: More Restrictive / Less Creative

Some indicated that the 100% funding would lead to less creativity at the local level. "One shoe does not fit all." Some believe that it in fact would take longer for change as the provincial bureaucracy is slower moving than many local municipalities.

Theme: Ability to address local needs

Some responders anticipated a reduced ability to meet local needs and to function well locally. For example, local labour contracts would not work and the Board would lose its

local influence on appointments. It will be harder to reject programs that don't meet local needs and there would still be a need for additional funding to deal with local issues as it would be harder for the province to recognize small local issues.

36-42 QUESTION:

What sources of funding do you access in addition to municipalities and the province? How much do you get from each source? For what activities? What proportion is each source of your overall budget?

Where do you get your internal Human Resources, IT, legal and finance services? How are they funded? How do you determine appropriate charges for these?

QUESTION CATEGORY	**Funding**			SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Funding**
RESPONDENTS	MOH/CEO	√	**Yes**		
	Board	×	**No**		
	Management	×	**No**		
	Staff	×	**No**		

Introduction

This set of specific questions was collected and the information kept at a health unit level. The detailed information was passed to the CRC under separate cover.

Question Findings

The information was provided in either verbal or written format. Six health units did not respond to question 7 b. In general most health units are receiving some additional funding of $400,000 or less although one PHU received additional funding of $1,319,000 and at least three received no funding from other sources.

There were 33 respondents to question 7 c. Approximately 20 respondents have their own Human Resources and 18 outsource at least one other function (IT, Legal or Finance). Twelve receive services from their associated municipalities.

Section VII — Governance

Introduction to Governance

The Public Governance sub-committee posed a number of questions for the Phase II consultation. The questions focused on the governance implications of the two different funding approaches, overall questions on governance effectiveness, the configuration of health units, the sharing of services, surge capacity, partnering with other organizations and the organizational structure of the leadership within a Health Unit.

These questions were asked of the Board members, and/or the MOH/CEOs. We interviewed from 3-8 Board members per site, the CEO and MOH who were interviewed separately. Management and staff groups were not specifically asked governance questions but they often raised governance issues in a general question at the end of each focus group which asked them what other issues they wished to bring to the attention to the CRC? In several aligned organizations the CAO/General or City Manager or equivalent was also interviewed.

Each question or group of questions and the findings related to that question or question group are presented in the same format. The questions include a brief introduction and an overview or summary of the primary findings for that question. That is followed by a more detailed description of each theme used to categorize the responses of those interviewed or in focus groups. The words in that description follow those key words stated or put on flip chart paper by those interviewed or from the focus groups at the unit site.

Findings for Governance

Health units are looking for leadership, coordination and timeliness at a provincial level. All of the governance questions identified the need for improved provincial performance in one form or another. Common requests included the need for updated mandatory programs and guidelines that are standardized between health units. They see the need for equity in programs and access across the province and look to the province to ensure the supports and infrastructure are there for this to occur. A common thread running throughout the governance questions was the desire and need for the province to hold the Boards accountable. Many saw the governance issues had far more to do with the province holding Boards accountable than with structural issues. The need for funding approvals before the end of the year was mentioned often. The lack of coordination between Ministries is causing problems at the field level, with one manager stating that having "multiple ministries is an indication that the government isn't committed to Public Health." Other areas where leadership was needed was in the remuneration and recruitment of hard to fill positions, putting in provincial decision-making processes and measures , and providing tools to assist in the effectiveness of Boards and health units.

In terms of local Board effectiveness, the results were consistent with the interim report with Board orientation and Board Membership being mentioned most often. Respondents

mentioned the need for interest and experience in Public Health, diversity of members, need for local members and a skill based Board as areas to improve within the Board composition. There was some difference of opinion regarding the value of a skill based Board. The composition of the Board was mentioned more by autonomous health units than aligned. Just as prevalent as the nature of the Board members was the need to streamline the recruitment processes of the Board. The timeliness and selection processes for provincial appointees and the need to stagger terms were both mentioned frequently.

Strong concerns exist throughout the province regarding the current plans to move to a uniform model for governance. Respondents cautioned against changing something that was already working, with many seeing advantages of their own model. They cited the diversity of their different communities as reasons for needing different models. They saw the issues with governance as being more about accountability than structure and saw the province holding Boards accountable as part of the answer. A counter opinion is given by some MOH/CEOs who are frustrated with their current Boards and warn that without some changes more MOHs could leave Public Health. One MOH put it this way, "Public Health deserves good governance."

The importance of addressing local needs was another cross-cutting theme that emerged in the governance questions. Health units see the delivery of Public Health as a local issue – regardless of the funding models or governance structures selected. There is a strong leaning towards the 75/25 as this is perceived as providing more decision-making authority at the local level and more opportunity to address the local needs. There is an expectation that municipalities will have both the freedom and the budget to address the needs of their community. Even with 100% funding, Board members want to have their decision-making responsibilities reinforced.

The reconfiguration of health units also elicited strong opinions from health units. Population and geography were the two most commonly cited issues with population including the ability to service local needs and geography including the travel implications for staff, customers and Board members. Other factors which were often mentioned included the need to consider natural boundaries such as municipal or regional boundaries and the boundaries of partner organizations. The feasibility of amalgamation was also mentioned with concern that the costs and benefits in terms of health outcomes be considered as well as the financial implications. Respondents from health units that had already amalgamated agreed that there were short term issues with management attention, staff morale and service delivery. Longer term implications were mixed with one organization stating that they had experienced significant benefits, and the other not having seen any significant improvements in service delivery thus far.

From a structural perspective, respondents agreed that leaders within a health unit need a mix of Public Health knowledge and experience, business skills and people management skills with many MOHs mentioning that they did not feel prepared for the administrative aspects of their jobs when they took the position. There were strong warnings regarding having a lead executive that did not have Public Health experience as they would not understand the implications of many of the funding and staffing decisions to be made.

Opinions regarding whether the MOH and CEO roles could be split were divided with some tendency for those opinions to be based on what health units had in place now.

Surge capacity and emergency preparedness plans are underway in most health units although there is a lack of confidence that health units are really sufficiently prepared for a health crisis. (Some exceptions exist in health units who often respond to emergency situations.) Health units feel that more work is needed at a local level to complete the plan, but the real void is perceived to be at the provincial level where they feel there needs to be some coordinated decision-making, some funding and some holistic planning needed.

There is little in the way of services being shared now between health units although a willingness to do so in certain areas. Most commonly mentioned areas included specialized disciplines like toxicologists, hydro geologists and dentists. They also identified research and knowledge, program and communications development, administrative support and infrastructure were other opportunities for sharing.

Funding Model Implications

Introduction to Funding Model Implications Questions

The CRC Interim Report Governance section did not specifically address the governance implications of the current funding options. These two questions do and the responses are similar. The questions were asked of Board members only and are consistent with the responses given to specific questions on the funding model.

Findings for Funding Model Implications Questions

The Board's respondents certainly were more positive about their ability to govern in relation to local needs if the 75/25 approach were continued. At 100% funding, the Board members are adamant that local responsibility for decision making and Board membership be reinforced.

Regardless of the funding model chosen Boards want some discretion in allocation of budgets. This means latitude to move beyond mandatory programs in order to meet the needs of their local communities and local "autonomy" or freedom to make decisions in relation to local needs. To accomplish this, there needs to be local input and decision making authority. Decision-makers could include municipalities, regions or community members, although there was a strong emphasis on the need for continued municipal involvement in decision making

Boards emphasized that delivery is local no matter where the funding comes from, and thus governance and administration need to be local. It is at the local level that synergies for solution delivery are found.

Some Board members, both autonomous and aligned, are adamant about their local structures and their advantages and would greatly resist governance changes that do not respect what they have developed and learned over the last 20 years.

Clarity is required as to exactly what the 75% or the 100% will include. There is nervousness that the province's calculations will not reflect the true costs of the program (particularly administrative costs), or that funding will be granted and then arbitrarily

removed. With the 75% model, they are concerned that the provincial portion of the funding would dictate the municipal portion.

Question and Findings for Funding Model Implications

48 QUESTION:

If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?

QUESTION CATEGORY	**Funding Model Implications**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	×	**No**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Description of Themes

Theme: Flexibility to meet local needs

The largest response was from those who see the 75/25 funding approach as allowing local Boards to have flexibility in governing and allocating funding in ways that meet local needs. Input from the local community is required for good governance and could be from municipalities or from citizens. In any case, some Boards believe a 75/25 split will give them more discretion in allocation of budgets. They also believe it will allow them to find synergies to deliver solutions with other departments in a region or municipality. Some do not see the province as funding those with the highest needs. The approach would allow some municipalities to approve a program the government might disapprove. It gives latitude beyond the mandatory programs.

Theme: Continued Autonomy

These respondents believe that the autonomy of local Boards from the province is important – whether they are autonomous or aligned Boards. They believe that the municipalities should be equal partners with the community in decisions or that the current local Board should continue to have local control in governing the unit. These local Boards believe they still need to approve budgets be it for single or multiple years. They also want to develop business plans that incorporate key issues, like pandemic planning. At least one is insistent that if the autonomy of local Boards from the province is substantially changed, they may not come up with their 25%. Some municipalities would still want the majority vote at the table.

Theme: Don't really have any say (loss of control)

Some Boards are fearful that even the 75/25 funding approach will remove control from the local Boards and local municipalities or regions. One saw the 25% as just a "carrot to get engagement that doesn't really give us control" since many programs are mandated. Ultimately they believe the municipality has to have control over the money it spends. They believe that the more that province puts in – the more the municipal costs will rise. They do not want to be at whim of provincial dictates and expect to be consulted on any initiative that changes the funding relationship.

Theme: No change

Some Boards would not see any change in their current governing processes when the funding shifts to 75/25.

Theme: Responsible use of money

Other Boards believe local politicians are better at both money management and administration than the province.

Theme: Clarity for public regarding accountability

Some Boards took the opportunity to try to clarify the roles. One believes that the province should set programs and standards and allow the Board to hire and set policies. That would lead to more clarity in local governance. Some Boards were wondering what the province expects for the local 25%. It was not clear to them.

49 QUESTION:

If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?

QUESTION CATEGORY	**Funding Model Implications**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:		**Governance**
RESPONDENTS	MOH/CEO	×	**No**	
	Board	√	**Yes**	
	Management	×	**No**	
	Staff	×	**No**	

Description of Themes

Theme: Lack of Control

With 100% provincial funding some Boards believe they will be "lame ducks". When they receive complaints from the community they will have no ability (or budget flexibility) to do anything about it. Those Boards expect that the province will be prescriptive and the health unit will only do mandated work. They foresee that the provincial appointments would be majority as it is the funder who usually decides who sits on the Board. If not initially, they are concerned that the province will move to taking full control because it is paying the bill and thus there will be no accountability to the community

Theme: Same as current model

Others would see the shift to 100% funding leading to governance that is not substantially different form their current model, be they aligned or autonomous Boards. Some would see the municipality as equal partners. Others see the municipality as the deliverers of the service paid for by the province with clear accountability. They believe direct contact with the local municipalities is essential to effective Public Health services. Local people know the issues and know where connections to other local agencies and organizations. For this group, theoretically, decision making should not change – local people should be making decisions with respect to what is needed in their area.

Theme: Concern re: Buy-In

A few Boards expressed deep concerns that 100% funding would lead to rubber stamp local Boards. Some Board members were clear that if it went to 100% funding they would not be part of it. "If they pay, they run it".

Theme: Need for flexibility to meet local needs

These Boards emphasized that whether the province pays 75% or 100% it cannot deliver locally, making similar points to those above. Delivery will be done by some local Board which will have to have input on local needs (like an immigrant population). It will best be able to find synergies to deliver solution with other departments in a regional structure. It

will also know how to communicate and deliver effectively in a local community. It will be the most sensitive to local conditions. It was recognized that either model must still have 100% accountability to administer locally.

Theme: Still need municipal/regional input into directions

Some Boards repeated their concerns in a variety of ways. They wanted to be consulted on any initiative that changed funding relationship. With 100% funding they would expect to provide all the input and knowledge of their community so that the province could make decisions on how to expend resources. They re-emphasized that to get local synergies municipal involvement was required and local influence was needed.

Theme: 100% funding does not cover all costs

Some Boards struggled with the question. It was not clear to them what 100% funding means. "Is it per capita funding?" They wanted to know what such funding would mean if the province decides to change focus and the local community wants to keep the program going. With 100% funding from the province, the local Board or council involved could then get into trouble if the constituency wants to continue the service. They would need to find resources in addition to the "100%".

Overall Governance Effectiveness

Introduction to Overall Governance Effectiveness

These questions address the overall effectiveness in the governing of health units and what both the Boards of Health and the province could do to improve the effectiveness of governing these units. Both questions were asked of the Board members, with the MOH/CEO also being asked what the Board could do in improving its governing.

Findings for Overall Governance Effectiveness

The responses to these questions were consistent with the general direction of the CRC report. From a Board level, orientation and membership of Boards were seen as major issues with a number of themes addressing various aspects of membership.

The need for an independent Board was cited by a number of MOH/CEOs and by very few Board members. They indicated from a frustration with dealing with their Boards with one MOH/CEO warning that "If CRC doesn't make recommendations to remove embedded Boards, that people will leave Public Health."

From the perspective of what the province could do to support Board effectiveness, the findings were generally consistent with the CRC interim report with the need for timelier, harmonizing budget processes being identified as the number one issue. Two themes not reflected in the Phase 1 governance section included the need for the province to assume a stronger leadership role in creating uniformity between health units and supporting recruitment and remuneration for hard to fill positions such as MOHs, epidemiologists and Public Health inspectors.

The need for more Board and health unit accountability emerged again in both questions. In one question the emphasis was on the need for the province to hold the Board accountable, in the other it focused on the need for the province to provide the tools and measures so the Boards could hold their health units accountable.

Management and Staff at the end of their focus groups echoed many of the comments made by Boards, MOH/CEOs and CAO's. The following are some of the comments made by managers regarding the effectiveness of their governance bodies: "We need stable envelopes and multi-year budgets – programs get started and then stopped", "We need a consistent framework across ministries. We need the assurance of communication, collaboration and cooperation and timely information.", "We need leadership from Ministry.", "These are Public Health issues – it is no place for politicians to say no.", and "Multiple Ministries suggests that government isn't committed to Public Health – we need coordination and collaboration between ministries." Staff echoed similar concerns: "There is an urgent need for current meaningful mandatory program guidelines.", "We need consistency across province in program delivery.", "The mandatory programs are a huge limitation.", and "We need 3-5 year funding – sustainability and ability to show effectiveness. We should be able to carry-over budgets from one year to next. At a minimum, we need the budget before year end" and finally, "There is value for Public

Health to be integrated at community level – we need things to make sense for community."

29 QUESTION:

What 2-3 improvements in the governance of your health unit would have the greatest impact?

QUESTION CATEGORY	**Overall Governance Effectiveness**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**
RESPONDENTS	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Introduction

This question was asked to the Board, MOH/CEO's and CAO's in aligned organizations. The focus of this question was on how to improve governance overall. Some respondents were unclear as how to answer this question. They wondered whether they should respond based on their existing governance model, based on the way they would like their governance model to be, or the way they saw the province leaning from a governance perspective.

Question Findings

The top priority topic for improving Board effectiveness by providing orientation and training to ensure that those selected understand and are quickly educated on their mandate, roles and responsibilities. Board members indicated that "it takes a year to get the gist of the operation." The need for orientation is linked to the next point, Board membership as indicated by this Board members comment "There should be some orientation, some of us got on there because we got the short straw.

A key message that emerged from this question was how important people viewed the composition of the Board. Four of the top six themes discussed various aspects of who should be on the Board, how should they be recruited, and how to ensure that the membership of the Board remained effective over key transition periods such as elections. The need to have stability and solid processes for recruiting members was the second most often mentioned topic. Two Board member characteristics that were viewed as important included the interest and belief in Public Health, and the need for Board members to come from the local community as they are best able to assess local needs, they are connected to local infrastructure, and they are accountable through local politics. There was a difference of opinion as to whether a skill-based Board would be useful with some seeing the additional perspectives as being helpful while others were concerned about the tendency of skills-based members to micromanage. The four themes that emerged regarding the nature of the Board composition were stated far more often by autonomous Boards and smaller health units than by aligned Boards or larger health units which is not surprising as many respondents in aligned Boards assumed the membership was a given in their model.

The need for an independent Board was cited almost solely by MOH/CEOs (15 responses in comparison with 2 Board members.) There was a strong indication from CEO/MOHs of the frustration with dealing with their Boards. CEO/MOHs cited frustration with the fact that there is no separate forum where Council is the Board of Health. They described their frustration with the statement. One member articulated the frustration this way, "6 of our Board members of 9 are mayors or councilors. They have to have huge integrity to spend money they have in this room that they don't have in another room." One MOH/CEO warned that "If CRC doesn't make recommendation to remove embedded Boards, that people will leave Public Health."

The Board being held accountable for its mandate and the province holding the Board accountable emerged in this question as well as several others. This theme referred to having the province clarify the mandate and exert pressure from above. Respondents feel it is important to have an environment where the Board's performance expectations and execution as a Board is monitored.

Description of Themes

Theme: Board member orientation

Board member orientation was the most mentioned topic across all types of Health Units. Orientation is seen as extremely important with one Board member stating "It takes a year to get the gist of the operation". Standardized orientation and "templates" from the province would help. Specifically mentioned was the need to provide education on the mandate, roles and responsibilities of the Board. One member indicated that it is important to be more flexible around when orientation happens as it is not always easy to commit a day. Another member identified that "a buddy system" would be useful, so you had "someone who you could talk to help orient you."

Theme: Standardized Board member recruitment practices

The composition of the Board is extremely important to health units. This consists of both having the right members on the Board, ensuring the Board positions are filled in a timely way and working to stagger changes in the Board so that all Board members do not change at the same time. Related to this was the sense that there was a need to limit the time limits for seats, with one person specifically mentioning "limiting the tenure of the chair."

The number, timeliness and appointment process for provincial representatives was mentioned frequently. Respondents were concerned that the province doesn't put any thought into and that the process for appointing representatives is political with some people being appointed for the wrong reasons.

Some believed that there is a need to provide a "greater proportion of provincial reps vs. municipal reps" to "dilute the influence of ineffective municipal reps."

Theme: Interest/knowledge of Public Health

Respondents "dream of having members who are advocates of Public Health." They perceive current appointments as being made as part of an "old boy network" and would like the Board of Health to be able to determine what skill sets they need. Their feeling is that if people are on the Board for the wrong reasons, it can be very destructive.

Theme: More diversity of members

This theme covered both the need to have a mix of politicians and community members that included both citizens and partner organizations such as school Boards with a skill-based Board. There was a difference of opinion on the concept of having a skill-based Board. Some people felt that it would bring a variety of backgrounds and expertise with one MOH stating "I was a lot sharper when I had a skill based Board." Others expressed concern that the skill-based Board could cause "micromanaging."

Theme: Independent Board

This had to do with the Board of Health being independent from the elected council. There are two options included within this theme. One key message was the need to have the Board as a separate entity from the regional or municipal council. The other aspect, which was not mentioned as frequently, was the need for council to meet separately as a Board of Health where only Board of Health issues were addressed.

Theme: Accountability to local community

Respondents identified the need to have the majority of Board members come from the local community. Some saw this as including both local citizens and elected representatives while there was a very strong message from elected Board members that "if they are not elected, they have no accountability. The message was that there needed to be a very strong link between the payer and the operation of the health unit. They saw the Board as being a political responsibility and would resist having an outside Board. This theme emerged in both autonomous and aligned Boards. The messages regarding the need for citizen members were equally passionate with one respondent indicating it was important to have representation from the "average Joe" so they could say "this would work for me, this wouldn't."

Theme: Funding

The funding themes that emerged in this question mirror the themes that emerged in many other questions. There is a need for stable funding, so that when funding is put in place it is not taken away a few years later. Somewhat related to this is the need for faster approval of their budgets. This theme also incorporated the need of some units to have a bigger tax base in order to support their programs. Finally, it relates to the tension between the money and oversight that occurs with municipal politicians.

Theme: Visibility of Board

This was the need to have the Board visible to the community with its agenda being visible and published in the press. One respondent described some Boards as a "secret society" due to the current lack of visibility.

Theme: Board Accountability for Mandate

This theme emphasized the need for the province to take a leadership role in setting and monitoring the performance of the Board. There is a need for standardized performance metric that are monitored by an overall governor. This theme also referred to the fact that the MOH needed to report directly to the Board. Related to this theme but reported separately was the request of one Board to have better reporting from their staff regarding how their programs were doing against key indicators, trends and benchmarks and the availability of a "tool to help us know how well we are doing with respect to mandatory programs."

47 QUESTION:

What support from the province would help your Board maximize its effectiveness in governing?

QUESTION CATEGORY	**Overall Governance Effectiveness**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	×	**No**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Question Findings

The Board of Health responses to this question mirrored and supported a number of the findings from the Phase 1 work of the CRC, the strongest being a need to ensure sustainability and stability of the health units and the greatest concern within this area was addressing the issues associated with timelier and harmonized budget approval processes between local governance structures and the province. This theme was mentioned more often by smaller health units than larger ones.

There are two themes that were not reflected in the Phase 1 governance work. The first, "Assume stronger leadership role creating more uniformity among health units" reflects a desire for the province to play a much stronger role in identifying and supporting province-wide programs and not having health unit's "reinventing the wheel." Respondents want to see the province taking a leadership role in benchmarking, promoting a consistent and positive image of Public Health among Ontarians and helping to ensure portability and accountability across health units. One suggestion was to change guidelines into legislation with the cooperation of health units and to enforce that legislation. A caution goes with this desire. It is hoped that a stronger leadership role would not be operationalized by increased bureaucratic requirements from the MOHLTC.

The second theme "Support Recruitment and Remuneration for hard to fill Public Health positions" links more directly to the Public Health Human Resources sub-committees work. It reflects the Board's need for help with staffing certain hard to recruit for positions (e.g. MOH, epidemiologists and Public Health Inspectors).

Description of Themes

Theme: Funding

This is about disconnect between municipal/regional and provincial funding processes. This is predominantly about timelier and harmonized budget approval processes – "It's November and we don't have the 2005 budget approved yet". Other ideas are about ensuring consistent funding so programs aren't started and then funding taken away. Increased funding is needed as respondents perceive that health units are not given

enough resources to deliver mandatory core programs or that the province does not include sufficient funding for administrative costs in 100% funded programs.

Another aspect that emerged in this theme related to the MOHLTC bureaucracy and the "funny accounting that is done." Respondents see this as a "total disrespect for the needs of the community."

Theme: Appointment Process

This included timeliness and clarity on criteria and selection processes for provincial appointees including a better recognition of local Boards' recommendations. They want clarity of roles including better representatives of provincial mandate, and faster approvals of provincial appointees. There were also some concerns about the make-up of the Board being linked to elections and the need to stagger terms. This included ideas around the focus of Boards needing to be on Public Health and not be clouded by other competing priorities. This theme was identified almost solely by autonomous units with only one aligned unit indicating that this was a priority. This is not surprising as elections dictate the membership of the Boards in aligned units.

Theme: Assume stronger leadership role in creating uniformity among health units

This has to do with the province playing a stronger leadership role on province-wide programs so health units did not need to "reinvent the wheel." A number of areas where the province could play a role were identified induding: benchmarking, public image of Public Health, helping to ensure portability and accountability across health units and changing guidelines into legislation.

Theme: Governance Guidelines

This theme had to do with providing tools that would support the Board including provincial templates, bylaws, a constitution, and standard operational procedures.

Theme: Allowing local flavor

This had to do with allowing for local programs to meet the specific needs of the communities within the health unit. It also required the MOH to do research and guide the health unit at a local level.

Theme: Recruitment and Remuneration

This theme was identified only by autonomous units and had to do with providing help with staffing certain positions that were chronically hard to recruit due to an overall shortage in the province. Examples provided included MOHs, epidemiologists and Public Health inspectors. Specific ideas included campaigns highlighting Public Health positions and the possibility of creating a shared pool of these types of resources.

Theme: Health Unit Assessment

This theme was also only identified by autonomous units and indicated the need for the province to improve the ability to track health unit compliance. The focus of this theme seemed to centre on the ability of the Board to track Health Unit compliance more than the ability of the province to track the performance of the Board. The Board is asked to evaluate the MOH but it has no benchmarks on programming." There is a need for a better operational effectiveness assessment of health units and the need for tools to better assess the non-financial aspects of health unit performance.

Theme: Better Communications

This theme was identified only by aligned units and included two aspects. The first is the communication externally to the public on the nature and role of Public Health. The second reflects the internal dialogue between the province and the health units that is needed to support the setting of directions, and specifically the concern that the directions set tend to be Toronto-centric. 'They listen to Toronto – that does not apply here. We are simply puppets acting on behalf of the ministry."

Governance Model

Introduction to Governance Model

The CRC Interim Report indicated that it was exploring what would be required to move, in a staged manner, from the multiple models of Public Health governance currently in place across Ontario now, to a single model of governance for Public Health with far more circumscribed opportunities for variation to reflect local needs.

These questions explore with Board members, MOH/CEOs and CAO's the potential characteristics and implications of such a move. The questions regarding the implications of a change were somewhat problematic as respondents either made assumptions regarding what the new model would look like, or resisted answering because they couldn't until they understood the nature of the model being proposed.

Findings for Governance Model

Respondents questioned the need to develop a uniform model for governance. There were strong indications that many health units saw the advantages in the model that was currently in place and many expressed concerns about changing something that was working well. This theme emerged, both by respondents in either type of model with respondents articulating the advantages of their own model, and by the request to not fix Boards that are not broken. The diversity in governance, history, culture, and size were all stated as reasons why a single model was not the right direction.

The overall sense was that the question is not what the model is but how well it is functioning. This is about improving the effectiveness and accountability of Boards and not the structure.

Other responses included themes about factors that need to be in place regardless of the model chosen. These factors included effective Board members and membership processes, the ability of the Board to reflect the community they represented, clarity on purpose, roles and responsibilities and the need for stable funding.

Consistency in Programs and access to programs across province was also mentioned, as was the need for Board accountability and the need for the province to hold Boards accountable.

The questions regarding the impact of a change to the structure were problematic as the model being considered was not public information and therefore the question was speculative in nature. Nevertheless the answers to these questions supported the concerns identified in the question regarding the nature of the model.

Some staff and management focus groups were frustrated that they did not have a say in governance model because of how strongly this influenced their work so many added comments during the open-ended question at the end of their focus groups. The following are some of their comments that relate specifically to this topic. They are generally consistent with the themes already identified.

One manager echoed the leaders sentiments by noting, "The assumption is that all health units need to be fixed – this is a disservice to communities." One CAO interviewed asked "Why are the ones that are working, working? Investigate a health unit where it is working well – everyone talks about evidence based – look at evidence of where it is working" and another CAO stated "My sense is that they have already decided where they are going". A Board member stated that "We do not need a decision made in the South, the North had better be making decisions that affect us. We've been called Neanderthals (not by someone in the health sector], yet it shows the mindset of people decisions."

Governance Model Question Findings

30 QUESTION:

What do you think should be the key characteristics of such a model?

QUESTION CATEGORY	**Governance Model**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**
RESPONDENTS	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Introduction

This question was asked to MOH/CEOs, Board members and CAO's and elicited very emphatic responses from all three groups.

Question Findings

The responses to this question issue some strong cautions about changing the structure of Boards. The themes " Choose free standing / independent" and "Choose integrated because" can be really summarized as "Choose me because". 25 autonomous vs. 2 aligned units mentioned "choose free-standing independent" and 8 aligned vs. 2 autonomous mentioned "Choose integrated because". This is further supported by the theme that indicates that "One size doesn't fit all." There are clearly concerns about changing health units that are working well now as articulated by the several respondents who said "If it ain't broke, don't fix it." One important consideration is to have security and continuity for each area. Some specifically mentioned the danger of making structural changes in the midst of potential pandemic crises. Health units cited the many differences among health units – governance, history, culture, size…as reasons why a single model was not the right direction.

A number of other themes are more about the core factors that need to be in place regardless of the model. And all of these confirm what has already been suggested in the Phase 1 report and in previous questions. The most frequently mentioned was the need for effective Board members and membership processes. The others are the ability of Board to reflect community (which is mentioned more often by Board members); clarity on purpose, roles and responsibilities of Board; and stable funding.

There was also a desire to have Consistency in Programs and access to programs across province.

Board accountability in meeting its obligations once again brings up the need for the province to play more of a leadership role in clarifying Board obligations and ensuring that Boards are accountable and the willingness for the province to step in when they are not.

Description of Themes

Theme: Effective Board members and membership processes

This recurring theme was about Board turnover and instability and selection of Board members based on expertise or interest. As well it was about separation of roles and clear understanding of roles (better orientation and direction from province and the need to distinguish the role of the Board vs. management). The desire for a skills based and policy oriented Board was mentioned as was the need for people who are passionate, informed and interested in Public Health. There is a sense that Boards are in better shape now than they were when they had 100% political appointees. The need for timely approvals for appointees was mentioned, as was the desire for Board members to be selected from a community-based shortlist. There was also mention that membership depends on the form of Board and should be connected to funding.

Theme: Choose free standing/independent…

This is a mix of choose autonomous (don't change us) and ensuring that the Board of Health is fully focused on Public Health and the Public Health interests of the community (no competing priorities). The need to be able to speak and not worry about political fall out was specifically mentioned. Also mentioned was the need to have municipalities as partners but not front and centre.

Theme: Ability of Board to reflect community

This is about a connection and accountability to the community and ability to represent them and address their individual characteristics and needs. The interim report, in their effective governance principles, calls this: "Ability to reflect and represent the community." This is about recognizing that Public Health needs to be local and needs relationships with key stakeholders in order to achieve its objectives. This theme reflects the need to ensure that connections with local communities and partners are not lost and to involve local consumers who can represent some of the geographic issues within the Health Unit. Not surprisingly, this theme was mentioned most often by Board members who represented 19 responses vs. 6 by MOH/CEOs.

Theme: One size does not fit all

There are strong concerns about changing health units that are working well now with many health units saying "If it ain't broke, don't fix it." Health units don't believe that one single model is best for Ontario. The fact that school Boards have not decreased costs was mentioned several times. The many differences among health units such as governance, history, culture, size implies a need for variation. "Don't apply rural solutions where they don't fit" , "don't impose Toronto model on others", and "The governance model must fit the needs of the community" were three comments that articulated this need for variation. .

Theme: Board accountability in meeting its obligations

This includes the need for the Province to take a leadership role in ensuring that Boards are accountable and meeting their obligations. There needs to be clear expectations, evaluations at Board level and Board performance measures put in place. Imposing "clear consequences for not fulfilling its mandate" is part of the role of the province. The responsibility of the Board of Health needs to be taken seriously. It needs to think about Public Health and not just think of dollars. "The money should be shown as accountable and transparent of where it goes."

Theme: Clarity on purpose, roles and responsibilities of Board

This would include examples about clear purpose, roles, and responsibilities. Who has control of the purse strings needs to be clear. There is also clarity needed regarding the level of authority of the MOH, particularly in relation to the Board. Comments were made on whether or not the MOH should report to the CEO with differences of opinions on this issue. There was a sense that there is a need for provincial level coordination especially between Ministries.

Theme: Choose Integrated because…

Aligned Boards often felt that their model was the best because of the ability to get more leverage on our health care dollars through the ability to have more influence as a result of dealing with other departments on a daily basis. They also saw the advantages of the cost savings associated with administrative functions. They "can't see how standalone units can survive"; sharing these functions "takes advantage of economies of scale." They also saw Public Health as a public service like the others and should be handled as such. Finally, they saw it as important to link with other Boards that tie into Public Health; the dollars are multiplied when Public Health works with others.

Theme: Consistency in Programs and access to programs across province

Everyone should have same access to Public Health across province. Stable funding and assurance of equity across province taking into account population and geography are important. To do this, clarity and direction on the requirements set by government is needed. They feel they need backing and legislation from the province. and clarity on core Public Health functions.

Theme: Stable Funding and better timing of funding

This included "Pay for Say" comments. It also included arguments about why the municipality/region should continue to play a strong role on the Board of Health as they were the best representatives of the community, they are known, and they have the best fiscal responsibility.

It also included issues around the different approval times for municipal and provincial funds, control of money (75/25 vs. 100) and the fact that some respondents don't see connection between Public Health and municipal tax levies. Finally it referenced the issue

regarding the shift in funding that is associated with political changes, "Look at MOE and how they were gutted when less than sympathetic government came into power."

31 QUESTION:

What might be the impact of such a change on your Health Unit?

QUESTION CATEGORY	**Governance Model**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	×	**No**
	Staff	×	**No**

Introduction

This question was asked to MOH/CEOs and CAO's and was problematic. Many did not answer it because they said they could not if they were not told what the model was.

Others assumed that the model was their model so there would be no change and so could not see the significance of the question.

Others assumed that the model would include the key characteristics they had just described in their answer to question 30. So they could see only positive impact of such a change.

And others used the occasion to continue their argument for their current model and not any other.

Question Findings

The findings from this question are completely analogous with those from question 30 and can be summarized as you should choose me and you will be better off because… The caution regarding a single model not being the right answer continued and concerns regarding amalgamation also emerged.

Description of Themes

Theme: One single model isn't best for Ontario

Responses included concerns about the effect a change would have on both staff and Board members. Respondents felt that there isn't one single model that is best for Ontario and worried that the change would be disruptive. One MOH/CEO was concerned that they "would hate to lose the support."

Theme: Choose integrated

This included more arguments about the value of having aligned Boards. There was a sense by some that aligned organizations enabled the ability to integrate health issues with other municipal functions and avoided duplication especially of administrative

functions." They were also concerned that the proposed changes may reduce the level of funding provided.

Theme: Choose free standing/independent

Comments in this area included the pros of autonomous Boards and the cons of aligned Boards. Autonomous Boards can focus exclusively on Public Health and are not tied to the municipal or regional pay systems. It is easier for MOH to say the tough stuff with the autonomous model. Aligned Boards cause a loss of independence, loss of identity and decrease the health unit's ability to deal with issues.

Theme: Consistency in programs, health outcomes and assessment tools

This theme can be summarized as "if you change the model according to what I suggested in question 30" the impact would be positive. The baseline mandatory stuff would be cleared up, struggles around budget would decrease. We would all standardize what we do and would all be judged by the same criteria.

Theme: May involve integration with other health units

This was expressed more as a concern about possible amalgamation and the health units getting too big and being unable to manage that significant growth. It also included concerns about the needs of local populations getting lost.

79 QUESTION:

What might the impact of such a change be on your municipalities or region?

QUESTION CATEGORY	**Governance Model**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	×	**No**
	Board	√	**Yes**
	Management	×	**No**
	Staff	×	**No**

Introduction

This question was only asked of Board members and was also problematic. Again many refused to answer without understanding the model.

Assumptions were also made regarding the model and their answers reflected these assumptions.

The trend to continue their argument for their current model and not any other was also observed in this question.

Question Findings

Once again the findings from this question emphasized the desire to keep the current models. The people who felt they could respond to this question put forward a variety of arguments for the status quo including their desire to maintain control and accountability to local communities. Some were adamant that pulling out of a municipal base would lead to substantial costs for the Ministry and reduce services for the region. They believe that the provincial government cannot be trusted to take action based on their past lack of willingness to play a leadership role.

Also mentioned was a reiteration of their preferences regarding the two possible funding models.

Description of Themes

Theme: Nothing/minimal

This was based on the assumption that it would be their model that would be chosen

Theme: We would have no power or accountability

This included all the arguments for not going to a provincial model or a model where municipal or regional councils had less power. Concerns that were raised were: decreased local representation, ability to address local needs, lack of ownership, lack of

control and accountability. It was felt that the government did not need control as long as the local Boards understood and accepted their responsibilities.

Theme: Depends on model

This was identified by respondents who felt they could not answer because they were not told what the model was.

Theme: Less efficient

Many of the responses were arguments for keeping aligned or embedded health units. These arguments included the synergies that existed between health units and other city or regional departments and greater surge capacity. If a change was made you would lose efficiencies, accountability and become more reactive. Concerns about impact on staff (union/ pension plans/ benefits) were also mentioned several times.

There is a second type of response around arguments for not going to a provincial model or “uploading to the province.” This cites the lack of trust in the province and their history of “not taking action or playing a leadership role.” It also mentions concerns around the ability to consult and interact.

Theme: Financial Impacts

This question discussed the preferred financial models as well as the potential financial impacts of the model that the respondents assumed would be implemented. Arguments for both shared and for 100% provincial funding were put forward.

Municipalities also indicated that they feel they are more efficient in delivering services and there would be an increased cost for delivery of health services if the province were to take on the delivery. As a result the governing of health units should be left to municipalities.

Theme: Lose public support

This is the argument about visibility in the community, ability to respond to community needs and connection and representation of local diversity.

Configuration

Introduction to Configuration

The CRC is working to determine the "right" size and configuration of health units. This set of questions seeks to clarify the factors that should be considered when determining health unit boundaries and to draw on the experience of those who have undergone amalgamation to understand its impacts in the short and long term.

Findings for Configuration

The population and geography associated with a health unit were mentioned most often as key factors that should be considered in the configuration of health units. These two factors were mentioned by all respondent groups. This includes taking into consideration travel, and referral patterns as well as the needs of the local community. Also of importance was to consider the natural boundaries and structures within the communities and common partners (such as school Boards and community agencies) and the municipalities and regions with which the health unit works.

Another set of factors had to do with the feasibility of the amalgamation. Respondents emphasized that the impact on health outcomes and costs must both be weighed when considering amalgamation and questioned whether amalgamation would really improve their ability to deliver. This area was mentioned frequently by CAO's who generally felt amalgamation should not occur. Political will and the culture of the health units involved play a key role on whether realistically the potential benefits will be realized.

The experience of health units that had undergone amalgamation was mixed. All agreed that there were significant short term costs associated with amalgamation. The most often mentioned short term impacts were on the diversion of management attention, service delivery and staff morale. There was considerable polarity regarding the long term benefits. Only two health units had amalgamated for more than six months and their amalgamations had occurred under quite different circumstances. One of the two health units felt there was a very strong improvement in service and their statements about the positive impact were quite deep and broad. The other health unit had amalgamated a number of years ago at the same time as downsizing had occurred and had not yet seen significant improvements in service delivery.

The few health units which had taken steps towards amalgamation reinforced the short term negative implications of amalgamation and indicated that although these attempts occurred several years ago, the impact on the staff was still being felt.

6 QUESTION:

What factors should be considered in determining how and whether to reconfigure Public Health units?

QUESTION CATEGORY	**Configuration**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	√	**Yes**
	Staff	×	**No**
	Partners	×	**No**

Introduction

This question was asked of Board members, MOH/CEOs, CAO's and management. The smaller and autonomous Boards responded with significantly more responses in almost every category which may be explained by the fact they felt more threatened by the possibility of amalgamation.

Question Findings

Respondents suggest that the size of a unit's catchments area in terms of population and geography, are the most important factors to consider in reconfiguration of Public Health. Many of the factors that were identified in the study are similar to the factors identified in the interim report.

Respondents emphasized that Public Health is a community-based service which depends on knowledge of the local community, its customs and structures. The time required for staff to get to their service locations is a critical factor in their capacity to deliver the quantity and quality of service needed. From the alternative perspective, it is important that all potential consumers of Public Health be able to get to the point of service delivery. From a governance perspective, it is important for Board members to be within a reasonable travel distance to attend meetings.

Every unit strives to address the unique characteristics and needs of the local communities served. These include demographic factors such as aging populations, unique cultural communities such as immigrant communities, first nation reserves and Mennonite communities. Also important are the at risk communities such as the economically disadvantaged. One of the most highly mentioned subjects in this factor was the importance of keeping urban units with urban units and rural with rural units. There was an acknowledgement by both urban and rural units that the needs of rural units would likely get overshadowed if combined with large urban units. Management identified both population and the needs of the local community more often than the CEO or Board. This may be due to the fact that it is the management team that struggles with these issues on a day to day basis.

Any reconfigured boundaries should also consider natural boundaries and structures within the communities, *typical travel patterns*, *and* common partners (such as school

Boards and community agencies) and the municipalities and regions with which the health unit works.

The third level of factors had to do with the feasibility of the amalgamation. The base operating capacity of the unit has to do with whether the health unit has the critical mass necessary to support the infrastructure skills and expertise necessary to effectively serve its community. Some respondents felt that surge capacity should be part of what was considered in the base operating capacity of the unit while others felt that the answer to surge capacity was partnerships not amalgamations. Beyond the basic critical mass question, was the question of whether or not the benefits of the amalgamation would outweigh the costs? Respondents emphasized that the impact on health outcomes and costs must both be weighed when considering amalgamation and questioned whether amalgamation would really improve their ability to deliver. There seemed to be a general sense that there was a limit to economies of scale and that “Bigger is not always better.”

The next group of factors has to do with some of the key implementation factors of amalgamation. The first has to do both with whether the political will exist, and the number of political bodies the new health unit will need to deal with. The second has to do with the similarity or differences in the cultures of the health units involved. Both of these factors will have a considerable impact on the ease or difficulty of a major change. It is interesting to note that the management team mentioned current governing structures almost twice as often as either the MOH/CEO or the Board (15 vs. 8 for both MOH/CEO and Board).

Description of Themes

Theme: Geography

This has to do with the physical size and characteristics of the health unit’s catchments area. It describes the difficulty in providing service with a coverage area that is too large and includes the risk of losing touch with the periphery. It also includes the perception of accountability to the communities involved and the risk of distancing the relationships with the local, elected officials. More remote places are a particular problem. Inherent within this topic is the time required to cross the coverage area and how far customers need to go to get service.

Theme: Population

This has to do both with the overall numbers of people served but also the characteristics and needs of unique populations within the community. This also has to do with being able to know the community – if it is too large, it gets harder to know the community and its unique needs.

Theme: Boundaries, number and structure of related organizations/partners

This has to do with the boundaries of related organizations such as school boards, municipalities and partner organizations, as well as the natural travel and commercial patterns that exist within the related communities. Another sub-theme is the pre-existing alliances and networks and referral patterns that exist.

Theme: Base operating capacity of unit

This theme is about the critical mass necessary to support the infrastructure, skills and expertise required for *a unit to serve its* communities *and fulfill the mandatory requirements*.

Theme: Cost Benefit analysis

This has to do both with whether the affected communities can support the health units and whether the improvements in the health of the community and /or the efficiency of the organization will outweigh the health impacts and financial costs of the amalgamation.

Theme: Need for service (Local Needs)

This theme was mentioned separately although in many ways it is a sub-theme of population. The theme has to do with being able to service the unique characteristics of specific communities such as rural vs. urban and other unique communities such as Mennonites or aboriginals.

Theme: Maintenance of Accessibility

This theme was mentioned separately although it is highly related and essentially a sub-theme of geography. This theme has to do with travel time and travel/communication/ referral patterns. Travel time refers to how far/long public must travel to get service, to how far/long service providers must go to get to where service must be delivered, and for Board members to get to meetings locations. Travel and communication patterns refer to the naturally occurring patterns for service and communication. For example, people in Kenora often go to Winnipeg for services and for airline travel, rather than to Thunder Bay. Natural boundaries and other governance boundaries also receive mention here, with specific reference to LHIN boundaries not being used as template for amalgamation because they don't make sense for Public Health.

Theme: Current Governing Structures

This has to do with both the effectiveness of the current governance structures in terms of supporting the health units and whether or not the political will to amalgamate exists.

Theme: Adjacent Health Units

This has to do both with the effectiveness of the health units that are candidates for amalgamation as well as the compatibility of the cultures within the organizations and governing bodies.

Theme: If it ain't broke don't fix it

This speaks to the concern that some health unit's are operating effectively and amalgamation could affect their performance. One suggestion is that it may be more

effective to look at integration or sharing of services with other health care agencies rather than amalgamation.

4/5 **QUESTION:** How did consolidation improve or detract from your ability to provide Public Health services in the short and long term?

QUESTION CATEGORY	Configuration	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	Governance

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	√	**Yes**
	Staff	×	**No**
	Partner	√	**Yes**

Introduction

This question was formally asked to only four health units although a number of other health units identified the fact that they had been involved in amalgamation discussions.

Due to the small number of health units, the data was manually reviewed to develop the findings.

First the data from the four amalgamated health units was considered, then, where appropriate, additional information was gleaned from those health units where some steps towards amalgamation had been taken.

Question Findings

There was a significant polarity in the results of this question. The impressions of the two health units who have amalgamated for some time were at opposite ends of the spectrum, while the two more recent mergers acknowledged they were at the early stages and could not comment on the long term implications.

There was one health unit who felt there was a very strong improvement in programs and this was emphasized in all three of their respondent groups. Their statements regarding the positive impact on programs and their community as a whole carried some breadth and depth. While the other health units identified improvements in service, their statements were sparse and sometimes quite qualified such as "increased consistency in some programs." Improved communications and increased surge capacity were both identified by two health units and a strengthening of the management team (but not front-line) was identified by one unit. Two of the health units acknowledged that the fact that the merger was very recent had an impact on their ability to assess the success of the amalgamation. The fourth did see major improvements in service delivery as a result of the merger.

Three of the four health units identified an increase in resources and/or funding or their funding base as a positive impact of the merger.

In three of the four health units, there was at least one of the three respondent groups that either did not mention any positive impacts, or specifically stated that there were no improvements.

The data regarding how consolidation detracted from the ability to provide services provided slightly more consistency in results.

The most common issues cited were the impact on staff morale and the time and attention needed from management in dealing with the upheaval and integration of cultures and services. Making the management task even harder was the difficulty in planning caused by the changing environment. Both of these issues were identified by several of the respondent groups in several health units. Related to both of these issues was the associated loss of delivery performance. Both short and long term performance challenges were cited. All health units acknowledged the short-term impact on performance, while the two health units that amalgamated several years ago had opposite opinions as to whether there were long term improvements in service delivery performance.

The other issues mentioned included HR issues which included everything from union issues, to turnover to changing roles or loss of key staff. The difficulties associated with serving a larger area and the reaction of the affected communities was also mentioned. The governance issues associated with changing the governance structure and servicing more municipalities within a single health unit were mentioned a couple of times.

The polarity in responses is illustrated by the last two responses in which one health unit indicated that it did not detract from performance while the other indicated that amalgamations should not occur.

The few health units which had taken steps towards amalgamation cited morale issues and the one that had moved towards implementation also cited service delivery issues. Both health units indicated that although these attempts occurred several years ago, the impact on the staff was still being felt.

Partner's responses to the questions on how the consolidation improved or detracted from their ability to access services at their local health unit resulted in vague answers. Some of the responses included, "We used to have people come to schools more often, and there are fewer workshops now", "Putting an effort into streamlining services – this is a good thing", "The merger is helping, the key benefit to the merger is that the Health Unit has received more resources" and "No impact – I don't believe the consolidation either helped or hindered our health unit's ability to provide services" and one CAO noted "the integrated model is way more effective than setting a separate health board".

Organizational Structure

Introduction to Organizational Structure

This section has only one question which related to how much Public Health experience was needed by the executive director. It was asked to the MOH/CEOs. Respondents answered this question but also gave their views on whether or not the CEO and MOH should be a joint or two separate positions.

Findings from Organizational Structure

Respondents believe that a CEO type position should come with both an understanding and/ or experience in Public Health as well as business and people management skills. This was supported by MOH's who often mentioned that their training did not prepare them for the administrative aspects of their job.

Units with separate MOH / CEOs were less likely to indicate that there should not be separate roles (i.e. they felt roles could be separate) and more likely to indicate that Public Health experience is important. On the other hand aligned and larger units were more likely to mention that the roles should not be separated.

14 QUESTION: What type of Public Health experience is critical to being able to effectively carry out the role of the CEO/ED?

QUESTION CATEGORY	**Organizational Structure**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**
RESPONDENTS	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	×	**No**
	Staff	×	**No**

Description of Themes

Theme: Business Skills

This is about having strong administrative background and leadership skills. MOH's in particular report having insufficient training in this area – "I had zero prior CEO experience. It was a step learning curve.

Theme: Public Health Experience/Understanding

This is the need for the CEO to understand and/or have exposure to Public Health – its philosophy, politics, approaches and strategies. Some specific skills mentioned are epidemiology, evaluation, health promotion, policy analysis and an understanding of the social determinants of health. This was stated several times in several ways including, "If you do have the Public Health experience you are in a better position to access the need,

that's really important", and, "You are in a better position to interpret the mandatory programs. And if you have that you will be better at implementing it as intended", or "It is important to make decisions that are right for the community, not just the bottom line." One respondent mentioned that the extent of Public Health experience required depended on the health unit's access to a full-time MOH. They did not have a full-time MOH so the need for the CEO to understand Public Health was more critical.

Theme: Should Not Be a Separate Role

The message of this theme is that the MOH should have "primacy of command." There is recognition that MOH needs administrative support, which could come from an ED, CEO or CAO who reports to the MOH. People articulated the need for a combined MOH/CEO role in a number of ways. "The role should NOT be split. Should have one person as MOH/CEO and give them the right supports." "It's a real challenge if you don't have fiscal and personnel responsibilities, then you are advising the Board of Health on how to best do the job and they can easily ignore you. "[There is] endless friction where MOH reports to CEO." "[you can] put a strictly admin person in unit at a high level, but to put them in at the top level doesn't work – it does matter because they are the boss." "Non-medical people won't have a sense of what the ramifications of different situations might be."

Theme: People Management Skills

The theme relates to the ability of the MOH to work well with people, including both those above them and those below them. Respondents spoke about the need to understand and value staff, the need to have a comfort level with the "nebulous soft service". They also spoke of the need to deal with the Board of Health and associated politics. Respondents spoke of political expertise, leadership and policy making. They mentioned diplomacy and the ability to articulate issues to council.

Theme: Separate roles

This theme referred to the option of having the MOH and CEO as two distinct roles. Respondents in this theme included both those who advocated for two separate positions, and those who felt that either a joint role, or a separate role could work. Comments included things such as "Don't think doctors are necessarily the right people – the primacy of training is to be good physicians. I am glad to have someone else doing that role. That is not an area I am interested in", or "It could work both ways – it all depends on the people you hire – not the structure."

Theme: Some Specialized Skills

This theme is really a subset of the experience required in Public Health. Specifically mentioned were skills like epidemiology, and more generally "the person should have enough technical knowledge so they don't go out on a limb."

Surge Capacity

Introduction to Surge Capacity

These questions address both what has been done to prepare for Public Health crisis and what further needs to be done. The questions were asked to the MOH and managers and were clearly understood by both groups.

Findings from Surge Capacity

Conceptual planning for emergencies are in place in many health units and many have begun work on identifying sources of extra staff and ways to cross-train and /or redeploy staff. Pandemic planning is underway but in some cases is less far along than emergency planning.

What seems to be absent in many health units is the confidence that these plans are sufficient for responding to a crisis, although some health units feel well prepared because of their history and experience in dealing with emergencies or because their physical location creates some inherent threats. The sense is that while plans are there on paper, there is still a ways to go to have everyone really prepared. One respondent indicated that "surge capacity is a problem here." "Others responded with statements like "I am not sure about this overall." It appears that units have received more money to staff up, but even then in anecdotal comments from MOH and managers, there's not enough capacity to respond to a crisis. They still feel that they do not have enough staff to accomplish their day to day work, never mind addressing a Public Health crisis. It is interesting to note that answers by the CAO's to this question were completely consistent with those of the health unit staff.

Some health units have relationships with other agencies and municipal partners and several mentioned doing "table-top" exercises or emergency preparedness simulations. In other units the MOH's or other senior staff sit on Regional or Provincial committees.

Looking at the data cuts, two areas stand out. MOH is much more likely to mention Pandemic Response Plans than are managers. One reason for this may be that MOH are more likely to sit on Regional and Provincial Pandemic planning committees. On the other hand, managers are more likely to discuss Unit Emergency Preparedness plans than are MOH's.

There seems to be uneasiness over health unit's ability to respond to a crisis. Many feel overburdened with just responding to the needs of the provincial mandatory programs. Some "northern" unit MOH's did mention that they send staff when Toronto has a crisis but doubt whether there would be a similar response to a crisis up north.

The answers to what is needed refer mostly to system issues – provincial plans, coordination, knowledge, and funding. These are what you might expect from any organization working with a central presence where there are shared but unclear accountabilities and authorities. So we read this: we need more staff, more funding, better and complete plans, and clearer decision making processes.

19 **QUESTION:** How have you prepared for a possible Public Health crisis requiring support from other health units and agencies and the province?

QUESTION CATEGORY	Surge Capacity	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	Governance

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	√	**Yes**
	Staff	×	**No**

Description of Themes

Theme: Unit Emergency Preparedness Plans

Preparedness centers mostly on staffing: hiring additional staff, and in particular nurses and staff for infectious disease. This is also about cross-training and reconfiguring staff to better respond. Some mention also having a group of retired nurses on call. On the planning side, mention was given to emergency systems committees, plans based on past outbreaks, how to redeploy staff and what to stop.

Theme: Local/Regional Emergency Plans

This is about working with the local municipalities/communities in planning exercises and on planning committees. Participation in simulations and mutual local aid agreements also receive mention.

Theme: Pandemic Response Plans

Reference here was made more often to the need for such planning. Some units currently developing their plans.

Theme: Connect to Other Health Units

Here there are two poles – some units have formal agreements with other health units, while others have informal agreements. There is also indication that some units are either developing mutual aid agreements or have one in place. But there is no uniform sense of this from data.

Theme: Multi-Level Plans

This is a mix of names of governments and organization to which units have or are building relationships with. These include all levels of government, police, social services, PHAC and Center for Disease Control.

20 QUESTION:

What else needs to be put in place?

QUESTION CATEGORY	**Surge Capacity**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	×	**No**
	Management	√	**Yes**
	Staff	×	**No**

Description of Themes

Theme: Agreements and Mutual Aid

This is about the need for formal agreements with other health units, though in both management and MOH interviews other inter-agency agreements were also mentioned. The question of whether this should be mandated by the province is raised.

Theme: Staff and Support Strategy

From the MOH perspective, this is needing enough staff and more capacity to deal with a crisis. It also is about need for stable funding, and more funding for environmental health, inspectors, and a pool of resources to call upon.

Theme: Improved Government Decision-Making/Support

This is about the need to improve government response – both to budget needs ("Public Health is approximately 1.5 – 2% of total health care expenditures") and to creating specific provincial and regional plans, as well as clear decision making processes. There's some suggestion in the responses that Ministry personnel need to be better informed and trained in order to help health units.

Theme: Provincial Pandemic Planning

This is essentially the same as Improved Government Decision-Making although is focused specifically on pandemic planning.

Theme: More Training

This is about exercises and testing of response, augmenting cross training and better trained communicable disease investigators

Theme: More Staff

This is about the need for more staff, both to handle any surge and to address day to day service requirements and needs

Theme: Finish Plans

This reinforces comments in the previous question that emergency preparedness and pandemic plans need to be updated and completed.

Theme: MOH in Every Unit

The only comments were from managers about the need for authority and credibility when there is a crisis.

Theme: Nothing Major

This theme was mentioned only by managers.

Theme: Theoretically temporary reactivation of licenses

This comment was made with no additional explanation provided.

Shared Services

Introduction to Shared Services Questions

These questions were asked to Board members, the CAO's, MOH/CEOs and management.

Many respondents did not clearly understand, or interpreted differently, the term "shared services". Rather than understanding it as a contractual relationship, they tended to focus on the 'sharing' aspects of collaborative working with other Health Unit's. Many of the Boards were not aware of this level of operational detail, and were not able to respond accurately to the question, or referred the interviewer to the MOH or management for further corroboration. This lack of consistency in understanding the question also yields inconsistency in reporting between respondents, i.e. for the same location, management and MOH may provide different responses to what are largely questions of fact, vs. questions of interpretation or opinions.

The question regarding what services could be shared was well understood and produced much better data at the CEO and management levels. Board members and CAO's had the same issue of not having sufficient understanding of the operational details to be able to answer this question effectively.

Findings from Shared Services Questions

Most health unit's have very few contractual relationships for shared services. Where these exist they are narrow in scope and are largely for specialized skills such as dentistry. Many report no sharing of services. Nevertheless, many health units collaborate with each other in formal ways such as MOH coverage or mutual aid agreements, or in informal ways such as sharing information or shared development of programs and services. Voluntary collaboration appears to be working well. When sharing of services does not work well, it appears to be due to differences in health unit infrastructure (organizational level, policies, protocols, reporting lines) and differences in program and service delivery priorities based on the varying needs of local populations.

Dental collaboration appears to be working well

Voluntary collaboration and cross-health unit sharing appears to be working well, particularly with regard to information and ideas. It is noted that a key competency of any health unit is their ability to develop local partnerships, so many use this skill with each other, particularly where they have similar goals and collaboration will result in cost savings, or 'not re-inventing the wheel'. The effectiveness of the collaboration may depend on the specific program area.

Ineffective collaboration appears to be caused by differences in health unit infrastructure (organizational level, policies, protocols, reporting lines), differences in program and service delivery priorities based on the varying needs of local populations and hence different levels of priority within health units.

There was more substantial data collected in terms of what services could be shared. Health Units report needing greater access to specialized disciplines like toxicologists, hydro geologists and dentists to provide effective services to their communities. They also identified the opportunity to share critical supports to enable them to be efficient service delivery units. Research and knowledge, program and communications development, administrative support and infrastructure were some of the support services mentioned.

7,8,9,61 QUESTION:

Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they? What works well? What does not?

QUESTION CATEGORY	**Shared Services**	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**

RESPONDENTS			
	MOH/CEO	√	**Yes**
	Board	√	**Yes**
	Management	√	**Yes**
	Staff	×	**No**

Description of Themes

Theme: Collaboration with other health units

Many health units talked about 'sharing' in a spirit of co-operation, referring specifically to MOH vacation coverage, mutual aid agreements, support during outbreaks participation in regional networks and specific program or service development. This collaboration is not reported by health units serving the largest population areas (>600,000).

Theme: No

Most health units have very few contractual relationships for shared services. This lack of formal arrangements seems to be more pronounced for aligned and large health units than for autonomous which is not surprising as aligned and large health units would tend to be more likely to have the scale to be self-sufficient. A common response to this question was "No, we don't share officially" and then proceed to talk about various collaborative arrangements with other units.

Theme: Dentistry

Several health units reported sharing a Dentist or Dental Consultant. This was more often indicated by Autonomous than Aligned health units and not mentioned at all by health units serving the largest population areas (>600,000)

Theme: Health Communication and Promotion

Specific collaborative arrangements are reported to support health communication and promotion, i.e. joint programming or partnerships on specific campaigns, media coverage (e.g. tobacco, obesity strategies, Northern Healthy Eating Campaign).

Theme: Research and Evaluation

Some report collaboration on Research and Evaluation, referring to sharing of information, resources, libraries services, Regional Information Control Network, and through PHRED's.

10 QUESTION:

What types of services could be shared or configured differently?

QUESTION CATEGORY	**Shared Services**		SOURCE CAPACITY REVIEW SUB-COMMITTEE:	**Governance**
RESPONDENTS	MOH/CEO	√	**Yes**	
	Board	×	**No**	
	Management	√	**Yes**	
	Staff	×	**No**	
	Partners	×	**No**	

Description of Themes

Theme: Research and Knowledge Transfer

Responses here tend to corroborate other findings for more structure and coordination in research and knowledge transfer, specifically the need for a central clearing house for research findings, sharing of ideas and best practices, program evaluation, library services and collaboration with PHRED units and universities.

Theme: Communications

There is a sense of significant duplication of effort in developing health promotions and communication campaigns. "Don't understand why 36 Health Units do their own thing." Specific elements include regional communication campaigns such as Tobacco – "smoking is smoking", development of creative materials, graphics design and shared media purchases.

Theme: Support Services & Administration

There is some endorsement that sharing of support services would lead to efficiencies and cost savings. Suggested services include legal, certain aspects of HR such as legal expertise or payroll, centralized purchasing, IT, and translation services. It is not surprising that the opportunities for sharing administration and support were mentioned somewhat less by the largest health units.

Theme: MOH

This refers to having an MOH at the regional level overseeing 2 or 3 health units depending on the substructure. This would require having more associate MOH's at the local level. One health unit indicated the possibility of having one MOH for multiple health units if each health unit had its own CEO.

Theme: Specific Technical Disciplines

A range of specific disciplines were mentioned where a health unit needed access to but could not justify a full time resource, or where resources were particularly scarce.

Disciplines mentioned included toxicologists, epidemiologists, hydrogeologists, and dentists.

Theme: Directors

The possibility of sharing directors but not managers was mentioned twice. The emphasis of this statement was on not sharing managers between health units.

Partnering

Introduction to Partnering Section

A key role of the health units is that of partnering and creating connections in the community. These partnerships help educate and create awareness around Public Health goals, and enable more effective and efficient programming, wherein working together they are able to increase their efficiencies, reduce costs and reach more clients.

Information on health unit partnerships was collected from both an internal and an external perspective

The management and staff focus groups were asked which municipal or regional staff they worked with most closely and what worked and what could be improved in these partnering relationships. They were asked a similar question of local agencies. The answers to these questions are provided in the first part of this section

Each health unit was asked to identify three partner organizations to interview. The partner organizations were asked to describe their relationship with the health unit, what was working well in the partnership, how they would describe their organizations communication with their health unit and what they would like to see improved. They were also asked whether or not they had ever attended a Board of Health meeting and why or why not. The answers to these questions follow the questions above.

Partners who work with health units that had amalgamated in the last ten years were asked about the affect of that amalgamation. These questions are the same as those asked of the health unit and the answers are integrated in with the configuration questions in the governance section of this document.

Findings for Partnering

58, 59, 60 QUESTION: ***Which municipal or regional staff do you work with most closely? What works well? What could be improved?***

QUESTION CATEGORY **Partnering** SOURCE CAPACITY REVIEW SUB-COMMITTEE: **Partnering**

RESPONDENTS		
MOH/CEO	×	**No**
Board	×	**No**
Management	√	**Yes**
Staff	√	**Yes**

Introduction

These questions were asked of the management and staff groups. Each group answered in a similar fashion, both with respect to the types of people they work with (groups), the frequencies (number of times each group was mentioned) and the reflections on what was

working well. There were no comments recorded on what could be improved, perhaps because of the length of the list or the timeframe for the overall task.

Description of Findings

The names of these groups are self-evident and the responses are listed in order of frequency mentioned:

- Social Services
- Office Administration
- Regional and Municipal Councilors
- Planning (Land Use)
- Municipal Government (City By Laws and Licensing)
- Children's Services
- Fire, police
- Community and Public Works
- Liquor inspectors
- Other government agencies
- Recreation
- MOE
- MOHLTC
- Federal Government (aboriginal and Health Canada finance and administration)

43 QUESTION:

What local agencies do you work with most frequently? Most effectively?

QUESTION CATEGORY	Leadership and Professional Development	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	Partnering

RESPONDENTS			
	MOH/CEO	√	Yes
	Board	×	No
	Management	√	Yes
	Staff	√	Yes
	Partners	×	No

Introduction

This question was asked in the staff and the management focus groups. The majority of the respondents in each group listed the agencies they worked with and concluded that all of their relationships with the listed 'partners' worked well. There are no significant differences between the staff and the management group either in how they answered the question or the content of their answers. Indeed the frequencies of responses per theme are approximately the same across both respondent groups.

A key role of the PHUs (detailed in the MHPSG) is that of partnering and creating connections in the community. These partnerships help educate and create awareness around Public Health goals, and enable more effective and efficient programming, wherein working together they are able to increase their efficiencies, reduce costs and reach more clients. Thereby, the responses to this question indicate that both the management and the staff are well aware of this mandate, and perceive themselves to be working toward meeting it.

This question was also included in the MOH interview, however there were no MOH responses recorded. Probable causes include a) the interviewer did not ask the question because s/he knew it would be covered with the other respondent groups, b) the MOH had already addressed the answer to the question in a previous response (i.e. what are your key accomplishments) and thereby it appeared redundant, c) there wasn't enough time to provide a considered response given that it was toward the end of the interview (and for many interviewers there were too many questions to cover in the allotted time).

The 'themes' for these are self-evident. The organizations are listed in the order of frequency mentioned:

Description of Findings

Theme: Education

- School Boards
- Universities & College

Theme: *Health Agencies and Professionals*

- Hospitals
- Heart & Stroke
- Canadian Cancer Society
- Long Term Care
- Community Health Centres
- CCACs
- Other Health Units
- Health Labs
- Physicians
- Dentists
- Pharmacists
- Chiropractors
- Veterinarians

Theme: *NGOs, Coalitions, Volunteer groups*

- Lung Association
- Infant Development
- Cancer
- Heart & Stroke
- Literacy
- Diabetes
- MADD
- Community Living
- Food Inspection agency
- Salvation Army
- Red Cross
- Poverty Prevention
- AIDs Organizations
- CFIA
- OMAPHRA
- Resettlement agencies
- Neighbourhood Associations
- Farm Organizations
- Agencies working with First Nations populations

Theme: *Children's Agencies*

- CAS, FACS
- Treatment Centres
- Children's' Mental Health
- OEYC/College
- Day Care
- Infant Development

Theme: *Recreational Agencies*

- YMCA
- Conservation Authorities

Theme: Police, Fire, and Ambulance

- None listed

Theme: Business

- Workplaces
- Chamber of Commerce

Theme: Media

- None listed

78-84	QUESTION:	***Describe the ways in which your organization partners with your local health unit. What is working well in your partnerships? How are your organization's needs and interests being addressed through these partnerships? How would you describe your organization's communication with your local PHU? What would you like to see improved? Have you attended a Board of Health meeting in the last year? Why or why not? What value did you get if you attended***

QUESTION CATEGORY	Partnering	SOURCE CAPACITY REVIEW SUB- COMMITTEE:	Partnering

RESPONDENTS			
	MOH/CEO	×	No
	Board	×	No
	Management	×	No
	Staff	×	No
	Partners	√	Yes

Introduction

Each health unit was asked to provide names of three partners to be interviewed in order to get an external perspective on health units. A total of 78 different partners were interviewed from a variety of different organizations including 16 school Boards, 15 hospitals, 28 community care or medical companies, 4 charities and 15 other types of organizations.

Most questions asked pertained to all partner organizations, a few pertained to only those organizations that had undergone configuration. These answers have been incorporated into the configuration section.

Findings

A wide variety of organizations were interviewed and not surprisingly they partnered with their local health unit's in a variety of ways. These included the support or creation of numerous programs. Some examples of these programs include a Pap Smear Clinic; a Hands Clean Campaign, Tobacco, Diabetes, AIDS, Shelters for Abused Women, Violence Prevention for Children, obesity programs and Health Eating programs. Organizations also partnered with their local health units to provide immunizations shots for Rubella, Influenza, Polio, and the Flu. Environmental Issues were also addressed by various health units including the testing of septic tanks, Health Inspections in homes and water testing. Family Support and Education was another key area that organizations partnered with their local health units. The units provide education on issues such as breastfeeding, outbreaks, and hand washing, provide Healthy Babies programs and pre-natal counseling for high risk women and teens and work with immigrants and refugees. Infection Control was also listed by several organizations including working with health units on West Nile, SARS and Influenza outbreaks.

Services provided in schools include Sun Care classroom teaching, Sexual Health clinics, and Child Obesity and AntiBullying programs. Health Units also provide partners with sponsorship and funding opportunities for a number of projects including an End of Life program, Flu Clinics and a program to enable home bound people to receive immunization shots. Pandemic Planning was also listed as a joint project along with emergency disaster planning for two nuclear plants.

Some partners noted that they share space and some resources with their Health Units.

When asked what was working well in their partnerships virtually all organizations interviewed replied that everything worked well, communication was good, leadership and program supports worked well and pandemic planning and infection control issues were being addressed. A few organizations commented that Health Units were doing a good job of training staff, and that "The health units have helped with relationship with all community agencies".

Partners were asked how their organization's needs and interests were being addressed through their partnerships. The majority of partners interviewed replied that their needs were being met well and some listed their various joint projects with little or no elaboration.

When asked to describe their organization's communication with their local health unit all but four partners responded that communication was good to excellent. Some responses included "gets better all the time", "SARS and pandemic planning have added extra layers of communication", "open and accessible"; "outstanding" and "first rate." Communication venues cited included e-mails, meetings (sometimes daily), newsletters, faxes and regular telephone calls. One partner did however note that it "Has been frustrating with SARS, trying to get consistent information" and others said "Not immediately evident as to who is in charge in an outbreak and "we had no communication during legionnaires disease".

Suggestions for what partners would like to see improved included: Additional resources and funding for their local health units, streamlined processes between municipal and provincial governments and more cooperation regarding pandemic planning.

The majority (66 respondents) of the partners interviewed had not attended a Board of Health meeting within the last year. The most common reason cited was that they had never been invited followed by a lack of interest in the topics discussed. Of those who had attended a meeting most were there to either comment or present on a particular initiative.

Appendix A Consultation Design and Methodology

Phase II of the Capacity Review Committee's work entailed a series of interviews and focus groups with health unit staff, managers, MOH, CEO, CAO(where appropriate), Board members and local partners *to probe* on specific issues identified by its subcommittees based on the information that had emerged during the Phase 1 survey and their other research activities. The objective of this phase was to gain a deeper understanding of the current issues faced by local Public Health Units and understand their current capacity so as to further inform the work and recommendations of the five CRC sub-committees. The evaluation was conducted between October 13 and December 15, 2005. All 36 Public Health Units were included in the stakeholder consultations The list of health units consulted can be found in Appendix D-Table 12 - Detailed PHU Demographics on page 108

Consultation Team

Starfield Consulting put together a team of 9 consultants and a logistics coordinator. Two principal consultants oversaw all components of the project and liaised with the CRC and its representatives. They were assisted by four other team members during the field consultations. These six consultants were then supported by three data management assistants to do the compilation and summarizing of data. The first and second levels of findings were done by the six field consultants and the final reporting of findings was prepared by the two principal consultants.

Design of the consultations

A one-day briefing meeting was held in mid-October with six of the Starfield team members. The purpose of the meeting was to review the project intent and deliverables, and provide context on each of the areas that the five CRC sub-committees were interested in exploring.

Starfield's two principle consultants then met with chairs of each of the sub-committees and the SPIB assigned staff person to clarify their lists of questions. In the one-half to one hour meetings, Starfield asked the subcommittee chairs and staff to clarify their intent in asking the question, and the wording, length and their identification of targeted respondents (which respondent group has expertise and context to provide the most meaningful and useful information). The questions developed were then also reviewed by senior staff within MOHLTC who made the final decision as to the questions to be asked. Some questions were eliminated and others revised based on the priorities of the CRC research and available time for the consultation at each Public Health Unit.

Some questions were asked of only one respondent group while others were asked of multiple groups. If a question was asked of multiple groups it was often framed differently in order to add clarity for that specific group. It was expected that Starfield would undertake one or more meetings/ interviews with all Public Health Units in Ontario and that medical officers of health and boards of health would be included in these as well as others on an as needed basis. After consultations with the subcommittees, it was decided that leadership (CEO, MOH, CAO, Commissioner of Health and others), board members, management and senior professionals, staff and partners would be consulted in all Public Health Units. Starfield's proposal for the work was that there would be one day on-site visits. Given the number of stakeholders, a proposed schedule for the interviews and focus groups was developed and confirmed. It was agreed that interviews with partners would be conducted by phone.

Each health unit was sent a letter from the Executive Lead, Public Health System Transformation explaining the purpose of the stakeholder consultations as engaging with health unit executive and staff, Board members and local partners for guidance, advice and feedback on Public Health policy and planning issues within the CRC mandate. The letter also introduced Starfield and requested that a date during November be identified for the on-site health unit consultation process; that a contact person be identified to be the point person to help arrange the visit and to provide support to the Starfield facilitator while on-site; and to contact Starfield by phone as soon as possible with this information.

Consultation Tools

Interview and Focus Group protocols

Draft protocols for the interviews and focus groups were developed based on the approved questions and respondent(s). Leadership, board members and partners had interview protocols and management/senior professionals and staff had focus group protocols. The reason for the two types of protocols was to accommodate difference in numbers between the respondent groups. There were four types of questions asked.

- Most questions were designed to understand participant's views on specific areas of interest for CRC subcommittees.
- A few questions were focused on issues experienced by only handful of health units (e.g. those who had undergone consolidation within the past ten years). These questions were asked to only the applicable Health Units. A general summary was done for these questions.
- A few funding questions required detailed information specific to the health unit. These questions were sent to the health unit prior to the consultation and prepared answers were collected during the MOH/CEO interviews. The health unit responses have been submitted separately and a high level summary is included in this report.
- Two questions were included to get an overall sense of the accomplishments of the Public Health System as a whole. A summary of these questions has been included at the beginning of the findings section.

Questions were sorted for appropriate flow to better engage conversation and cover similar topics at one time. This was seen as a necessity because of the overlap in interests

between some of the subcommittees' questions. In addition, a suggested on-site agenda and health unit instruction sheet was created (see Appendix H)

A total of 83 questions were included in the data collection process. The CAO and MOH/CEO respondent groups were asked 34 questions; Management and Senior Professionals were asked 33; Board members were asked 32; and staffs were asked 21. Up to three partners per Public Health Unit were also interviewed and they were asked ten questions each. All questions were coded and entered into an excel spreadsheet. A master list of questions and respondent lists of questions were created. See Appendix B for the master list of questions.

During the first week of November, the overall agenda and question protocols were trialed at four PHUs: Chatham- Kent; Haliburton, Kawartha and Pine Ridge; Grey Bruce; and Waterloo. These initial sites were selected based on their availability within a short lead-time. They also covered a reasonable representation of the demographic interests for the overall system (autonomous/aligned, size, region, leadership, and MOH status).

Based on the feedback from these sessions, some changes to the flow of protocols were made. As well, a triaging of questions for the Medical Officer of Health (MOH) and the Chief Executive Officer (CEO) was done to better distribute leadership questions when there were separate CEO and MOH interviews (one hour allotted for each was not enough time). The redistribution was based on who had the most context to provide meaningful responses. Given the time constraints the information collected from these first units was included in the findings.

Limitations of the protocols

The trial and adjustment of protocols was not intended to be a rigorous field testing of the questions as this was not possible given the timelines for the project. This was considered acceptable given the open-ended nature of the consultations and the type of reporting of findings that had been agreed to during the contracting process.

The development of questions did not follow rigorous research standards. A number of questions were not clearly separated out as two-part questions. Others did not give enough context to ensure comparable responses. And a few were leading questions. Question codes were assigned after field consultations began.

Coding template and theme sheets

All questions were open-ended and generated a tremendous amount of data. In order to manage the volume and type of data that was being gathered, a coding template was developed. Coding is the process of breaking down data into concepts and categories. Open coding involves detailed reading of interview transcripts and the identification of concepts (key words, succinct examples and quotes), which are then grouped as categories (themes). Theme sheets were developed as the tool for the open coding data analysis.

The coding template was based on the type of analysis that had been requested of Starfield: a reporting of themes, patterns, and trends seen in the data. See Appendix I for

a copy of the coding template tool, which was produced in Microsoft Word. The template was designed to link locations where theme descriptors appear in the responses and to include descriptors to ensure that themes were well understood. All themes and descriptors within a response were recorded so that for some locations, opposing themes could be included. It also meant that no level of prioritization could be attributed to responses, which is also a function of the questions asked. What could be seen through this analysis was how often an idea was raised. This could be considered a type of priority but should be considered more of a "top of mind" response. Questions would have needed to be framed differently and design of the consultations changed had priorities been sought.

A theme sheet based on the coding template was generated for every question. Questions that were shared between respondent groups were first themed independently. During the first round of data entry into the theme sheets all relevant quotes, key words and succinct examples were captured for all themes. Interview notes from nine health unit's (Chatham-Kent, Durham, Grey Bruce, Halliburton, Kawartha & Pine Ridge, Lambton, Niagara, Perth, Waterloo, Wellington-Dufferin-Guelph) were used in the first round.

The themes and key ideas were then quickly reviewed for each of the theme sheets. For those questions that were asked of multiple respondent groups, the theme sheets were compared and harmonized (same theme sheets created across all respondent groups). No data was discarded during this process; however, it became apparent that the use of theme sheets was not possible for all questions. Some questions generated minimal data while others generated long laundry lists so that approximately 50% of the questions were themed.

This first set of harmonized theme sheets was then used for data input for the next 18 health units. After data entry into the sheets was complete for this set of interviews, the "top" themes were identified. As the work on identifying "top" themes was being done, some inconsistencies in theming were noted and a number of questions were re-themed to address this. Again, the first set of harmonized theme sheets with the exception of the re-themed question sheets were used for theming the final nine health unit's.

A total of 26 theme sheets were developed for MOH/CEO questions; 34 for Board questions; 29 for Management and Senior Professional questions; and, 14 for Staffs questions. For those questions that were asked of multiple response groups, theme column is identical for respondent groups; location and description or keyword columns are not, although description columns are similar because they represent the different stakeholder perspectives on the same theme.

Limitations of the theme sheets

Many people were involved in the development of the theme sheets allowing for a richer but probably less consistent coding of the data. The very aggressive consultation schedule did not permit a rigorous level of quality control. It did, however, allow for a general testing of assumptions and highlighting of patterns around demographic cuts.

Demographic cuts

Although it was possible to identify some of the demographic interests of the CRC subcommittees by reviewing the approved questions, Starfield requested that the demographic foci for the data reporting process be confirmed on November 6. The final cut for the demographics was given on November 11 and included a cut of: 1) autonomous or integrated, 2) combined or separate MOH/CEO; 3) filled or acting MOH, 4) size of PHU and 5) PHU region. Toronto was included in the Central East region to preserve confidentiality. In addition to these five cuts, there was a potential sixth cut, depending on how many respondent groups were asked the same question. Numerical codes were used to identify demographic differences. Each health unit was assigned a location code and with the exception of the respondent codes that changed depending on which respondents were asked a question, all other related demographic codes were linked to each location code. Appendix D Table 3, Table 4 and Table 5 contains the demographic listings.

Limitations of the demographic cuts

Demographics were based on the Province of Ontario Public Health Unit Demographic Data sheet forwarded to Starfield for briefing purposes and what was recommended be used for development of the database. During the preparation of demographic lists for the consultation, it was noted that there were differences in the information reported by health unit's on Acting and filled MOH positions compared to the information used for constructing the database. Given the short timelines and the need to start the data entry before the consultation phase was complete, the information provided by the Ministry (rather than the information collected in the field) was used for the analysis.

Information Collection

One consultant conducted a day long process at each health unit. During that day the MOH (and the CEO if separate) were interviewed for up to 2 hours. In aligned units the CAO, City Manager or equivalent was interviewed for one hour. A management and senior professional focus group was conducted over 2 hours. A staff focus group was run for 2 .5 hours. And a group interview of board members was conducted over 1.5 hours. If needed and to accommodate people who may have to drive long distances, both videoconference and teleconference participants were included.

Focus groups were designed to gather the greatest amount of data in the shortest period of time. Participants were asked to divide into five groups for the first hour and to write up their responses onto flipcharts. This was a brainstorming and not a consensus or prioritization exercise so opposing ideas were included and ideas only appeared once even if they may have been considered by many. Responses during group interviews were also handled in a similar fashion with all ideas being recorded and respondents encouraged to not repeat ideas that had already been covered as the time for questioning was very limited.

The second hour of the focus group was spent as a large group reviewing and adding to flipchart responses. There was also a prioritization exercise that was done for many of the

questions. After consultation with CRC representatives, it was decided that there was no need to include this information in the interpretation of findings.

Responses for interviews were recorded based on field consultants' preferences; some took handwritten notes and transcribed them later; while others typed notes into a laptop during the interview. Responses for focus groups were taken from flipcharts. After each site visit, approximately 30 – 40 pages of interview and flipchart notes were typed and forwarded to Starfield resulting in approximately 1,500 pages of transcribed data after the partner interview notes were added.

Health units made the decision as to who was included in each of the meetings and were asked to provide a cross section of participants for each of the focus groups and board group interview. Instructions were given to refrain from including multiple respondent groups within a meeting in order to protect the confidentiality of these discussions. All participants were guaranteed confidentiality, in that no names would be used in for the report, nor titles or examples that identify an individual.

The MOH was asked to provide the names and contact numbers for three partners to be interviewed separately by phone and at another time. Although it had been planned that there would be three partner interviews for each health unit there were some partners that could not be reached within the short timeframe allowed for data collection.

Limitations of data collection

Given that the data recording and transcription was done by six people and that a tape recorder was not used for interviews, the potential for translating the qualitative data into statistically valid quantitative data was limited. As well, the limited time set for each meeting sometimes required omitting questions so not all respondent groups were asked all questions; fortunately, this did not happen often.

For the most part, the interview and focus group protocols were followed in the same manner at each site. However, there were several anomalies because an adjustment needed to be made to meet the needs of the health unit. For example, in several situations no board members available on the day of the consultation so interviews were conducted by conference call after the site visit. There were several sites where the consultation was done over two days, either to accommodate the health unit's or the consultants' scheduling needs (complexity of travel often influenced this adjustment). There was one site where the Board and MOH insisted on a joint interview, and another site where the MOH and CEO observed the board interview prior to their separate interviews. A few MOH interviews were done by phone. And several interviews exceeded or did not meet the minimum/maximum number of suggested participants.

The potential impact of this process affected responses in that they were sometimes given based on individual agendas rather than questions asked. In other words, the same answer was given regardless of the question asked. This was most often encountered during the Board member interviews.

There was an inconsistency in preparation for consultation days. The CRC Interim Report was posted on November 2 in the evening, which did not allow for the first health unit to

review the report prior to its consultation day. It is also unlikely that the next three health unit's had a chance to adequately review the report before their consultation day. The interim report provided an excellent context for understanding protocol questions and as the consultations progressed it was found that respondents had reviewed the interim report as preparation and that this helped to inform some of their responses.

Data management

Confirming the Analysis Plan

The first round of "theming" helped to identify questions where no patterns or trends seemed to be emerging and which would need other approaches for managing and reporting findings. A CRC update meeting was held on November 16 and requested that some changes to the data collection and reporting processes be made.

At this time, questions were being themed and coded for a systemic summary of interview results. Non-attributable quotes or respondent group queries were not part of the original analysis plan. Starfield suggested that a revised plan be produced describing how data from different questions would be treated. It was agreed that there be a review with the executive lead and an increased analysis for certain questions was deemed appropriate given the results to date.

As well, the next week was spent confirming and refining the level of data analysis required for each question. The final analysis plan can be found in Appendix J — Data Analysis Plan

Theme Selection

In general, it was decided that a maximum of ten themes would be used for the demographic and respondent analysis. It was felt that ten would generate enough of an array of information to be considered for this part of the reporting of findings. No themes were eliminated from the overall discussion of findings since the theme sheets were used along with the response frequencies to frame and inform the interpretation of findings.

Some questions did not have as many as ten themes; these questions were usually associated with a single respondent group. For these questions all themes were used. Other questions where seven or eight rather than ten themes are reported is because the next 4-5 themes had the same number of responses and many were associated with only one or two locations. In this case, these themes were not included in the demographic analysis. The questions and most commonly cited themes were entered into an excel spreadsheet. Numerical codes were assigned to themes for each question code.

Limitations of theme selection

Theme selection was done after data collection and transcription was completed in 27 of the 36 health unit's so that data entry could begin. The final ten health unit's consultations were being done November 25-30. Starfield was requested to provide initial results to the CRC subcommittees December 5, five days after the last consultations. In order to meet

this request, data entry needed to begin before the consultation process was completed. It is possible that some of the themes included in the ten may have changed slightly if it had been possible to wait until the completion of the consultation process. Similarly, had only five themes been used for this process, it is likely that no changes would have occurred with the addition of the data from the final health unit consultations. Because the intent of the discussion of findings was to give as rich an overview as possible and because all themes were accounted for in the overall discussion, the use of ten themes for the demographic analysis was maintained. Response rates for the themes should be considered as a general indication of what is top of mind around the issues of concern to the CRC committee.

Data entry and analysis

An excel spreadsheet was designed for data entry. Manual entry of numerical codes was done for location, respondent, question code and theme. Demographic codes linked to each location through formulas (governance, size, leadership, region, MOH status) automatically filled. Data was read from concatenated theme sheets. The final database contained close to 8,000 rows of data.

All fields in the database were translated into numerical entries and then transported into SPSS. Although it was recognized that SPSS was a much more powerful statistical analysis tool than needed it was the program that was most readily available to Starfield and had the capabilities to perform the simple response rate queries needed for the discussion of findings. Cross-tabs were run for all questions based on all demographic cuts. Results were reviewed for only those questions that were identified in the analysis plan. Differences in response rates were used as an indicator to go and more closely review data from the interview notes and report findings accordingly.

Interpretation of Data

Levels of Analysis

Field consultants individually worked on assigned questions and prepared a first level summary of findings. Depending on the question and responses available, the summary took a variety of forms. For some, only quotes and succinct examples were used. For others a listing of types of responses was reported. For others, where the demographic tables were available, these were used to frame the analysis. The first level of analysis was documented and then used to produce a second level of analysis.

The second level of analysis shifted from reporting findings to describing patterns, highlights, emerging issues and outstanding polarities. It was also possible that none of these were present in the findings and interpretation of this was also done. The second level of analysis was also documented.

Both levels of analysis were shared with team members who gave feedback on areas where they thought more exploration of the qualitative data or interpretations should be done. This is what was used to provide feedback to the CRC subcommittees.

Report Compilation

The two principal consultants used the first and second level findings combined with the feedback from the six facilitators to prepare an initial draft of the final report and a presentation to the CRC committee which was given on December 15, 2005.

The initial report findings section was over 200 pages in length and deemed too long to easily digest by either the CRC committee or the wider audience it was intended for. The executive lead for the project agreed that the report should be divided into three sections

- Accountability, Funding and Governance
- Research and Knowledge Transfer
- Health and Human Resources

The principal consultants then used the feedback from the CRC meeting to revise the report ensuring committee member's questions and areas of interest were identified in the findings. The final report was released on January 12, 2006.

Appendix B Interview Questions By Stakeholder

Table 1 — Master List of Questions & their Assigned Codes						
Question Code		MOH/CEO/ CAO	Board	Management	Staff	Partners
1	What would you say are the three most important accomplishments of your health unit over the past year?	■		■	■	
2	What indicators would best demonstrate the effectiveness of your health unit to the community?	■		■	■	
2	How could you best demonstrate the effectiveness of your health unit to the community?			■	■	
2	What indicators would you use for reporting to the public?			■	■	
3	What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?	■		■		
4	Has this health unit undergone consolidation with another health unit in the past 10 years? Has it amalgamated?	■	■	■		■
4	How did the consolidation improve your ability to provide Public Health services in the short and long term?	■	■	■		■
5	How did the consolidation detract from your ability to provide Public Health services in the short and long term?	■	■	■		■
6	What factors should be considered in determining how and whether to reconfigure Public Health units?	■	■	■		
7	Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they?	■	■	■		
8	What works well?	■	■	■	■	
9	What does not work as well?	■	■			
10	What types of services could be shared or configured differently?	■		■		
11	What is behind the MOH vacancies across the province?	■				
12	What are possible solutions for filling these?	■				
13	What do you think might explain this discrepancy?	■		■		
14	What type of Public Health experience is critical to being able to effectively carry out the role of the CEO/ED?	■				
15	What has your unit done to successfully attract the "best and the brightest" human resources?	■				
16	What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?	■	■	■		
16	What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?		■			
16	What does your health unit need to do to increase its			■	■	

Table 1 — Master List of Questions & their Assigned Codes						
	Question Code	MOH/CEO/ CAO	Board	Management	Staff	Partners
	effectiveness in recruiting and retaining staff?					
17	What approaches have you found most successful in maintaining or improving morale?	■		■		
18	What technical expertise or skills would you like to augment or add to your health unit? Why?	■		■		
19	How have you prepared for a possible Public Health crisis requiring support from other health units and agencies and the province?	■		■		
20	What else needs to be put in place?	■		■		
21	What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?	■	■	■		
21	What strategies have you found to be most successful in strengthening their leadership qualities and skills?		■			
22	What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?	■		■		
22	What approaches to professional development have been put in place?			■		
22	what has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?				■	
23	What else could be done in this regard?	■				
23	What else could be done to better support you in networking and professional development?					
24	What types of activities have you found most helpful in strengthening your skills as a leader?	■		■		
25	What else would support you in your leadership role?	■		■		
26	What would adequate research and knowledge transfer capacity, look like at your health unit?	■		■	■	
27	What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?	■		■	■	
27	What is the minimum that the regional grouping needs to provide in order to support your health unit?				■	
27	What collectively should the regional grouping have to provide the minimum support to your work?					
28	What supports for research and knowledge transfer capacity needs to be in place at the provincial level?	■		■	■	
28	What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?			■	■	
29	What 2-3 improvements in the governance of your health unit would have the greatest impact?	■	■			
30	What do you think should be the key characteristics of such a model?	■	■			
31	What might be the impact of such a change on your Health Unit?	■				
32	Assuming the 75/25 level of funding with either model, what are the advantages ?	■	■			
33	Assuming the 100% level of funding with either model,	■	■	■		

Table 1 — Master List of Questions & their Assigned Codes						
	Question Code	MOH/CEO/ CAO	Board	Managemen t	Staff	Partners
	what are the advantages ?					
34	Assuming the 75/25 level of funding with either model, what are the disadvantages ?	■	■	■		
35	Assuming the 100% level of funding with either model, what are the disadvantages ?	■	■			
36	What sources of funding do you access in addition to municipalities and the province?	■				
37	How much do you get from each source?	■				
38	For what activities?	■				
39	What proportion is each source of your overall budget?	■				
40	Where do you get your internal Human Resources, IT, legal and finance services?	■				
41	How are they funded?	■				
42	How do you determine appropriate charges for these?	■				
43	What local agencies, Public Health related or other, do you work with most frequently and most effectively?	■		■	■	
43	What local agencies do you work with most frequently?		■		■	
43	What local agencies do you work with most effectively?				■	
44	We will interview 3 Partners, who should they be?	■				
45	Is there any other key issue that you would like to bring to the attention of the CRC?	■	■	■		
46	What does your Board of Health do well in governing of the work of your health unit?		■			
47	What support from the province would help your Board maximize its effectiveness in governing?		■			
48	If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?		■			
49	If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?		■			
50	What should be put in place to better ensure your health unit is accountable for meeting its program mandate?		■			
51	What role does your Board play in MOH or Senior Staff selection?		■			
52	What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?		■			
53	What support could the province provide with regard to recruitment and retention of senior staff?		■	■		
54	What are the strongest leadership qualities of your health unit's senior staff?		■	■		
54	What are the strongest leadership qualities of the managers and executives in your Health Unit?		■		■	
55	What manager and executive leadership skills would you like to see strengthened in your unit?				■	
56	What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?		■	■		
57	What recommendations would you make on how to ensure Public Health remains a high priority for the public?			■		
58	What municipal or regional staff do you work with most closely?			■		

Table 1 — Master List of Questions & their Assigned Codes						
	Question Code	MOH/CEO/ CAO	Board	Management	Staff	Partners
59	What works well?			■		
60	What could be improved?			■		
61	What does not?			■		
62	What kinds of things would help you to feel more valued?			■	■	
63	What collectively should the regional grouping have to provide the minimum support to your work?			■		
64	Describe a situation where you have felt most valued as an employee of your health unit?			■	■	
65	What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?				■	
66	What are the main factors that keep you and your colleagues working in public heath?			■	■	
67	How could marketing be used to support recruitment and retention and to promote a career in Public Health?				■	
68	What do you have now?				■	
69	Which municipal or regional staff do you work with most closely?				■	
70	What would you like to see improved?				■	
71	Describe the ways in which your organization partners with your local health unit?					■
72	What is working well in your partnerships?					■
73	How are your organization's needs and interests being addressed through these partnerships?					■
74	How would you describe your organization's communication with your local PHU?					■
75	What would you like to see improved?					■
76	Have you attended a Board of Health meeting in the last year?					■
77	Why or why not?					■
78	What value did you get if you attended?					■
79	What might the impact of such a change be on your municipalities or region?		■			
80	What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?		■			
81	Unused					
82	What are the strongest leadership qualities of your health unit's MOH?		■			
82	What are the strongest leadership qualities of your health unit's CEO?		■			
83	What leadership qualities or skills would you like to see strengthened in your senior staff?		■			

Appendix C Interview Questions by CRC Subcommittee Area of Interest

Table 2 - Interview Questions by CRC Subcommittee Area of Interest	
Question Code	**Question**
	Subcommittee
	Accountabilities
2	What indicators would best demonstrate the effectiveness of your health unit to the community?
2	How could you best demonstrate the effectiveness of your health unit to the community?
2	What indicators would you use for reporting to the public?
3	What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?
50	What should be put in place to better ensure your health unit is accountable for meeting its program mandate?
	Funding
32	Assuming the 75/25 level of funding with either model, what are the advantages ?
33	Assuming the 100% level of funding with either model, what are the advantages ?
34	Assuming the 75/25 level of funding with either model, what are the disadvantages ?
35	Assuming the 100% level of funding with either model, what are the disadvantages ?
36	What sources of funding do you access in addition to municipalities and the province?
37	How much do you get from each source?
38	For what activities?
39	What proportion is each source of your overall budget?
40	Where do you get your internal Human Resources, IT, legal and finance services?
41	How are they funded?
42	How do you determine appropriate charges for these?
	Governance
4	How did the consolidation improve your ability to provide Public Health services in the short and long term?
5	How did the consolidation detract from your ability to provide Public Health services in the short and long term?
6	What factors should be considered in determining how and whether to reconfigure Public Health units?
7	Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they?
8	What works well?
9	What does not work as well?
14	What type of Public Health experience is critical to being able to effectively carry out the role of the CEO/ED?
19	How have you prepared for a possible Public Health crisis requiring support from other health units and agencies and the province?
20	What else needs to be put in place?
29	What 2-3 improvements in the governance of your health unit would have the greatest impact?
30	What do you think should be the key characteristics of such a model?
31	What might be the impact of such a change on your Health Unit?
43	What local agencies, Public Health related or other, do you work with most frequently and most effectively?
43	What local agencies do you work with most frequently?

Table 2 - Interview Questions by CRC Subcommittee Area of Interest	
Question Code	Question
Subcommittee	
43	What local agencies do you work with most effectively?
47	What support from the province would help your Board maximize its effectiveness in governing?
48	If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?
49	If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?
58	What municipal or regional staff do you work with most closely?
59	What works well?
60	What could be improved?
61	What does not?
69	Which municipal or regional staff do you work with most closely?
70	What would you like to see improved?
71	Describe the ways in which your organization partners with your local health unit?
72	What is working well in your partnerships?
73	How are your organization's needs and interests being addressed through these partnerships?
74	How would you describe your organization's communication with your local PHU?
75	What would you like to see improved?
76	Have you attended a Board of Health meeting in the last year?
77	Why or why not?
78	What value did you get if you attended?
79	What might the impact of such a change be on your municipalities or region?
Human Resources	
10	What types of services could be shared or configured differently?
11	What is behind the MOH vacancies across the province?
12	What are possible solutions for filling these?
13	What do you think might explain this discrepancy?
15	What has your unit done to successfully attract the "best and the brightest" human resources?
16	What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?
16	What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?
16	What does your health unit need to do to increase its effectiveness in recruiting and retaining staff?
17	What approaches have you found most successful in maintaining or improving morale?
18	What technical expertise or skills would you like to augment or add to your health unit? Why?
21	What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?
21	What strategies have you found to be most successful in strengthening their leadership qualities and skills?
22	What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?
22	What approaches to professional development have been put in place?
22	What has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?
23	What else could be done in this regard?
23	What else could be done to better support you in networking and professional development?
24	What types of activities have you found most helpful in strengthening your skills as a leader?

Table 2 - Interview Questions by CRC Subcommittee Area of Interest	
Question Code	**Question**

Subcommittee

Question Code	Question
25	What else would support you in your leadership role?
51	What role does your Board play in MOH or Senior Staff selection?
52	What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?
53	What support could the province provide with regard to recruitment and retention of senior staff?
54	What are the strongest leadership qualities of your health unit's senior staff?
54	What are the strongest leadership qualities of the managers and executives in your Health Unit?
55	What manager and executive leadership skills would you like to see strengthened in your unit?
56	What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?
57	What recommendations would you make on how to ensure Public Health remains a high priority for the public?
62	What kinds of things would help you to feel more valued?
64	Describe a situation where you have felt most valued as an employee of your health unit?
65	What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?
66	What are the main factors that keep you and your colleagues working in public heath?
67	How could marketing be used to support recruitment and retention and to promote a career in Public Health?
68	What do you have now?
80	What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?
82	What are the strongest leadership qualities of your health unit's MOH?
82	What are the strongest leadership qualities of your health unit's CEO?
83	What leadership qualities or skills would you like to see strengthened in your senior staff?

Research and Knowledge Transfer

Question Code	Question
45	Is there any other key issue that you would like to bring to the attention of the CRC?
26	What would adequate research and knowledge transfer capacity, look like at your health unit?
27	What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?
27	What is the minimum that the regional grouping needs to provide in order to support your health unit?
28	What supports for research and knowledge transfer capacity needs to be in place at the provincial level?
28	What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?
63	What collectively should the regional grouping have to provide the minimum support to your work?

Appendix D Public Health Unit Demographics Summary

PHU Demographics Summary

PHU Governance Structure

Table 3 - Autonomous Vs. Integrated PHU Governance Summary	
PHU GOVERNANCE STRUCTURE	
NUMBER OF AUTONOMOUS PHU'S	25
NUMBER OF ALIGNED PHU'S	11

PHU Governance Structure	
Number of Autonomous PHU's	25
Number of Aigned PHU's	11

PHU Geographic Summary

Table 4 - Regional Summary	
REGIONAL SUMMARY	
CENTRALEAST	7
CENTRALWEST	7
EASTERN	6
NORTHEAST	5
NORTHWEST	2
SOUTHWEST	9

PHU Service Population

Table 5 - PHU Population Served Size Summary		
POPULATION SERVED	SIZE	#
	<135,000K	15
	135K – 299K	9
	300K – 599K	8
	>599K	4

PHU Leadership Summary

Table 6 - PHU Leadership Summary	
Number of Vacant MOH Positions:	1

Table 6 - PHU Leadership Summary	
Number of MOH's interviewed:	27
Number of Acting MOH's interviewed:	8
Both MOH & CEO	21

Appendix E Public Health Unit Interviews and Focus Groups Summary

Staff Focus Groups

Table 7 — Staff Focus Group Roles

Role	# of Participants
Health Promotion / Planning / Development	51
Nurse	204
Program Supervisor/Coord/Assistant/ Support	22
Human Resource Associate / Resource Coordinator / Project Specialist / Community Liaison	33
Dental Hygienist	21
Dental Health	11
Secretary/Admin Assistant/Clerical	58
Communications / Marketing / Media	17
Speech/Language Pathologist	4
Epidemiologist	10
Dietician/Nutritionist	28
Health Inspector	73
Analyst (Health Information/Environmental/ Policy)	7
Systems Support Technician / IT / Library	13
Child & Youth Health / Baby & Parent Program (Health Babies)	10
Accounting and Finance	6
Tobacco	4
Family Visitor / Health Educator / Personal Support Worker / Family Health Worker	13

Staff Focus Group Years of Service

Table 8 — Staff Focus Group Years of Service

Years of Service	
Less than 1 year	11
1-5 years	192
6-10 years	119
11-15 years	79
16-20 years	68
20+ years	116
TOTAL	585

Management Focus Groups

Table 9 — Management Focus Group Roles	
ROLE	# OF PARTICIPANTS
ADMIN & HUMAN RESOURCES	38
DENTAL PROGRAMS	18
FINANCE / ACCOUNTING / COMPTROLLER	8
TOBACCO & ADDICTION PROGRAMS	9
SEXUAL HEALTH	11
COMMUNICABLE DISEASE & INFECTIOUS DISEASE	19
EPIDEMIOLOGIST	20
CHRONIC DISEASE/INJURY PREVENTION	14
PROGRAM SUPERVISOR/MANAGER/DIRECTOR *	52
HEALTH DETERMINANTS / EVALUATION / PLANNING / POLICY ANALYST	15
FAMILY HEALTH AND COMMUNITY RESOURCES	32
PUBLIC HEALTH LIBRARIAN / LIBRARY SERVICES	2
INFORMATION SPECIALIST / RECORDS MANAGEMENT / IT	7
ASSOCIATE/ACTING MOH/ACTING BAO / ASSOCIATE COMMISSIONER	12
IMMUNIZATION & VACCINE PREVENTABLE DISEASE	7
ENVIRONMENTAL HEALTH & LIFESTYLE RESOURCES	48
MARKETING/COMMUNICATIONS/MEDIA RELATIONS	8
EARLY CHILD DEVELOPMENT / HEALTHY BABY	9
CENTRAL RESOURCES	2
POPULATION HEALTH	5
CLINICAL SERVICES	10
HEALTH PROMOTION	21
HEALTH PROTECTION	14
HEALTH INSPECTION	6
CHILD & YOUTH SERVICES & HEALTH	8
PUBLIC HEALTH NURSING & NUTRITION	12
QUALITY IMPROVEMENT / CONTINUOUS IMPROVEMENT & STRATEGIC PLANNING	8
CORPORATE SERVICES / DIRECTOR, PUBLIC HEALTH /LEGAL COUNSEL	12
PHRED	3

- Note: As their role, many just indicated "Program Manager", "Program Supervisor", Program Director" or just "Manager" with no further clarification to classify them by – they are incorporated here.

Management Focus Groups Years of Service

Table 10 — Management Focus Group Years of Service	
MANAGEMENT FOCUS GROUP YEARS OF SERVICE	
LESS THAN 1 YEAR	**9**
1-5 YEARS	**86**
6-10 YEARS	**74**
11-15 YEARS	**61**
16-20 YEARS	**56**
20+ YEARS	**144**
TOTAL	430

Partner Interviews

Table 11 — Partner Interview Demographics

PARTNER INTERVIEW DEMOGRAPHICS	
SCHOOLS	16
HOSPITALS	15
COMMUNITY CARE/MEDICAL COMPANIES	28
CHARITIES	4
OTHER	15
TOTAL	78

Appendix F Province of Ontario Public Health Unit Demographic Data

Table 12 - Detailed PHU Demographics					
Locations	Autonomous/ Aligned	Size	Region	Leadership	MOH Status
Algoma	Autonomous	>135,000	Northeast	Same CEO/MOH	Filled
Brant	Autonomous	>135,000	Central west	Different CEO/MOH	Acting
Chatham-Kent	Autonomous	>135,000	Southwest	Different CEO/MOH	Acting
Durham	Aligned	300,000 - 599,999	Central East	Different CEO/MOH	Filled
Eastern Ontario	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Elgin-St. Thomas	Autonomous	>135,000	Southwest	Different CEO/MOH	Acting
Grey Bruce	Autonomous	135,000 - 299,999	Southwest	Same CEO/MOH	Filled
Haldimand-Norfolk	Aligned	>135,000	Central west	Different CEO/MOH	Acting
Halliburton, Kawartha, Pine Ridge	Autonomous	135,000 - 299,999	Central East	Same CEO/MOH	Filled
Halton	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Hamilton	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Hastings & Prince Edward Counties	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Huron	Autonomous	>135,000	Southwest	Different CEO/MOH	Filled
Kingston-Frontenac	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Lambton	Autonomous	>135,000	Southwest	Different CEO/MOH	Filled
Leeds, Grenville & Lanark District	Autonomous	135,000 - 299,999	Eastern	Different CEO/MOH	Acting
Middlesex-London	Autonomous	300,000 - 599,999	Southwest	Same CEO/MOH	Filled
Niagara	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
North Bay Parry Sound	Autonomous	>135,000	Northeast	Same CEO/MOH	Filled
Northwestern (Kenora)	Autonomous	>135,000	Northwest	Same CEO/MOH	Filled
Ottawa	Aligned	<599,999	Eastern	Different CEO/MOH	Acting
Oxford	Aligned	>135,000	Southwest	Different CEO/MOH	Acting
Peel	Aligned	<599,999	Central East	Different CEO/MOH	Filled
Perth	Autonomous	>135,000	Southwest	Same CEO/MOH	Filled
Peterborough	Autonomous	>135,000	Central East	Same CEO/MOH	Filled
Porcupine	Autonomous	>135,000	Northeast	Different CEO/MOH	Filled
Renfrew	Autonomous	>135,000	Eastern	Same CEO/MOH	Filled
Simcoe Muskoka	Autonomous	300,000 - 599,999	Central East	Same CEO/MOH	Filled
Sudbury	Autonomous	135,000 - 299,999	Northeast	Same CEO/MOH	Filled
Thunder Bay	Autonomous	135,000 - 299,999	Northwest	Different CEO/MOH	Acting
Timiskaming	Autonomous	>135,000	Northeast	Different CEO/MOH	Acting
Toronto	Aligned	<599,999	Central East	Different CEO/MOH	Filled
Waterloo	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Wellington-Dufferin-Guelph	Autonomous	135,000 - 299,999	Central west	Same CEO/MOH	Filled
Windsor-Essex	Autonomous	300,000 - 599,999	Southwest	Same CEO/MOH	Filled
York region	Aligned	<599,999	Central East	Different CEO/MOH	Filled

Appendix G Sample Interview Form

Capacity Review Committee
Board of Health On-site Interview
Research Protocol Script

Greetings & Introductions

- Thank you, on behalf of the Capacity Review Committee, for giving us your time for this interview.

- As you are aware, the Capacity Review Committee was established to meet objectives set out in *Operation Health Protection.* The mandate is to "review the capacity of local public health units and how public health services and programs are delivered across the province. It will advise the government on options to improve the local public health unit systems." The CRC will deliver its report to Ontario's Chief Medical Officer of Health, Sheela Basrur, in early 2006.

- Phase 1 of the Committee's work - surveys of health units, health unit staff and Board members - has been completed and the CRC's interim report is forthcoming.

- **Phase 2 entails a series of interviews and focus groups with health unit staff, Board members and local partners *to probe* on specific issues identified by its subcommittees given the survey results and their other research activities.**

- The Capacity Review Committee has engaged Starfield Consulting to carry out those interviews, focus groups and roundtable discussions and that is why I'm here with you today.

The information sought from you

- We are interviewing members of each Board of Health using the questions developed by the five CRC Sub-Committees and the CRC in consultation with Starfield.

- **The questions pertain to the key issues that the CRC Committees are now pursuing and where they need your individual or collective input or opinions.**

- The CRC recommendations and thus the questions are for the most part focused on the overall Ontario Public Health System, although we acknowledge that your experience of your Unit contributes to your perception of the overall system. There are a few questions where information specific to your health unit would assist the work of the committees.

What will be done with the results?

- **Your answers to these questions will be combined with those of other Board of Health members. Starfield Consulting will synthesise the information** gathered from these interviews and focus groups into a report to be presented to the CRC. The CRC will present a final report to the MOHLTC in early 2006 which will include the findings from these consultations.

- We will be looking for patterns in the responses to the questions as well as strong individual statements.

- Neither your name nor your health unit will be mentioned in relation to your specific answers without your consent.

Confidentiality

- We and the Ministry assure you that **all information gathered will be held in the strictest of confidence.** We (Starfield) will document and store the input to the consultations, and this information will be used for the purposes of this review only. As previously stated, no information will be released or printed that would identify any person by name.

- Your participation today is voluntary

Research Protocol

Timing: The Group Interview should last 1.5 hours

Context Questions – Let's start with some questions about you?

- What are your **roles** on the board?

- **How** did you become a board member?
  - Election (Are you a municipal or regional council member?)
  - Municipal Appointment
  - Provincial Appointment

- It is our understanding that your health unit is a _______ is that correct?
  1. City or Single Tier Health Department
  2. Regional or Upper Tier Health Department
  3. County or District Health Unit

- Is your Board **autonomous** of the city, region or county/district structure or is the **board aligned or embedded** in those structures.

Interview Questions

Context & Question	Com
1. GOVERNANCE STRUCTURE & EFFECTIVENESS	
a. What does your Board of Health do well in governing of the work of your health unit?	
Different types of improvements in public health governance have been suggested as part of the capacity review. For example: • selection of board members based on specified expertise • more orientation of Board members • standardized Board member recruitment practices • greater visibility of the board ***b. What 2-3 improvements in the governance of your health unit would have the greatest impact?***	Gov
c. What support from the province would help your Board maximize its effectiveness in governing?	Gov
The Capacity Review committee is exploring the option of moving, over time, to a more uniform provincial model for governance of Public Health which would differ from the current ones. ***d. What do you think should be the key characteristics of such a model?***	Gov
e. Autonomous Board: What might the impact of such a change be on your municipalities? ***e. Aligned Board: What might the impact of such a change be on your municipality or region?***	Gov
2. FUNDING AND ACCOUNTABILITY	
The CRC is currently considering two possible models for funding health units (75/25 cost sharing, and 100% provincial). ***a. Assuming the same level of funding with either model, what are the advantages and disadvantages of each approach?***	Fund
b. If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making? ***c. If funding were 100% provincial, what would you see as the municipalities'/region's role in decision making?***	Gov

Submissions to the capacity review have identified that existing accountability structures and tools are inadequate. ***d. What should be put in place to better ensure your health unit is accountable for meeting its program mandate?***	Acnt
3. CONFIGURATION	
a. Has this health unit undergone consolidation with another health unit in the past 10 years? [prompt – has it amalgamated]?	
(only for health units who have been reconfigured – **Toronto, Simcoe-Muskoka, North Bay-Parry Sound, & Grey Bruce**) ***b. How did the consolidation improve your ability to provide public health services in the short and long term?*** ***c. How did the consolidation detract from your ability to provide public health services in the short and long term?***	Gov
The Walker report recommended reconfiguring the public health system. ***d. What factors should be considered in determining how and whether to reconfigure health units?***	Gov
e. Do you share any services with other health units for example, communications, risk assessment, epidemiology, or toxicology? ***f. What works well?*** ***g. What does not work as well?***	Gov
4. RECRUITMENT AND RETENTION	
a. What role does your Board play in MOH or Senior Staff selection?	
b. What have you done to successfully attract and retain the "best and brightest" senior staff? MOH?	HR
(For health units with an acting MOH.) ***c. What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?***	HR
d. What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?	HR
e. What support could the province provide with regard to recruitment and retention of senior staff?	HR

5. LEADERSHIP	
a. What are the strongest leadership qualities of your health unit's senior staff? MOH? CEO?	HR
b. What leadership qualities or skills would you like to see strengthened in your senior staff?	HR
c. What strategies have you found to be most successful in strengthening their leadership qualities and skills?	HR
d. What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?	HR
6. OTHER	
Is there any other key issue that you would like to bring to the attention of the CRC?	

Closing

Given the short timeframe for initiative and our desire to ensure accuracy, we want to confirm what we have heard at this point. So, I will quickly report back to you what I have heard and recorded in your responses to each section to confirm that I have understood the direction of your comments.

We will be gathering information throughout this month and then submit our report in December.

The CRC is to complete its report in early 2006.

Thank you for your time and active participation.

Appendix H Sample On-site Agenda and Small Group Guide

Leadership & Professional Development

Please self-organize your small group discussion, answer the questions together and **prepare a flip-chart summary of your response to each question.** You will be asked to post the flip charts for review by the group at this session. During your brainstorm or discussion please record your differing views and also clearly mark where you do have agreement in your small group.

A. Decide on Roles

As a group, decide who will play the following roles for this small group work:

Table Group Roles:

Role	Description
Facilitator	Initiates group discussion, ensuring that the task is accomplished and that everyone has the opportunity to speak.
Time Keeper:	Keeps track of time given to complete the task at hand. Let the group know how much time is left for discussion. You will have 15 minutes.
Recorder	Legibly records group responses to the questions on flip chart.
Reporter.	Reports back to the whole group when called upon.

B. Questions

Ensuing effective leadership and strong professional skill levels has been identified as a challenge facing public health.

a. What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff? What approaches to professional development have been put in place?

b. What approaches has your health unit put in place to support the staff in connecting with peers within their discipline?

c. What else could be done in this regard?

d. What types of activities have you found helpful in strengthening your skills as a leader?

e. What else would support you in your leadership role

STARFIELD CONSULTING

Appendix I Sample Coding Template Tool

MOH/CEO Template for Entering Themes

Respondent: MOH/CEO (1)

Question 1.b What indicators would best demonstrate the effectiveness of your health unit to the community?

Cross Reference Question (2)

Location Code	Theme	Examples, Quotes and Keywords

Appendix J Data Analysis Plan

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
1	MOH 1a Staff 5a Mgmt 1a	***What are three-five most important accomplishments of this last year?*** General analysis based on interview notes Include quotes and dramatic examples
	Governance	
46	Board 1a	***What does your Board of Health do well in governing of the work of your health unit?*** General analysis based on interview notes Include quotes and dramatic examples
29	MOH 6a Board 1b ***Overall Governance***	***What 2-3 improvements in the governance of your health unit would have the greatest impact?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
47	Board 1c ***Overall Governance***	***What support from the province would help your Board maximize its effectiveness in governing?*** Extract themes and code Standard demographic run First & Second levels of analysis
30	MOH 6b Board 1d ***Governance Model***	***What do you think should be the key characteristics of such a model?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
31	MOH 6c ***Governance Model***	***What might be the impact of such a change on your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
79	Board 1e ***Governance Model***	***What might the impact of such a change be on your municipalities or region?*** Extract themes and code Standard demographic run First & Second levels of analysis
48	Board 2b ***Funding***	***If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?*** Extract themes and code Standard demographic run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
49	Board 2c ***Funding***	***If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?*** Extract themes and code Standard demographic run First & Second levels of analysis
6	MOH 2d Board 3d Mgmt 2d ***Configuration***	***What factors should be considered in determining how and whether to reconfigure Health Units?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
4 & 5	MOH 2a, 2b Board 3a, 3b, 3c Mgmt 2a, 2b Partner 3a, 3b, 3c ***Configuration***	***Has this Health Unit undergone consolidation with another Health Unit in the last 10 years?*** ***How did the consolidation improve your ability to provide Public Health services in the short and long term?*** ***How did the consolidation detract from your ability to provide Public Health services in the short and long term?*** General analysis based on interview notes Extract themes
7	MOH 2d Board 3e Mgmt 2d ***Shared Services***	***Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they?*** Extract themes and code Standard demographic run First & Second levels of analysis
8	MOH 2e Board 3f Mgmt 2e ***Shared Services***	***What works well?*** General analysis based on interview notes
9 & 61	MOH 2f Board 3g Mgmt 2f ***Shared Services***	***What does not work as well? OR What does not?*** General analysis based on interview notes
10	MOH 2g Mgmt 2g ***Shared Services***	***What types of services could be shared or configured differently?*** Extract themes and code Standard demographic run First & Second levels of analysis
43	MOH 8a Staff 5c Mgmt 1e ***Partnering***	***What local agencies, Public Health related or other, do you work with most frequently and most effectively?*** List agencies in order of frequency mentioned General analysis based on interview notes Responses for most frequently and effectively were very poor (not answered by many)
58, 59, 60	Staff 5d Mgmt 1f ***Partnering***	***What municipal or regional staff do you work with most closely?*** ***What works well?*** ***What could be improved?*** List agencies in order of frequency mentioned General analysis based on interview notes Responses for works well and could be improved were very poor (not answered by many)

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
44	MOH 8b ***Partnering***	***We will interview 3 Partners, who should they be?*** Report demographics of partners interviewed
71	Partner 1a ***Partnering***	***Describe the ways in which your organization partners with your local health unit?*** General analysis based on interview notes
72	Partner 2a ***Partnering***	***What is working well in your partnerships?*** General analysis based on interview notes
73	Partner 2b ***Partnering***	***How are your organization's needs and interests being addressed through these partnerships?*** General analysis based on interview notes
74	Partner 2c ***Partnering***	***How would you describe your organization's communication with your local PHU?*** General analysis based on interview notes
75	Partner 2d ***Partnering***	***What would you like to see improved?*** General analysis based on interview notes
76, 77, 78	Partner 4a, 4b ***Partnering***	***Have you attended a Board of Health meeting in the last year?*** ***Why or why not?*** ***What value did you get if you attended?*** General analysis based on interview notes
19	MOH 3h Mgmt 3g ***Surge Capacity***	***How have you prepared for a possible Public Health crisis requiring support from other health units and agencies and the province?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
20	MOH 3i Mgmt 3h ***Surge Capacity***	***What else needs to be put in place?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
14	MOH 3c ***Organization Structure***	***What type of Public Health experience is critical to being able to effectively carry out the role of the CEO/ED?*** Extract themes and code Standard demographic run First & Second levels of analysis
	Accountability / Performance Management	
2	MOH 1b Staff 5b Mgmt 1b ***Performance Management***	***What indicators would best demonstrate the effectiveness of your health unit to the community?*** ***How could you best demonstrate the effectiveness of your health unit to the community?*** ***What indicators would you use for reporting to the public?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
50	Board 2d ***Performance Management***	***What should be put in place to better ensure your health unit is accountable for meeting its program mandate?*** Extract themes and code Standard demographic run First & Second levels of analysis
3	MOH 1c Mgmt 1c ***Performance Management***	***What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
	Funding	
32, 33, 34, 35	MOH 7a Board 2a ***Funding***	***Assuming the same level of funding, what are the advantages of 75/25?*** ***Assuming the same level of funding, what are the advantages of 100%?*** ***Assuming the same level of funding, what are the disadvantages of 75/25?*** ***Assuming the same level of funding, what are the disadvantages of 100?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
36, 37, 38, 39, 40, 41, 42	MOH 7b, 7c ***Funding***	***What sources of funding do you access in addition to municipalities and the province?*** ***How much do you get from each source?*** ***For what activities?*** ***What proportion is each source of your overall budget?*** ***Where do you get your internal Human Resources, IT, legal and finance services?*** ***How are they funded?*** ***How do you determine appropriate charges for these?*** High level summary (actual responses handed into subcommittee)
	Research and Knowledge Transfer	
26	MOH 5a Staff 4a Mgmt 5a ***Research and Knowledge Transfer***	***What would adequate research and knowledge transfer capacity, look like at your health unit?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
68	MOH 5a Staff 4a Mgmt 5a ***Research and Knowledge Transfer***	***What do you have now?*** This question was mostly ignored as it was asked within previous question –not able to report on it

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
27, 63	MOH 5b Staff 4b Mgmt 5b ***Research and Knowledge Transfer***	***What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?*** ***What is the minimum that the regional grouping needs to provide in order to support your health unit?*** ***What collectively should the regional grouping have to provide the minimum support to your work?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
28	MOH 5c Staff 4c Mgmt 5c ***Research and Knowledge Transfer***	***What supports for research and knowledge transfer capacity needs to be in place at the provincial level?*** ***What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
	Human Resources	
51	Board 4a ***MOH and Senior Staff Recruitment and Retention***	***What role does your Board play in MOH or Senior Staff selection?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
11	MOH 3a ***MOH and Senior Staff Recruitment and Retention***	***What is behind the MOH vacancies across the province?*** Extract themes and code Standard demographic run First & Second levels of analysis
12	MOH 3a ***MOH and Senior Staff Recruitment and Retention***	***What are possible solutions for filling these?*** Extract themes and code Standard demographic run First & Second levels of analysis
13	MOH 3b ***Recruitment and Retention***	What do you think might explain this discrepancy? Extract themes and code Standard demographic run First & Second levels of analysis
52	Board 4c ***MOH and Senior Staff Recruitment and Retention***	***What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?*** Extract themes and code Standard demographic run First & Second levels of analysis
53	Board 4e ***MOH and Senior Staff Recruitment and Retention***	***What support could the province provide with regard to recruitment and retention of senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
82	Board 5a ***Leadership***	***What are the strongest leadership qualities of your health unit's senior staff? MOH? CEO?*** Extract themes and code Standard demographic run First & Second levels of analysis
54	Staff 3a ***Leadership***	***What are the strongest leadership qualities of the managers and executives in your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
83	Board 5b ***Leadership***	***What leadership qualities or skills would you like to see strengthened in your senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis
55	Staff 3b ***Leadership***	***What manager and executive leadership skills would you like to see strengthened in your unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
56	Board 5d ***Leadership***	***What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
64	Staff 1a Mgmt 3a ***Being & Feeling Valued***	***Describe a situation where you have felt most valued as an employee of your health unit?*** General analysis based on interview notes Include quotes and variety of examples
62	Staff 1b Mgmt 3b ***Being & Feeling Valued***	***What kinds of things would help you to feel more valued?*** Extract themes and code Standard demographic run First & Second levels of analysis
65	Staff 1c ***Being & Feeling Valued***	***What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?*** Extract themes and code Standard demographic run First & Second levels of analysis
17	MOH 3f ***Being & Feeling Valued***	***What approaches have you found most successful in maintaining or improving morale?*** Extract themes and code Standard demographic run First & Second levels of analysis
66	Staff 2a Mgmt 3c ***Recruitment and Retention***	***What are the main factors that keep you and your colleagues working in public heath?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
80	Board 4b ***Recruitment and Retention***	***What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?*** Extract themes and code Standard demographic run First & Second levels of analysis
15	MOH 3d ***Recruitment and Retention***	***What has your unit done to successfully attract the "best and the brightest" human resources?*** Extract themes and code Standard demographic run First & Second levels of analysis
81	Board 4d ***Recruitment and Retention***	***What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis
16	MOH 3e Staff 2b Mgmt 3e ***Recruitment and Retention***	***What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?*** ***What does your health unit need to do to increase its effectiveness in recruiting and retaining staff?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
18	MOH 3g Mgmt 3f ***Recruitment and Retention***	***What technical expertise or skills would you like to augment or add to your health unit? Why?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
67	Staff 2c ***Recruitment and Retention / Public Profile***	***How could marketing be used to support recruitment and retention and to promote a career in Public Health?*** Extract themes and code Standard demographic run First & Second levels of analysis
57	Mgmt 1d ***Public Profile***	***What recommendations would you make on how to ensure Public Health remains a high priority for the public?*** Extract themes and code Standard demographic run First & Second levels of analysis
21	MOH 4a Board 5c Mgmt 4a ***Professional Development***	***What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?*** ***What strategies have you found to be most successful in strengthening their leadership qualities and skills?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
22, 23	MOH 4b, 4c Staff 3c, 3d Mgmt 4b, 4c ***Professional Development***	***What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?*** ***What approaches to professional development have been put in place?*** ***What has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?*** ***What else could be done in this regard? What else could be done to better support you in networking and professional development?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
24	MOH 4d Mgmt 4d ***Professional Development***	***What types of activities have you found most helpful in strengthening your skills as a leader?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
25	MOH 4e Mgmt 4e ***Professional Development***	***What else would support you in your leadership role?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
45		***Is there any other key issue that you would like to bring to the attention of the CRC?*** General analysis based on interview notes