Evaluation of the
WRHA 2008 New Initiatives Review Process

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KEY POINTS

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- The purpose of this collaborative, multi-method evaluation was to: a) assess the revised WRHA New Initiatives priority setting process (2008), b) assess the Priority Setting (PS) Criteria (and associated resources) developed to support the project, and c) provide guidance for ongoing improvement of this and other evolving PS processes.

- None of the New Initiative submissions scored highly based on the review template developed for this project, and a number of limitations were identified with the scoring/review system. As a result submissions were not ranked, although six proposals were prioritized using alternate criteria, and presented to Executive Committee.

- The Executive committee selected a list of 10 priorities that did not overlap with the 6 put forward.

- Because of the limitations of the revised process, project results should not be interpreted as lack of organizational readiness to adopt a revised process intended to make priority setting more transparent, fair, and evidence informed.

- Significant insights emerging from this demonstration project should be used to inform future planning:

    - The need to differentiate between appropriate processes for:
      a) identifying priority issues to be addressed by the organization, and
      b) informing the solutions to respond to these issues
    - The importance of focusing on development of processes to inform evidence informed solutions to identified issues
    - The importance of ensuring meaningful “bottom up” *processes* that allow regional decision making to be informed by program experience
    - The need for creative strategies to support innovation and integrated responses across the region

- Immediate attention is required to:
    - Ensure appropriate planning time to incorporate findings into the 2009 Priority Setting process
    - Address common cynicism and possible misperceptions about organizational willingness to adopt evidence-informed processes

- The significant limitations identified related to the use of a template of criteria providing quantitative scores for each submission indicate that alternate methods of rating and ranking proposals are required.

- *Priority setting processes should be further improved, and Senior Management commitment to changed processes confirmed, before programs are evaluated on use of evidence in proposals*

- Organizational support for evidence informed processes, combined with the insights gained through the implementation and evaluation of this revised process, position the WRHA well for further development of priority setting activities.

Table of contents

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SUMMARY OF PROJECT

In 2008, the Winnipeg Regional Health Authority piloted a new process for priority setting related to New Initiatives (NI). Changes were made to make the priority setting process:

1. More fair and transparent
2. More evidence-informed (support and facilitate appropriate use of evidence)
3. Integrated from a regional perspective in terms of planning.

A meeting between the WRHA Research and Evaluation unit, the WRHA EXTRA fellows and participants in the Royal Roads Graduate Certificate in Health Systems Leadership identified a shared interest in improving internal processes to support evidence use in health planning. One suggestion from finance/program representatives was to focus on the New Initiatives planning process, as there were already plans resulting from discussions with Manitoba Health and Healthy Living about increasing evidence in health plans. For this, and other reasons (timing, alignment with other changes already underway; support from the Divisional Director of Financial Planning and an expectation that changes to this process may be less threatening than in other priority setting processes), the NI process was, therefore, selected as the first activity. Awareness of related work by the WRHA Resource Allocation Initiatives Working Group led to a decision to build on this work already underway in order to avoid duplication and divergent approaches to similar issues. This committee had developed draft Priority Setting Criteria based on similar work in other regions, as well as input from the WRHA Community Health Advisory Councils (Winnipeg Regional Health Authority, 2004). Consequently, the initiative evolved as a collaboration between finance/planning, the Resource Allocation Initiatives Working Group and the Research and Evaluation Unit.

The new process was evaluated through the CIHR funded *From Evidence to Action* research grant (Co-Principal Investigators S. Bowen; P. Martens). Phase 1 of this project (Bowen & Erickson, 2007) explored RHA decision-makers perspectives on evidence and barriers to its use. Phase 2 has been focused on developing strategies to promote evidence use; one activity funded through the research was evaluation of the revised WRHA priority setting process. It was recognized that the changes to the New Initiatives process implemented in 2008 were one step in an iterative, evolving process, and that participatory evaluation was one strategy to assist in this ongoing improvement process. The purpose of this collaborative, utilization-focused evaluation was to a) assess the revised WRHA New Initiative priority setting process, b) assess the Priority Setting (PS) Criteria (and associated resources) developed to support the project, and c) provide guidance for improvement of other priority setting processes. This collaborative evaluation, approved by both the University of Manitoba Health Research Ethics Board and the WRHA Research Review Committee, included:

- Participant and non-participant observation of New Initiative planning meetings; presentations to programs, planning days, and executive; educational sessions, and proposal review committee meetings
- Process documentation
- Content analysis (project communication, briefing notes, submitted proposals, scoring sheets, evaluation forms from NI planning day)

- Semi-structured interviews with staff and executive involved in the review process (Appendix A)
- Anonymous on-line survey for both reviewers and submitters. (Appendix G).

A summary timeline of project activities can be found in Appendix B.

A Briefing Note was developed for Senior Management which emphasized the need for executive support for the proposed process change, described the links with the larger *From Evidence to Action* research project, and outlined other proposed changes to the NI process (e.g. promotion of regional, not only program specific proposals). Presented by the Senior Management Liaison with the planning process, the recommendations were accepted April 14, 2008.

The research team, consisting of Sarah Bowen (Principal Investigator) and Ashley Struthers (Project Coordinator), in collaboration with the planning committee, developed a number of resources to support the new process: all were based on the Priority Setting Criteria (PSC). Two resources were developed to support program staff in preparing submissions:

- A Users Guide (Appendix C), based on the PSC, provided background on the initiative, gave practical definitions of evidence and its various types, the expectations for each section, and made practical suggestions for developing the submission.
- An On-line Health Planners' Toolkit, developed in collaboration with library services provided guidance both on good (and not recommended) sources of evidence and served as a one-stop link to many relevant data sources.

Several activities were undertaken to create awareness among programs submitting proposals to the changed process; the criteria by which the proposals would be evaluated; and the tools to support the process. These included: a) introductory meetings with Administrative Directors/Finance staff to clarify the initiative and discuss concerns; b) presentation of resources being developed at regional health plan orientation day; c) a NI Planning Day which provided presentations on the revised process, PSC and tools, presentations of regional proposals, and opportunity for discussion; d) inclusion of information on the Users Guide and On-line Health Planning Toolkit, in packages sent out to those preparing submissions; and e) a contact name for more information.

Following the Regional NI Planning day, which provided an opportunity for all regional (but not program specific) proposals to be presented and briefly reviewed, resources were also developed to support the review process:

- The Reviewers Template (Appendix D) was a scoring sheet designed to evaluate each proposal based on the strength of the evidence provided for each of the priority setting criteria. It included a series of items for which a quantitative score was expected, and two general assessment questions focusing on the importance of the problem and reviewer's confidence in the proposed solution.
- The Reviewers Guide (Appendix E) provided additional explanation on the Reviewer's template, as well as scoring instructions.

The planning and development of the new process operated in real time and was dependent on the availability of very busy people. Consequently, several changes to the

initial NI Submission plan were made as the project proceeded, requiring ongoing adaptation of the evaluation plan. Despite agreement on the advisability of orientation sessions for both submitters and reviewers, for example, the committee decided that is was not feasible to schedule these within given timelines. Because of the number of proposals, only "regional", but not program-specific, proposals were reviewed. In addition, although the original plan was to have one review team review all proposals, only two hours could be scheduled for this activity in the timeframe required to meet deadline of presentation to Senior Executive. Review of all regional proposals (n=21) in this time allotment was deemed unrealistic, with the result that two different review teams of four persons were formed, and a focused discussion guide developed (Appendix F). Each team (with representation from finance/planning leadership, Resource Allocation Initiatives Working Group, Research, and one of EXTRA/Royal Roads team participants) was assigned 10 or 11 proposals.

An outline for the review process was developed and associated tools were piloted with a 3-person review team (similar in make up to the formal review teams). This pilot resulted in a revised review outline, including steps to mitigate problems identified with the scoring system.

Each reviewer reviewed the 10 or 11 New Initiative submissions assigned to their group using the standardized Reviewer's Template described above. Reviewers were provided with copies of the proposals, a Reviewer's Template for each, and copies of the User's and Reviewer's Guides. They were requested to individually rate the proposals according to the PSC and come prepared to discuss their evaluation. The finance/planning lead facilitated and participated in the discussion with the other three participants in their groups. Notes were taken by the Principal Investigator and Project Coordinator who were non-participant observers to the process. Following sharing of overall rankings, the groups assessed any areas of major disagreement. At this point there was focused discussion around two questions: the importance of the issue, and reviewer confidence that the proposal was a good/best solution to the problem identified. Following discussion, each reviewer was invited to change their scores if desired.

As the template produces an average score for each proposal, the plan was to use these to rank all of the regional submissions. However, the average group scores reflecting reviewer assessment of the evidence presented in the proposals were very low, (ranging from a low of 16% to a high of 53%), and the confidence of reviewers in many of the solutions/interventions proposed was limited. These and other factors resulted in a recommendation by the Research team that ratings and rankings not be used as planned to make recommendations of priorities for Manitoba Health. It was also noted that in at least one case there was striking inconsistency between qualitative assessment (i.e. Reviewers assessment of strengths and weaknesses of proposal and their confidence in the solution) with the final quantitative scores. For example all reviewers in Reviewer Group 2 stated they had **No confidence** in the proposed solution of the second highest ranked proposal, suggesting important limitations to the scoring approach.

Other identified limitations of a review process included the fact that two different review groups, with different patterns of rating, made it impossible to compare results of the two groups; an evaluation of the proposals from an economic perspective was not included in this year's Review Template, although it was recognized this would be an important consideration in priority setting; acknowledgment by reviewers that it was difficult to put

aside their personal knowledge in rating the proposals; confusion about whether the proposal concept or the evidence to support it was the focus of the assessment; inconsistency in use of the "not applicable" category; and reviewers experience that not all criteria were appropriate (or equally appropriate) to all proposals.

In addition, as became apparent through the discussion among review team members and at Executive committee, there was a mismatch between what senior management was seeking to do (identify the most pressing issues), and what the process had done (identify the strongest proposal, therefore also requiring strong evidence for a particular solution).

In an attempt to identify the strongest proposals submitted, however, the planning team requested that Research and Evaluation review the proposals and determine a way of selecting the top proposals. Six proposals were identified as meeting the criteria of:

- Minimum of one reviewer identifying initiative as VERY important. (Note: this number selected as requiring more than one reviewer to so identify would have eliminated almost all submissions in one Reviewer group)
- Minimum of two reviewers being at least somewhat confident that the submission proposed a good solution.
- Within the top five of rankings within the group.

This selection was confirmed by members of the review committees as being congruent with the review teams' assessments, and results were presented in a brief report to the WRHA Executive Committee. Following committee discussion, however, and recognizing that the prioritization process did not work as well as anticipated, Executive committee selected 10 priority areas, none of which overlapped with the 6 identified through the review process.

Following this process, all the reviewers and Executive team were invited to participate in semi-structured individual interviews. An anonymous survey, including both closed and open-ended questions, was sent to these individuals as well as those who had submitted proposals. Forty individuals (all submitters, reviewers, and participating senior managers) were emailed a link to the survey (surveymonkey.com); email reminders were sent to all 8 and 12 days later. Twelve of the 16 individuals invited to participate completed individual interviews; 22 of the 40 of those invited to complete the online survey did so.

EVALUATION FINDINGS

Overall, strong buy-in for changed process from most stakeholders

All phases of the project identified a strong appetite within programs for changes to existing processes, and strong support for the concept of using evidence in decision-making. This appetite for change to existing processes was, however, tempered with a high degree of skepticism from some program participants about the politicized nature of decision-making and the likelihood of change. This general skepticism, combined with the knowledge of submitters that New Initiative submissions almost never resulted in new funding, provide important context for interpretation of project results.

Disappointment but not surprise at outcome
All stakeholder groups agreed that aside from increased insights into the complexity of priority setting, and the limitations of existing processes, the intervention had limited impact this year. Many participants (among both submitters and reviewers) expressed frustration and disappointment at these results, but few were surprised.

Diverse perspectives on reasons for outcome
There were, however, diverse perspectives on the reasons for this outcome, with important differences observed between those involved in the planning and review process; and those, such as submitters, who were not directly involved. Areas of divergence included:

- ***Extent to which limitations of the revised priority setting process and associated template for assessing criteria were recognized***. Those involved in the review process (and the Executive members who were briefed on the findings) were well aware of the limitations experienced in using the review template; they also saw these challenges as issues to be addressed in subsequent iterations. However, most submitters were only aware of the final outcome of the process.
- ***Acceptance of appropriateness of non-research sources of evidence*** in priority setting. The process used a broad definition of evidence that included… "*research findings and also other source of evidence, such as client/family experience, results of community consultations and locally produced evidence such as that resulting from program evaluation and quality improvement activities*". However, many reviewers struggled with the appropriateness of non-research forms of evidence. The appropriateness of political context as a factor for consideration was the source of some profound differences among stakeholders. On the one hand it was accepted as a given by most on Executive Committee, but many reviewers and submitters viewed the inclusion of political considerations as antithetical to evidence-informed decision-making.
- ***Awareness of immediate findings from the process***. Several insights to guide future planning (discussed in detail on pages 10-12) emerged from the review and Executive meetings. Submitters were not, however, in a position to benefit from these immediate insights.
- ***Understanding of Senior Management rationale for maintaining the current NI submission process given unlikelihood of funding***. While the Executive Committee expressed reluctance to "do away with" the NI process as they saw this as an important mechanism for ensuring program input into regional priority setting over the long term, this was not necessarily appreciated or understood by all participants.

  > *We need to help people understand that they're not doing it to get funding, you're making a roadmap for when funds are available, you're raising the profile of the issue.*

These factors appear, at least in part, to explain some of the negative perspectives identified through the evaluation process.

Significant limitations to use of template for scoring
There was generally good support for the review criteria: some of the priority-setting criteria were almost universally accepted as important (87% support for appropriateness and access), with only consultation (at 37.5%) receiving less than 60% support. The low support for the criteria of consultation is an interesting finding given this year's emphasis

on integrated regional submissions. However, there were divergent perspectives on the importance of pre-screening criteria, with some feeling they were essential (*These are fundamental, this is the ethical piece*) and others indicating that they were relatively meaningless given that any proposal could be made to fit them (*I don't see much value in the pre-screening criteria; they're so high level that you can find a way to make anything fit them.*)

While most reviewers found the criteria useful as a means of guiding discussion, and some appreciated the structure provided by the template, serious limitations were identified with using a quantitative template to score a broad variety of proposals.

> *There should be critical points to think about, not a score, but clarity of the problem and the intervention should be scored separately*

Both the experience of the review committees and the follow up interviews highlighted significant concerns about the overall "validity" of the scoring system. The reviewer's template used to score proposals was described as *"too rigid", "too long", "too detailed", "didn't apply equally to every proposal",* could be "*gamed"*, did not evaluate financial implications, and was of questionable validity (i.e. a proposal could score high and not be that important or feasible). There were concerns around weighting of criteria and lack of agreement that all criteria should be given equal weight in scoring proposals. Reviewers questioned *"whether we are judging whether the proposal was well written, or the idea? Are we looking for the proposal with the best evidence or the most evidence*?"

A lack of fit was observed between the criteria and scoring system, and cognitive processes actually used to make decisions; and it was observed that the two summary questions (focusing on the importance of the issue, and reviewer confidence in the proposed solution) were often the most useful.

Other concerns identified related to lack of orientation and training on use of the review tools. These included inconsistency in use of the "not applicable" category; lack of clarity and consistency regarding what was acceptable as "evidence"; whether the proposal or the idea was being evaluated; the role of personal knowledge; and an expressed need for general orientation to the review categories.

Strong support for the resources developed to support the process.

In spite of concerns about the process and use of the template for scoring, the resources developed to support use of the template (the Users and Reviewers Guides, and On-line toolkit) were very positively evaluated by those who had used them.

> *It helped us understand what we should be looking for, what are the strengths and weaknesses, it was like having crib notes, Coles notes. The Users guide, online toolkit were fabulous, captured the essence of what was expected, well written, not written in research language, written in a way that someone who was not a proposal writer could take and apply.*

However, in spite of the activities to disseminate these resources identified earlier, not all submitters used these resources. Several comments were made regarding the need for in-person orientation/training, and the limitations of simply providing tools to support changed processes. It is also important to recognize that tools to support an ineffective process are not, in themselves, useful.

A range of barriers to buy in to "using evidence" in proposals will need to be addressed

Results indicate that many submitters, in particular, were unhopeful of achieving a fair process; expressions such as "*biased"* and "*based on lobbying*" were commonly used.

> *I am not convinced the process is unbiased and fair.*
>
> *Belief that our voice doesn't and will not impact decisions as from past history*
>
> *The political monster decides where the investment goes.*

This perspective appears to be exacerbated by the knowledge that few New Initiatives were funded: leading many to believe participation was a waste of time ("*It created more work for the submitters and in the end, all the extra work was really for nothing.")*

The common cynicism around likelihood of a fair process, combined with the fact that the pilot was developed to support a "low hope" process, may explain in good part why so little evidence was identified by reviewers in proposals. Survey results indicated that a small number of submitters used the criteria or tools in preparation of their proposals. Only 8.3% stated that they used all of the criteria in their proposals; half of respondents indicated that they did not use the on-line toolkit, and 45.5% did not use the Users guide to prepare their submission. When asked for reasons for why they did not use them, many responded that they *did not believe it would make a difference* to the result (63% did not use criteria, 40% did not use the online toolkit, and a third did not use the User's guide for that reason) (Appendix F).

Other factors commonly identified as barriers included:

- Issues related to time (not enough time, or information coming too late)
- Issues related to continued use of the Manitoba Health template, which was not a "fit" for the criteria. There was also frustration on the part of some submitters who stated that they had in the past included evidence, but were told to "keep it short".
- Issues related to capacity: A smaller number identified the need for orientation or assistance in developing evidence informed submissions.

Additionally, the evaluation identified low investment in changing the NI process among some participants as many talked openly about using "back door" processes, such as mid year briefing notes, to get the funds they needed. This concern was recognized by the planning committee, which initiated discussions on changes to Briefing Note in order to make it consistent with draft priority setting criteria.

Important insights to guide further revision of Priority Setting processes

Despite the failure of the process to change the final stage of the priority-setting process, there was strong evidence that implementation/evaluation process resulted in significant insights into existing priority setting processes and needed areas of change among those involved in the process (planning committee/reviewers/executive). As one participant commented:

> *I don't think the process changed much, but it made us aware of significant gaps in the process. It created an awareness. It made me aware of the deficiencies. The outcome didn't change, but our understanding has changed. It made me realize we need to find a different way to do this and value our programs.*

These insights included:

- ***Recognition of the need to differentiate various stages of priority setting -*** "*identification of a priority issue*" vs. *"selecting effective solutions to address priority issues"*. This insight, a key finding from the pilot process, has major implications for further revision of priority setting processes. A related issues is the mismatch identified between what senior management was seeking to do (identify the most pressing issues), and what the process had done (identify the strongest proposal, therefore also requiring strong evidence for a particular solution). Participants also expressed concern regarding organizational ability to select strong solutions: both the NI submissions and participant comments demonstrated a focus on using evidence to promote recognition of the problem, with less ability to use evidence to inform solutions to identified problems.

  The solution piece is very weak, there was almost no evidence that any of them were the right solution to the problem. The problem is usually very well defined, but they present no solutions, their idea and the status quo.

- ***Appreciation of the complexities of priority setting and limitations of rigid scoring systems.*** In addition to insights regarding the phases of priority setting, there appeared to be enhanced appreciation of the complexities of designing an objective "system" for setting priorities. Most participants noted that while the criteria did help them think objectively about the evidence and were a useful framework for discussion, use of criteria to score or rank submissions, appeared problematic.

- ***Identification of diverse perspectives around who should be involved and how in determining priorities.*** Many Executive members clearly believed that individual programs were not best positioned to select regional priorities: and that as an executive body they would be most appropriate to select these areas. They saw the NI process, however, as an opportunity for programs to get their needs "on the agenda" in order that they could be included (with other forms of evidence) into future planning activities – it was seen as a bottom up opportunity to inform decision-making. However, these were not the perspectives of many submitters (or reviewers).

- ***Inadequacy of current strategies for obtaining program input in priority setting***. Related to previous point, limitations of existing processes for ensuring "bottom up" input, and need to develop more effective strategies were identified.

- ***The need for creative strategies to promote both innovation and integration between program areas***. The executive committee placed a stronger emphasis on the criteria of innovation and partnerships; criteria that were rarely emphasized in proposals.

- ***A need for organizational capacity building around evidence use***. Several subthemes were identified in this category:
  - ***Need for development of a shared understanding of what evidence is, how to synthesize various forms of evidence, and how evidence should be used in planning.*** In spite of inclusion of a definition of evidence in all resources, many participants struggled with this issue, demonstrating diverse and often contradictory perspectives on the role of non-research based evidence. The relative weight to be given to various sources of evidence in a particular context emerged as a challenge.
  - ***Diverse perspectives on what kind of capacity building was needed and who needed it.*** Stakeholder groups generally identified a need for capacity

building related to the appropriate use of evidence, but often indicated that it was members of another stakeholder group who were really in need. It is important to note that capacity building was not the major barrier identified by program respondents, who focused more on the transparency and objectivity of processes, and senior management capacity to implement processes that were truly evidence informed.

- ***The importance of ensuring adequate time and resources to support proposed changes.*** In addition to the inherent limitations of the tools trialed, reviewers in particular also recognized that failure to ensure adequate time for planning, orientation, preparation and review was a potentially contributing factor to the final results. That time could not be found for orientation to the new process for either submitters or reviewers, and the intermittent attendance at the NI planning day, both demonstrate the reality of time pressures on these change activities. In addition, in response to the survey question of why criteria were not used in preparation of the submission, 72.7% of respondents indicated that they did not have time, and 54.5% indicated that the information came too late. However, consistent with the theme that "there is always time for the important things", this finding must also be considered in the light of the significant number who indicated that they did not believe it would make a difference to the result.

- ***Need for active steps to address cynicism related to likelihood of change***

Those closely involved in the revised process generally identified positive results from the revised process even though the final process of setting priorities did not change. Strengths of the revised process included a) an explicit focus on promoting evidence informed planning; b) a clear, transparent process with definable steps; c) tools to support the process, and d) an attempt to promote dialogue between programs and senior management. Many described the pilot as a "good first step", and were encouraged by results. The experience that evaluating the revised process also led to shared insights around needed change was also highlighted as an important achievement.

However, those not directly involved in planning or review did not generally identify these positive outcomes, and it appears that the results may have entrenched existing cynicism around organizational readiness to change processes. Meetings with program representatives early in the process identified common skepticism and distrust around the initiative. Of those completing the survey following the process, 44% felt that the revised process was "*about the same as*" the year before with (non-significant) differences among those who felt it was better or worse, and many comments were made indicating a profound cynicism around organizational readiness to adopt transparent processes.

DISCUSSION

It is important to review the findings of this evaluation in light of similar research and evaluation activities. Many of the findings of this evaluation are consistent with themes identified through review of the priority setting literature. It is increasingly recognized that priority setting must take into account multiple criteria, and that as it is impossible to achieve agreement on what should be prioritized, attention should be focused on establishing a fair process for decision-making. The most well-known among these

approaches, Accountability for Reasonableness (AFR) (Daniels and Sabin, 1998) proposes that such processes must meet the four criteria of relevance, publicity, revision, and enforcement, with a proposed additional condition of empowerment (Gibson et al, 2005). Several research activities assessing decision-making within Canadian health authorities, however, suggest that current processes rarely meet these conditions (Gibson et al, 2006, Menon et al. 2007; Mitton & Donaldson, 2004; Teng et al., 2007).

Other authors have also reported that interventions to improve priority setting did not achieve their intended outcomes. Gibson et al. (2005) noted that some decision-makers have found themselves in the position of having drafted a great set of criteria, but actually making decisions based on unrelated information. Dixon et al. (1997) in an assessment of the added value of introducing academic research gathering and appraisal skills into an existing priority-setting process, found no correlation between strength of evidence and final priority ranking. They also noted that little evidence was provided by "bidders", the impact of time and resource constraints, and the "dilution" of the impact of research as it moved through the decision-making process. They also observed the "paucity of strong evidence" (defined as research) in many areas. Other authors have noted that ethics interventions related to priority setting have had had educational benefit but little impact (Yeo et al., 1999). These results, like ours, suggest that priority setting may be more complex than many interventions have previously recognized.

There is some question about the common assumption that "rational" approaches to decision-making are superior, and it is proposed by some that certain decision-making skills are closer to the "recognition-primed" decision making in clinical medicine or in professions such as fire fighting (Baker et al., 2004). That the "template" approach to priority setting may not always be the ideal was recognized by the participant who observed:

> *We make an assumption that decision-makers aren't using evidence… Dermatologists recognize rashes by sight so if you provide them with a written description of a rash, it gets in the way of their decision making.*

Our findings also support the work of other authors who promote caution around focusing "simple technical fixes" for a process that is recognized as "inevitably messy and difficult" (Klein, 1998); or on using priority setting criteria to "score" proposals. Mullen (2004), for example, has raised questions about whether such decisions can be quantified, citing frequent lack of clarity about objectives, lack of understanding about why particular techniques are being employed or their appropriateness, and a number of issues related to weighting. She also notes that many tools are available, and many tool development activities appear to be a "reinvention of the wheel". Giacomini et al. (2008) also note that many priority setting tools have been adopted before the tools themselves have been evaluated for qualities of robustness, coherence and meaningfulness.

Further planning must consider both the complexity of the priority setting process and the challenges in developing processes and resources to support the various phases of priority setting. These plans must also address the lack of confidence in current processes among many in the organization, and take into account the multiple barriers identified. Whatever process is adopted, transparency is a fundamental condition for acceptance by organizational members.

As earlier identified, this evaluation reviewed the first step in what is intended to be an ongoing change process. The interest and commitment of WRHA program staff in using evidence in planning and in supporting evidence-informed processes; and the openness of Senior Management to exploring more effective strategies for ensuring "ground up" input into priority setting, suggest that the organization is well positioned to make continued improvements in this area; and to implement changes that address the *complexity* of priority setting processes. This collaborative evaluation also provides context-specific guidance, as outlined in the recommendations that follow, for addressing the challenges - experienced by every organization – to implementing fair, transparent, and evidence-informed priority setting processes. Further activities to continue development of priority setting processes is recommended.

RECOMMENDATIONS EMERGING FROM EVALUATION

General process

1. Take active steps to address the cynicism around the usefulness of using evidence in WRHA planning.

a. ***Proactively communicate the decisions and rationale for priorities selected by Senior management this year, along with commitments for next year's process.*** These actions are required to address the disappointment around the outcomes of this year's process, and will mitigate the risk that results will be interpreted as Senior Management lack of support for evidence-informed decision-making.

b. ***On an ongoing basis, take action to ensure transparency of what ever decision-making process is adopted***, including priority setting outcomes and rationale.

2. ***Secure Senior Management commitment to revised processes before proceeding with further change***. Even though significant learning came out of this pilot process, the perception that additional work resulted in no change in outcome risks exacerbating an already high level of cynicism about the likelihood or benefits of an evidence-informed approach.

3. ***Revise the New Initiatives process to address the two identified phases of priority setting process***: a) Determining regional priority areas, and b) Determining the intervention to address the problem. This approach recognizes that different forms of evidence are appropriately given different weight for different kinds of decisions, and that different individuals, perspectives and skills may be appropriate for each. Engagement with program areas will be essential to ensure that there is buy in to the process and that adequate processes are in place to ensure meaningful program input.

4. ***Provide Research and Evaluation support for the short listed priority issues*** to promote and support evidence informed solutions. Assessing and synthesizing diverse sources of evidence is a specialized skill, and may not be the most appropriate task for programs who are in the position of making a convincing case for the importance of their initiative. There may, therefore, be a role in for the WRHA Research and Evaluation unit to assist with this component of the health planning process by assessing the strength of the evidence in focused areas. However, given the time requirements for a quality review, a limited number of such issues can be comprehensively addressed. It is also essential to ensure Senior Management support

for any changed process before requesting this research assistance in order to avoid the failures experienced by other such initiatives (Dixon et al., 1997).

5. ***Revise time lines and order of activities to achieve revised processes***. As indicated through the pilot, there was insufficient time allocated to key aspects of the process, and several questions were raised about the order of activities. All activities, order of baseline and New Initiatives submissions, and timelines for preparation should be reviewed to ensure that processes support priority setting objectives.

   a. Actively disseminate information on process, expectations, parameters, timelines, and resources available to assist programs well in advance of proposal development.

6. ***Ensure consistency of expectations for all funding requests.*** Issues related to "back door" requests for funds (e.g. Briefing notes) were a theme throughout the evaluation. A new process is unlikely to have credibility unless the same requirements for evidence use are incorporated into all reviews of funding requests.

7. ***Develop and implement strategies to build capacity throughout the region in appropriate use of evidence.*** This capacity building should first focus on revision of existing processes to support evidence use. Such organizational change, combined with development of senior management support of the revised process is more important than, and should precede, any educational sessions on using evidence.

8. ***Initiate discussions with Manitoba Health around identified limitations of the existing template and process.***

Review Process

9. ***Following clarification of a revised process, establishment of any review team should consider:***

   a. The composition of teams (size, breadth, clinical insight, impartiality)
   b. Orientation and training needed for reviewers
   c. Allocation of sufficient time for orientation, proposal review, and discussion and decision-making
   d. A clearly defined process where reviewers hear back on final decision and rationale.

Priority Setting Criteria and Tools

10. ***The PSC, and associated tools, should be reviewed and revised with a view to their use as a discussion guide, rather than as a template to score and rank proposals***. Several limitations to the use of criteria to rate and rank proposals were identified by participants. However, most participants noted that the criteria did help them think objectively about the evidence and were a useful framework for discussion; in addition, several noted that the qualitative questions at the end were in practice most useful. This recommendation also reflects the current research literature highlighting the limitations of a technical approach to multi-criteria priority setting

CONCLUSION

In spite of the fact that there was no change in outcomes (in the end, a similar process was used to identify priorities as in previous years), and a number of difficulties were

identified regarding the submission prioritization process, the pilot and its evaluation provided valuable insights into the complex multi-stage nature of decision-making; limitations of existing PS processes; factors contributing to diverse perspectives on the PS process; and challenges related to using criteria to rank or score submissions. These findings position the WRHA well for further development of priority setting activities.

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APPENDICES

APPENDIX A: Interview Guide - Review Committee Participants

Introduction

This interview is a part of a research project to evaluate the revised WRHA New Initiatives process, and tools and resources to support that project. It is part of a larger research project that is focusing on identification of barriers to evidence-based planning and decision-making experienced by decision-makers within RHAs, and collaborative exploration of effective strategies to address these barriers. Results of the evaluation will be used to further improve the process, and inform other resource allocation processes.

Participation in the interview is voluntary, and you may decline to participate or withdraw from participation at any time. It is anticipated that individual interviews will take 20 - 30 minutes.

No personal information will be gathered in this study. All information gathered will be kept confidential, and shared only with the research team. The interview notes will be identified with a code, not with your name. Only the principal investigator and study coordinator will have access to these notes. Only the study coordinator and principal investigator will know that you have participated or not. Information gathered in this study may be published or presented in public forums; however, your name and other identifying information will not be used or revealed.

Do you have any questions before we begin?

First I'd like to talk a bit about the decision-making process in general, and then ask your feedback on the actual tools used.

Evaluation of revised process

1. Did you participate in any way (e.g. developing proposals, reviewing proposals, discussing proposals and decisions) in New Initiatives selection process in previous years?
    a. Probe: in what way?

2. a. **If so**, in what ways was the process similar or different this year? What were strengths and limitations of the new process?
    a. **If not**, was the process what you were expecting? In what ways? What insights do you have on strengths and limitations of the revised process?

3. *The revised process kept, as a focus, the evaluation of the strength of evidence for a particular submission.*
    a. What do you think of this focus on the strength of the evidence?
    b. In the User's and Reviewer's Guide, "The term evidence includes research findings and also other sources of evidence like client/family experience, results of community consultations and locally produced evidence such as that

resulting from program evaluation and quality improvement activities." From your experience, is this the definition of evidence that is commonly used in health planning? Do you think this definition of evidence is appropriate and helpful? In what ways?

c. What impact did evidence have on the discussion? Did this focus on strength of evidence ***affect*** the final Scores? In what ways?

4. <u>The Reviewer's Template and Guide attempted to create a level playing field for initiatives that were in the health promotion/prevention area (by giving extra points).</u>

a. Did this emphasis, in the Reviewer's guide and Template, affect how you rated the initiatives? Was this appropriate? Do you think it worked?
b. Do you think it affected the group rankings?

5. How did you feel your ratings compared to other members of the committee (state not asking comparison with individuals)?

6. *There has been interest expressed in looking at improvements to other priority setting activities within the WRHA, and other processes for reviewing funding requests, such as requests via briefing notes.* In what ways do you think that a similar process can be used in this setting?

7. In what other ways do you think that health planning within the region can be improved?

a. What are some of the challenges in making these improvements?
b. What would facilitate making changes?

<u>Evaluation of Tools and Resources</u>

1. *A number of tools and resources were developed to support this revised priority setting process: all of them based on the Priority Setting Criteria developed by the Resource Allocation Initiatives Working Group*.

i. What is your overall impression of the appropriateness of the Priority Setting Criteria to health planning in the region?

2. *Tools and resources were developed based on these criteria to guide the development of proposals. These tools include a web-based health planners' tool kit, and a users' guide.* Show picture or example of each.

a. Which of the resources have you had the chance to review?

b. For each resource mentioned:

i. How useful did you personally find this tool/resource?
ii. What changes would you recommend?
iii. What orientation do you feel users of these tools require?

3. *Now I'd like to ask some questions specifically around the Reviewers template and guide*:
    a. Did you feel that these resources assisted in the decision-making process? In what way?
    b. *The template and guide used are drafts that the NI committee was expecting would need to be adapted.*
        i. *I asked earlier about your impressions of the priority setting criteria.* Are there any additional comments that you would like to make related to their use and application to the review process?
            1. What other characteristics of the criteria did you find useful/not useful?
        ii. What were the strengths and limitations of the template? How could it be improved?
        iii. In general, did the overall score received using the template correspond with what you, in your experience, would have given it?
        iv. Did the template work better for some submissions than others?'
        v. Essentially this template combines how important the problem is with how appropriate the solution is to generate an overall score. Is this an appropriate way to set priorities in this context?
        vi. Did you use the Reviewers Guide?
            1. If not, why is this?
            2. If so, what were the strengths of the guide? In what ways could it be improved?

4. Are there any other tools or resources that you think would be useful to support health planning processes?

Interview Guide - Executive

Introduction

This interview is a part of a research project to evaluate the revised WRHA New Initiatives process, and tools and resources to support that project. It is part of a larger research project that is focusing on identification of barriers to evidence-based planning and decision-making experienced by decision-makers within RHAs, and collaborative exploration of effective strategies to address these barriers. Results of the evaluation will be used to further improve the process, and inform other resource allocation processes.

Participation in the interview is voluntary, and you may decline to participate or withdraw from participation at any time. It is anticipated that individual interviews will take 20 - 30 minutes.

No personal information will be gathered in this study. All information gathered will be kept confidential, and shared only with the research team. The interview notes will be identified with a code, not with your name. Only the principal investigator and study

coordinator will have access to these notes. Only the study coordinator and principal investigator will know that you have participated or not. Information gathered in this study may be published or presented in public forums, however your name and other identifying information will not be used or revealed.

Do you have any questions before we begin?

First I'd like to talk a bit about the decision-making process in general, and then ask your feedback on the actual tools used.

1. Did you participate in any way (e.g. developing proposals, reviewing proposals, discussing proposals and decisions) in New Initiatives selection process in previous years?

2. a. **If so**, in what ways was the process similar or different this year? What were strengths and limitations of the new process?

   c. **If not**, was the process what you were expecting? In what ways? What insights do you have on strengths and limitations of the revised process?

3. *The revised process kept, as a focus, the evaluation of the strength of evidence for a particular submission.*
   d. What do you think of this focus on the strength of the evidence?
   e. In the User's and Reviewer's Guide, "*The term evidence includes research findings and also other sources of evidence like client/family experience, results of community consultations and locally produced evidence such as that resulting from program evaluation and quality improvement activities*." From your experience, is this the definition of evidence that is commonly used in health planning? Do you think this definition of evidence is appropriate and helpful? In what ways?
   f. What impact did evidence have on the discussion?

4. *There has been interest expressed in looking at improvements to other priority setting activities within the WRHA, and other processes for reviewing funding requests, such as requests via briefing notes.* In what ways do you think that a similar process can be used in this setting?

5. In what other ways do you think that health planning within the region can be improved?

   g. What are some of the challenges in making these improvements?
   h. What would facilitate making changes?

6. What impact do you think the revised process has had? With senior management? With people preparing submissions?

APPENDIX B – Timeline

Date	Activity
October 22, 2004	Release of report of consultation with Community Health Advisory Councils “Council Prioritization and Feedback of Draft Criteria for Decision Making and Priority Setting”
September – October 2007	WRHA Board Ethics Committee provides Discussion Draft to senior management entitled "Ethics in Resource Allocation: Suggested Strategies & Resources for the WRHA"; Senior management forms the Resource Allocation Initiatives Working Group in response.
November 1, 2007	Initial meeting of the Resource Allocation Initiatives Working Group
Ongoing	Discussions with Manitoba Health and Healthy Living about increasing the use of evidence in the Regional Health Plan
December 3, 2007	Meeting of Evidence-informed Decision-Making/Knowledge Translation Working Group. Decision to pursue New Initiatives
January 24, 2008	Initial discussion with Director of Financial planning and decision to proceed
February 5, 2008	Meeting / presentation with Admin Directors/Finance
February 6, 2008	Research team joins Resource Allocation Initiatives Working Group meeting
March 25, 2008	Resource Allocation Initiatives Working Group develops smaller working group to refine criteria
April 14, 2008	Briefing note regarding changes to New Initiatives approved by senior management
May 6, 2008	Decision to take Priority Setting Criteria forward to senior management for approval
May 12, 2008	Senior management meeting
June 26, 2008	New Initiatives information and planning day
July and August	Development of User’s and Reviewer’s Guides
September 22, 2008	Pilot test Review Committee Discussion Guide and process
September 24, 2008	Review group meetings
September 25, 2008	New Initiatives committee meeting to discuss recommendation to executive
September 26, 2008	Presentation to, and priority setting by executive

APPENDIX C

WRHA Priority Setting Criteria User's Guide

Table of Contents

Introduction

The WRHA's draft priority setting criteria were developed by the Resource Allocation Committee to provide a framework to guide decisions related to setting priorities for health care planning in the region. The criteria were developed based on prior consultations with the WRHA Community Health Advisory Councils (CHACs) and other work done in Canada related to priority setting. The criteria are divided into *pre-screening criteria*, which consider the alignment of the proposal with WRHA and provincial goals and strategic directions and *review criteria* that will be used to rank submissions and determine priorities.

This user's guide has been developed to help in the preparation of submissions. The user's guide:

- Provides further understanding of each criteria
- Includes a glossary of relevant terms
- Provides guidance on the evidence that could be used to support each criteria
- Is a companion to the on-line Health Planners Toolkit which will help you to find appropriate evidence.

Senior decision makers will review the submissions, and priorities will be determined using these criteria.

This is a draft document only. Your suggestions and comments will help make this a more useful document. Please send any comments on this draft to researchandevaluation@wrha.mb.ca.

To access the 'Health Planner's Toolkit', visit http://home.wrha.mb.ca/research/hpt/index.php

WHAT IS EVIDENCE IN HEALTH CARE?

An effective and ethical priority setting process should be informed by evidence. It should reflect the ethical principles of equity, transparency, accountability and reasonableness.

What is evidence?

Evidence is information that comes closest to the facts of a matter. Findings of high quality, methodologically appropriate research are the strongest and most accurate evidence. However, because research is often incomplete and sometimes contradictory or unavailable, other sources of evidence are often necessary supplements to research (Adapted from CHSRF).

Not all information is quality evidence:

Both the quality of the evidence and its applicability to a specific situation must be considered. Three important questions to use in this process are:

1. Is it relevant to the purpose?
2. Is it credible or trustworthy?
3. Is it sufficient to draw conclusions or to act on?

Good evidence includes more than numerical data or quantitative research. If only quantitative research is used to make decisions, this eliminates many other appropriate sources of data, such as good qualitative research, and places decision-making about currently under-resourced areas at a disadvantage. The table on pages 6 and 7, outlines good sources of evidence and their potential for health planning. Poorer sources of evidence should be avoided.

Evidence-informed approaches recognize that, in addition to research findings, there are other legitimate factors affecting decisions making – these include values, resource availability, political judgment, and professional judgment. Other legitimate and useful sources of evidence may be client/family experience, results of community consultations and locally produced evidence such as that resulting from program evaluation and quality improvement activities. The challenge for decision-makers is to:

- Ensure that more weight is given to sources of evidence that reflect research rigour,
- Minimize the influence of other factors (e.g. habit, individual preference, lobbying)
- Make use and weighing of all these sources of evidence transparent.

Is evidence-based planning really possible?

The concept of "evidence-based" comes from clinical medicine and implies that the best answer lies in research findings. There are a number of concerns that this is not an appropriate approach for planning and decision making with the result that an *evidence-informed* approach has been proposed as an alternative. **An *evidence-informed* approach recognizes that:**

- Research may be lacking for the questions facing decision-makers,
- Research findings may not be available in a timely way,
- There is often a need for locally relevant information, and the results from health services research may not always be applicable in other settings

Potential evidence sources

GOOD SOURCES OF EVIDENCE	**CONTRIBUTION**	*WHERE TO START*
Systematic reviews, meta-analyses	Summarizes, according to strict, objective criteria results from all applicable studies	Request a literature search of reviews and meta-analyses from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
Results of expert consensus forums	Provides "cutting edge" thinking in situations where systematic research not available	Request a literature search of grey literature from the Health Sciences Libraries: http://www.umanitoba.ca/libraries/health/
Relevant MCHP reports	May provide other program relevant indicators; often provincial comparison available	MCHP website. Most reports available on line at: http://umanitoba.ca/medicine/units/mchp/
Well designed Program Evaluations	Combine research rigour with need for timely, context sensitive evidence	Contact specific programs, request consult from R & E regarding evaluation quality.
Well designed evaluations from other jurisdictions	Such findings from the grey literature often precede formal research activities	Direct contact with other RHAs. Request consult from Research and Evaluation Unit re: evaluation quality. Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
Synthesis of WRHA evaluation findings	Identifies themes emerging across region, not limited to one program	Contact R & E for information as to whether similar themes have emerged in other areas.
Concept papers, literature reviews commissioned by WRHA	Interprets current research for specific context, combines with critical review of research, other evidence	Check Insite for posted reports (Research and Evaluation pages), contact R and E to see if any related activities are underway. http://home.wrha.mb.ca/research/reports.php
Internal systematic literature review with contextual analysis	If done well, can integrate current research, other context-sensitive evidence	Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php Research and Evaluation Unit can provide guidance with literature review and can conduct review upon request from Senior Management.
WRHA Community Health Assessment	Region-wide analysis of provincially approved indicators; inter-RHA comparison	Available on WRHA website (Intra/Internet). This site also links to related reports, and will soon provide community area profiles. http://www.wrha.mb.ca/research/cha/index.php
Well designed community needs assessments	Can identify trends and issues not captured in information systems	Specific program area, CADs.
Results of quality improvement, activities	If well designed, can provide useful information on what works, doesn't work similar to	Consult specific program areas.

	program evaluation	
Performance measurement indicators	If valid, robust, non-gameable indicators, can provide comparison over time, provincial comparison	Can consult with R & E re: appropriate interpretation, use of indicators.
POOR SOURCES OF EVIDENCE	*RISKS*	*CONSIDER INSTEAD*
1 or 2 selected articles	"Decision-based evidence-making" – cherry picking of articles that are supportive of chosen initiative rather than a systematic review. May lack contextual evidence.	With assistance of Health Sciences Libraries search for meta-analyses or systematic review: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php If this is not available, consider undertaking a context-sensitive review under guidance of Research and Evaluation Unit.
Quick internet search	Hugely variable quality – may include "sponsored" research, lobby groups, etc.	Request a literature search the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
1 or 2 experts' opinion	Does not bring advantages of consensus forum described above; experts chosen may not be representative	Consensus conference findings. Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
1 or 2 case examples	Case examples may not be representative or frequent.	Systematic review of cases, client experiences
Poorly designed, "internal" program evaluations from within or outside the organization	May lack scientific rigour; may lack credibility (conflict of interest).	Have any evaluations reviewed by R & E
Media summaries	May not accurately represent research findings.	Systematic reviews; at minimum review original article

Pre-screening criteria

Pre-screening is the first step in the review of submissions. All submissions must meet the first 3 pre-screening criteria, and the 4th if it is applicable, in order to move on to the Review stage of the process.

The 4 pre-screening criteria are:

1. **Consistent with WRHA mission, vision, values and strategic direction.**

To view:	Please see:
WRHA mission, vision and values	http://www.wrha.mb.ca/about/mission.php
WRHA strategic direction	http://www.wrha.mb.ca/about/plan.php

All submissions should support or advance the WRHA's mission, vision, values and strategic direction.

2. **Consistent with organizational priorities.**

WRHA Organizational Priorities are:
- Access
- Aboriginal Health
- Patient Safety
- Workforce Safety and Wellness

3. **Consistent with provincial goals and strategies.**

Provincial goals:
1. Optimize the health status of all Manitobans.
2. Improve quality, accessibility and accountability of the health system.
3. Achieve a sustainable health system.

Provincial strategies:
1. Advance healthy living and public health, through strategic partnerships and re-alignment of resources.
2. Through partnerships, reduce health disparities for at risk populations defined by socioeconomics, ethnicity, geography and gender.
3. Lead innovation and system change through strategic partnerships.
4. Improve access and sustainability in health care delivery through strategic investment in resources.
5. Build an integrated primary care system.

4. Consistent with approved WRHA concept papers and directional documents (if applicable).

These documents, approved by senior management, provide a synthesis of the evidence and outline key principles and directions that will be considered in the priority setting process.

To view:	Please see:
WRHA concept papers	**http://home.wrha.mb.ca/research/reports.php**

Action:

1. Review the WRHA Mission, Vision, Values, Organizational Priorities and Strategic Direction and Provincial Goals and Strategies. Identify how your submission fits with these.
2. Check to see if your submission relates to one of the concept papers available on Insite (See: **http://home.wrha.mb.ca/research/reports.php**)
3. Write a brief paragraph describing:
    a. How your submission will support and advance the WRHA's Mission, Vision, Values and Strategic Direction. Which organizational priorities this initiative will support and advance
    b. Which provincial goals and strategies this initiative will support & advance.
    c. If your submission relates to a concept paper, also describe how it is consistent with the direction set out in that paper.

Review criteria

1. Health Burden – The importance of the problem

Overview:
In this section, clearly state what problem your initiative is meant to address. Health burden describes the impact that an illness or health condition has both on the individual and at the level of the community.

For clinical initiatives, indicators such as incidence, prevalence, life expectancy and quality of life may capture health burden at the community or the individual level. These are only examples and you do not have to include all of them. Non-clinical initiatives will need to determine the best way to describe and provide evidence to support the problem they are addressing.

Action – Clinical Initiatives:
a. Clearly state the problem that this submission addresses.
b. The resources found in the Health Burden section of the Health Planner's Toolkit will help you to find evidence such as incidence, prevalence, life expectancy, and quality of life. Provide regional statistics if you are able to, but national or provincial statistics may also be used if these are not available. If some groups are particularly impacted, provide evidence to support this. If you are able to, you may also want to include projected incidence and prevalence, to demonstrate that this is a growing or emerging issue.
c. Be sure to provide references for the evidence you provide.

Action – Non-clinical Initiatives:
a. Clearly state the problem that this submission addresses.
b. The resources found in the Health Burden section of the Health Planner's Toolkit may help you to find evidence to describe the problem your initiative addresses. Describe the population that your initiative targets (if appropriate), the magnitude of the problem and what the consequences of the problem are at the organizational, community and/or individual level.
c. Be sure to provide references for the evidence you provide.

2. Health Gain – Proposed response to the problem

Overview:
Health gain can be thought of as the inverse of health burden. This is where you present evidence to show how your proposed initiative will impact the health of individuals and the community (clinical) or the organization and/or community (non-clinical), and why the intervention you have chosen is the preferred option. The *strongest* source of evidence would be a systematic review or meta-analysis, and therefore a good place to *start* is to look for one of these. However, these are not always available, and they also lack context specific information. Therefore, it is important to also look for other sources of evidence, for example evaluations (particularly randomized controlled trials). Examples of other good sources of evidence can be found in the Potential Evidence Sources on page 6 and 7 (and also in the Health Planners Toolkit). Look for evidence related to the outcomes of similar programs/strategies/ treatments that have been implemented. Very little information may be available related to innovative programs. However, there is likely a theoretical foundation on which the program has been developed.

Action:
a. **Clearly state what your proposed initiative is, and how it is anticipated to address the problem you have identified.**
b. You may want to start by outlining alternative solutions, summarizing the evidence for each. How does what you are proposing compare to alternatives that were considered? Are there contextual issues (for example related to Winnipeg or Manitoba) that must be considered? The resources found in the Health Gain section of the Health Planner's Toolkit will help you to find appropriate evidence.
c. If your initiative is an innovation with little evidence available in the literature to support it, describe the program theory that underlies the development of your submission.
d. How is this initiative expected to impact health at an individual and community level (clinical) or the organization/community (non-clinical)? Describe the anticipated short-term and long-term outcomes of the program.
e. How many individuals are expected to benefit from this program/treatment? How was this estimate made?
d. Be sure to provide references for the evidence you provide.

3. Access

Overview:
Access is one of the WRHAs organizational priorities, and ensuring equitable access is an important criterion for *all* health initiatives. Access can be defined as the "provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health" (Health Canada, 2001). Barriers to access include both those that prevent participation in preventive, health promotion and assessment services and those that limit needed treatments. Barriers may be financial, geographical, linguistic, or cultural, and may affect initial access, quality of care, or health outcomes. Wait times are but one component of access. Initiatives will be reviewed with a view to their impact on various population groups. Special consideration should be given to issues of access for groups facing health disparities.

Action:
a. Describe how you have considered accessibility in the design of your program/ treatment. How will your proposal improve access to health care services, and what barriers to access will be addressed (eg. Financial, geographic, organizational and sociological)?
b. Describe how this initiative will help to address health disparities such as those based on geography or population group (ethnicity/race, language proficiency, socioeconomic status, gender, sexual orientation, physical, psychological or cognitive disability), as appropriate.

4. Appropriateness

Overview:
Appropriateness means the provision of the right kind of care, at the right time, in the right setting, for the right reasons. Effectiveness, efficacy and efficiency should be considered, as should alignment with best practice guidelines in the area, if available. Consideration should be given to moving interventions as far upstream as possible; in other words, focusing on prevention and promotion. Providing *appropriate* services may require finding a balance between the efficiency of the health care system and the needs of individual patients.

Actions:

a. If applicable, describe how this initiative supports or strengthens prevention and health promotion.
b. What is the evidence that your proposal provides a service at the best time? In the best place? The 'Appropriateness' section of the Health Planner's Toolkit will help you to find evidence to describe efficacy, effectiveness and efficiency, as appropriate to your submission.
c. Determine if there are best practice guidelines applicable to your initiative. The resources found in the Health Planner's Toolkit will help you to locate applicable best practice guidelines. Describe how your proposal is in-line with these guidelines. If no such guidelines are available, for example if you are proposing something innovative, state this in your proposal.
d. Describe how does this initiative balances health system improvement and redesign (including fiscal responsibility and safety of care providers) with the needs of individual patients (convenience of care, patient preference). The 'Appropriateness' section of the Health Planner's Toolkit will help you to find evidence that describes the cost effectiveness, patient preferences and safety issues associated with similar initiatives if they are available.
e. Be sure to provide references for the evidence you provide.

4. Consultation process

Overview:
In this context, consultation refers to providing opportunities for stakeholders (eg. staff, patients/clients/consumers, caregivers and community members) to have meaningful input into the development, or redesign, of a program or service. Who is appropriate to be included in consultation activities will vary depending on the initiative. Through consultation, the perspectives, insights and context-specific evidence from multiple stakeholder groups can be incorporated into planning.

Action:

a. Describe which stakeholders are affected by this initiative (e.g. program team members, patients/clients/ residents, and community); how they have been involved in the development of this initiative, and the outcomes of these consultations. If consultations have not been done, provide a brief explanation.

6. Innovation and partnership development

Overview:
Innovation is about doing things in new and different ways. Your submission may be innovative or new to the WRHA, or you may be proposing a new way of doing something that has never been tried anywhere. This category does not simply refer to technical innovations, but to new approaches to old problems (for example, initiatives that move intervention as far upstream as possible). Regardless, you will want to provide your rationale and evidence for why you have chosen this particular approach to the problem identified.

The most effective initiatives are those that are the result of genuine partnership between all relevant stakeholders. Partnerships can also contribute to better system integration and therefore improved patient care. They may be formed within the region (eg. between programs) or with external agencies and organizations. Greater weight will be given to those initiatives that cut across a number of programs or that address more than one health risk or issue.

Action:

a. Describe what is innovative about your proposal. If your proposal is not "new" explain why changes to existing strategies are not needed.
b. Describe your rationale for choosing this new approach. The resources found in the Innovation and Partnership Development section of the Health Planner's Toolkit may help you to find appropriate evidence.
c. Describe how partnerships that have been developed will improve system integration and overall patient care.
d. Be sure to provide references for the evidence you provide.

7. Evaluation

Overview:
There is increasing recognition of the importance of evaluation within health services research, as well-designed evaluation combines research rigour with decision-maker needs for timely, relevant, and context sensitive information.

Evaluation can be defined as "the systemic collection of information about the activities, characteristics and outcomes of programs to make judgments about the program, to improve effectiveness, and/or inform decisions about future programming" (Patton, 1997).
Performance measurement involves the tracking and monitoring of program outcomes using valid indicators or performance measures (Blalock, 1999). If collected reliably, performance measures can be an important source of data for answering some types of evaluation questions. However, evaluation is broader than performance measurement, and is able to address complex questions facing the healthcare system, contributing insights to such questions as "why are we seeing these results?" and "how best can we address this issue?"

Actions:
a. Has an evaluation of this program been undertaken to date? Did the results of an evaluation recommend the development of this proposal? If so, explain.
b. Describe your plan to objectively evaluate this initiative, and how the evaluation results will be utilized. This plan should include:
    i. The engagement of appropriate stakeholders in all stages of the plan
    ii. Strategies to assess how well the planned intervention has been implemented
    iii. Outcome measures
    iv. Strategies for moving learning from this new initiative into organizational planning, and for sharing learning between programs.
c. Be sure to provide references for the evidence you provide.

Glossary

Access: "The provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health" (Health Canada, 2001).

Appropriateness: The provision of the right kind of care, at the right time, in the right setting, for the right reasons.

Best practice guidelines: Agreed upon procedures that are believed to result in the most efficient and effective provision of a service (CAOT, 2005).

Consultation: Providing opportunities for stakeholders (eg. staff, patients/clients/ consumers, caregivers and community members) to have meaningful input into the development, or redesign, of a program or service.

Effectiveness: "The extent to which a specific intervention, procedure, regimen, or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population" (Last, 1995, p. 52).

Efficacy: "The extent to which a specific intervention, procedure, regimen, or service produces a beneficial result under ideal conditions. Ideally, the determination of efficacy is based on the results of a randomized controlled trial" (Last, 1995, p. 52).

Efficiency: "The effects or end results achieved in relation to the effort expended in terms of money, resources, and time. The extent to which the resources used to provide a specific intervention, procedure, regimen, or service of known efficacy and effectiveness are minimized" (Last, 1995, p. 52).

Evaluation: "The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming" (Patton, 1997, p. 23).

Health burden: Impact of illness or condition on individuals and the community.

Health gain: The impact of an intervention on the health of individuals and/or the community.

Health disparity: A "difference in health status between a defined portion of the population and the majority. Disparities can exist because of socioeconomic status, age, geographic area, gender, race or ethnicity, language, customs and other cultural factors, disability or special health needs" (Minnesota Department of Health).

Health Promotion: "The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their

everyday lives, rather than focusing on people at risk for specific diseases , and is directed toward action on the determinants or causes of health" (WHO, 1986).

Incidence – The number of new cases of a condition in a given population in a given period of time (Last, 1995).

> Eg. In 2006, the incidence of HIV in Canada was 2557. In other words there were 2557 new HIV cases reported in Canada that year.

Innovation: Innovation is about doing things in new and different ways.

Life expectancy – The average number of years a person of a given age is expected to live, if mortality rates remain unchanged (Last, 1995).

> Eg. A baby born in 2005 is expected to have a life expectancy of 80.4 years.
> Eg. In 1992, the life expectancy of a child born with cystic fibrosis was 32.9 years.

Partnership: A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal (American Heritage Dictionary).

Performance Measurement: The use of data to determine if a program is meeting its goals and objectives.

Prevalence – The number of people in a given population that have a specific illness or health condition at a point in time (Last, 1995).

> Eg. On Dec. 31, 2006, the prevalence of breast cancer in Winnipeg was 4437. In other words there were 4437 people with breast cancer in Winnipeg at this time.

Prevention

> **Primary Prevention:** "The protection of health by personal and communitywide effects" (Last, 1995, p. 130). For example, immunizing children.
>
> **Secondary Prevention:** "Measures available to individuals and populations for the early detection and prompt and effective intervention to correct departures from good health" (Last, 1995, p. 130).
>
> **Tertiary Prevention:** "Measures available to reduce or eliminate long term impairments and disabilities, minimize suffering caused by existing departures from good health, and to promote the patient's adjustment to irremediable conditions" (Last, 1995, p. 130).

Quality of Life – A person's "emotional, social and physical wellbeing, and their ability to function in the ordinary tasks of living" (Hayword Medical Communication).

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APPENDIX D

Priority Setting Criteria Reviewer's Template

1. Health Burden – What is the problem that this submission addresses, and why is it important?	**0**	**1**	**2**	**3**	**N/A**
a. The problem that this submission addresses is clearly stated.	Not stated	**Stated but unclear**	**Somewhat clear**	**Very clearly stated**	
b. There is evidence that the problem is important because of its impact on quality of life.	**Anecdotal/ No evidence**	**Weak evidence of impact on QOL**	**Good context specific OR research evidence**	**Strong context specific and research evidence**	
c. There is evidence that the problem is important because of the number of people impacted.	**Anecdotal/ No evidence**	**Weak evidence of importance related to #s affected**	**Good context specific OR research evidence**	**Strong context specific AND research evidence**	
d. There is evidence that the problem is important because the number of people impacted is increasing.	**Anecdotal/ No evidence**	**Weak evidence of importance related to #s affected**	**Good context specific OR research evidence**	**Strong context specific AND research evidence**	
e. There is evidence that the problem is important because of its impact on mortality rates.	**Anecdotal/ No evidence**	**Weak evidence of impact on mortality rates**	**Good context specific OR research evidence**	**Strong context specific AND research evidence**	
f. There is evidence that the problem is important because of other factors (please describe).	**Anecdotal/ No evidence**	**Weak evidence of importance**	**Good context specific OR research evidence of importance**	**Strong context specific and research evidence**	
g. Overall, this problem poses a significant health burden.	**No health burden**	**Minimal health burden**	**Moderate health burden**	**Significant and increasing health burden**	

2. Health Gain – Is this the best way, in this context, to address the issue	**0**	**1**	**2**	**3**	**N/A**
a. **The proposed initiative is clearly described.**	Not described	**Described but unclear**	**Somewhat clear**	**Very clear**	
b. Short and long terms objectives are clearly described.	**No short-term or long-term objectives.**	**Short and long-term objectives unclear.**	**Clear short and/or long-term objectives.**	**Clear short and long-term objectives.**	
c. Alternative solutions are described.	**No**	**One other alternative is described.**	**Two or more alternatives described, with some evidence of strengths and limitations.**	**Strong evidence of objective review of the literature.**	
d. There is evidence that the initiative will positively impact the health of individuals.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
e. There is evidence that the initiative will positively impact the health of the community.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
f. There is evidence that the initiative will positively impact the organization (WRHA).	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
g. There is evidence that the proposed initiative is the best solution to the problem in this context.	**Anecdotal/ No evidence**	**Weak evidence**	**Good evidence**	**Strong evidence**	
h. Overall, this solution will reduce health burden and have a positive impact on individuals/ community/ organization.	**No impact.**	**Minimal impact.**	**Moderate impact.**	**Significant**	

3. Accessibility	**0**	**1**	**2**	**3**	**N/A**
a. **There is evidence that the proposed initiative will have a positive impact on addressing known barriers to access.**	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
b. There is evidence that the initiative will have a positive impact on reducing health disparities, or provide enhanced access to vulnerable communities.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
c. The inclusion and exclusion criteria are appropriate.	**No clear criteria/ Limits access**	**Criteria do not reflect best evidence of need/ priority**	**Criteria will promote access to groups most in need**	**Criteria will promote access to groups most in need and includes a strategy to monitor appropriate-**	

				ness of criteria.	

4. Appropriateness	**0**	**1**	**2**	**3**	**N/A**
a. **The initiative has an appropriate emphasis on health promotion and prevention.**	**No**	**Prevention and promotion could be strengthened**	**Prevention or promotion could be strengthened**	**Prevention and promotion appropriate**	
b. There is evidence that the proposed initiative is the most efficient alternative.	**Anecdotal/ No evidence**	**Weak evidence that it is the most effective**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
c. There is evidence that the proposed initiative is the most effective alternative.	**Anecdotal/ No evidence**	**Weak evidence that it is the most effective**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
d. The proposed initiative is supported by "best practice" guidelines.	**Contradicts guidelines**	**Does not meet best practice guidelines**	**Generally meets best practice guidelines**	**Meets and/or exceeds best practice guidelines**	
e. The initiative provides service in the most appropriate setting for users and providers.	**Evidence suggests location is not the best**	**Weak evidence, Anecdotal/ No evidence**	**Some evidence**	**Strong evidence**	
f. The initiative provides service at the most appropriate time.	**Evidence suggests time is not the best**	**Weak evidence, Anecdotal/ No evidence**	**Some evidence**	**Strong evidence**	
g. Overall, this initiative is the most appropriate solution in this context.	**Definitely not the most appropriate**	**Somewhat appropriate**	**Mostly appropriate**	**Definitely the most appropriate**	

5. Consultation	**0**	**1**	**2**	**3**	**N/A**
a. There is evidence of appropriate consultation with affected staff and related programs.	**No consult'n**	**Limited consult'n but not all stakeholders included**	**Consult'n representative of all staff, staff perspective/ concerns partially addressed**	**Consult'n representative of all staff, staff perspective/ concerns fully addressed**	
b. There is evidence of appropriate consultation with patients/clients/residents/ families.	**No consult'n**	**Limited consult'n - not representative of all stakeholders**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns partially addressed**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns fully addressed**	
c. There is evidence of appropriate consultation with community.	**No consult'n**	**Limited consult'n - not representative of all stakeholders**	**Consult'n representative of all stakeholders - stakeholders**	**Consult'n representative of all stakeholders - stakeholders**	

			perspective/ concerns partially addressed	**perspective/ concerns fully addressed**	

6. Innovation and partnerships	**0**	**1**	**2**	**3**	**N/A**
a. The proposed initiative is an innovation, or takes a new approach.	**No**	**Minimal innovation.**	**New to the WRHA**	**Cutting edge.**	
b. The evidence/theory to support the innovation is strong.	**Anecdotal/ No evidence**	**Weak evidence**	**Some theoretical basis OR good context specific or research evidence**	**Strong theoretical foundation and /OR strong context specific AND research evidence**	
c. The initiative contributes to health system improvement and system redesign.	**Anecdotal/ No evidence**	**Weak evidence**	**Is aligned with regional improvement/redesign strategies OR reflects evidence in the literature related to health system improvement and redesign.**	**Strong context specific and research evidence**	
d. The proposed initiative cuts across several program areas and sites.	**No, only 1 program/ site.**	**More than one site OR more than one program**	**More than one program AND more than one site**	**Several genuine partnerships within and without heath care system.**	
e. Proposed partnerships will contribute to system integration and improve patient care.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	

7. Evaluation	**0**	**1**	**2**	**3**	**N/A**
a. Evaluation results or quality improvement initiatives support the development of this initiative.	**No**			**Yes**	
b. There is a plan to objectively evaluate the initiative.	**No plan.**	**Weak evaluation plan**	**Strong plan, no funding**	**Strong plan and evaluation included in budget.**	
c. The proposal outlines how evaluation results will be utilized.	**No utilization plan**	**Utilization plan is not supported by stakeholders or KT evidence.**	**Utilization plan based on current KT research OR consult'n process**	**Utilization plan based on current KT research AND consult'n process**	

Based on personal/professional knowledge and experience, I would say that this problem is:

___ Not at all important ___ Of minimal importance ___ Somewhat important ___ Very important

Based on personal/professional knowledge and experience, I would say that this proposal is:

___ Poor ___ Fair ___ Good ___ Excellent

Score Sheet

Pre-screening: If the answer is 'No' to any pre-screening criteria, do not continue the review process.

Review criteria:

Criteria	Sum of assigned scores (A)	Total possible score (B)
1. Health burden		7 – [Number of Not Applicable] x 3 =
2. Health gain		8 – [Number of Not Applicable] x 3 =
3. Accessibility		3 – [Number of Not Applicable] x 3 =
4. Appropriateness		7 – [Number of Not Applicable] x 3 =
5. Consultation		3 – [Number of Not Applicable] x 3 =
6. Innovation and partnerships		5 – [Number of Not Applicable] x 3 =
7. Evaluation		3 – [Number of Not Applicable] x 3 =
Total	Sum (A) =	Sum (B) =

Total score (sum A/sum B) x 100 =

APPENDIX E

WRHA Priority Setting Criteria Reviewer's Guide

Table of Contents

WHAT IS EVIDENCE IN HEALTH CARE?

Introduction

The WRHA's draft priority setting criteria were developed by the Resource Allocation Committee to provide a framework to guide decisions related to setting priorities for health care planning in the region. The criteria were developed based on prior consultations with the WRHA Community Health Advisory Councils (CHACs) and other work done in Canada related to priority setting. The criteria are divided into *pre-screening criteria,* which consider the alignment of the proposal with WRHA and provincial goals and strategic directions and *review criteria,* used to rank submissions and determine priorities. These criteria form the base of the User's Guide, the Reviewer's Template and the Reviewer's Guide

To support staff in developing submissions to the health planning process, a Priority Setting Criteria User's Guide and an Online Toolkit (**http://home.wrha.mb.ca/research/hpt/index.php)** have been developed to guide participants through the process and help them to find appropriate evidence.

This reviewer's guide has been developed as a supplement to the Reviewer's Template (Appendix A). This guide is based on the Reviewer's Template, and is intended to guide assessment of the strength of the evidence incorporated into each submission. The guide also provides a framework for scoring submissions: these scores enable ranking of submissions. The Reviewer's Guide also:

- Provides an overview of appropriate sources of evidence
- Provides further description of each criterion
- Provides further information on the sub-categories and scoring criteria
- Includes a glossary of relevant terms

This is a draft document only. Your suggestions and comments will help make this a more useful document. Please send any comments on this draft to researchandevaluation@wrha.mb.ca.

To access the 'Health Planner's Toolkit', visit http://home.wrha.mb.ca/research/hpt/index.php

An effective and ethical priority setting process should be informed by evidence. It should reflect the ethical principles of equity, transparency, accountability and reasonableness.

What is evidence?

Evidence is information that comes closest to the facts of a matter. Findings of high quality, methodologically appropriate research are the strongest and most accurate evidence. However, because research is often incomplete and sometimes contradictory or unavailable, other sources of evidence are often necessary supplements to research (Adapted from CHSRF).

Not all information is quality evidence:

Both the quality of the evidence and its applicability to a specific situation must be considered. Three important questions to use in this process are:

4. Is it relevant to the purpose?
5. Is it credible or trustworthy?
6. Is it sufficient to draw conclusions or to act on?

Evidence-informed approaches recognize that, in addition to research findings, there are other legitimate factors affecting decisions making – these include values, resource availability, political judgment, and professional judgment. Other legitimate and useful sources of evidence may be client/family experience, results of community consultations and locally produced evidence such as that resulting from program evaluation and quality improvement activities. The challenge for decision-makers is to:

- Ensure that more weight is given to sources of evidence that reflect research rigour,
- Minimize the influence of factors such as habit, individual preference, lobbying)
- Make use and weighing of all sources of evidence transparent.

Good evidence includes more than numerical data or quantitative research. If only quantitative research is used to make decisions, this eliminates many other appropriate sources of data (such as good qualitative research or patient experiences), and places decision-making about currently under-resourced areas at a disadvantage. Appendix B outlines good sources of evidence and their potential for health planning. Poorer sources of evidence should be avoided.

Is evidence-based planning really possible?

The concept of "evidence-based" comes from clinical medicine and implies that the best answer lies in research findings. There are a number of concerns that this is not an appropriate approach for planning and decision making with the result that an *evidence-informed* approach has been proposed as an alternative. **An *evidence-informed* approach recognizes that:**

- Research may be lacking for the questions facing decision-makers,
- Research findings may not be available in a timely way,
- There is often a need for locally relevant information, and the results from health services research may not always be applicable in other settings,
- Other forms of evidence must also be considered.

Some General Guidelines

a. While many sources of evidence are appropriate in planning, scientific evidence should remain central.
b. The *strongest* source of research evidence is a systematic review or meta-analysis; where available these should be given additional weight.
c. Additional examples of good sources of evidence are found in Appendix B
d. For truly innovative initiatives, there may not be *research* available to support review criteria such as Health Gain or Appropriateness. However, there should be context specific evidence (such as evaluation, consultations, quality initiatives) and/or theoretical evidence available. Consider these forms of evidence when scoring innovations.

Scoring Guidelines

1. If you check off not applicable for a sub-category, this sub-category is not included in the calculation of the overall score. In other words, submissions will not be penalized if certain sub-categories do not apply to them.
2. The score assigned to each of the 7 review criteria will be the average score of all applicable sub-categories for that criterion.
3. To determine the average score for a review criterion:
    a. First sum the scores that you have assigned to each applicable sub-category. In the example below, the sum equals 2 + 1 + 2 + 3 = 8. Enter this score into the appropriate box in column A on the last page of the Reviewer's Template (Score Sheet).
    b. Next, determine the total possible score:
        i. Subtract the number of items you scored as Not Applicable from the total number of items in that review criterion. In the example below, items scored as Not Applicable = 1, Total Number of Items = 5. So 5 – 1 = 4.
        ii. Multiply this number by 3. In the example below, 4 x 3 = 12. Enter this number is appropriate box in column B on the last page of the Reviewer's Template (Score Sheet).
4. To calculate the total score for a submission:
    a. Sum column A on the Score Sheet.
    b. Sum column B on the Score Sheet.
    c. The total score = (Sum of column A/sum of column B) x 100

Example:

6. Innovation and partnerships	0	1	2	3	N/A
a. The proposed initiative is an innovation, or takes a new approach.	No	Minimal innovation.	Close to the status quo	Cutting edge.	■
b. The evidence/theory to support the innovation is strong.	Anecdotal/ No evidence	Weak evidence	Some theoretical basis OR good context specific or research evidence	Strong theoretical foundation and /OR strong context specific AND research evidence	
c. The initiative contributes to health system improvement and system redesign.	Anecdotal/ No evidence	Weak evidence	Is aligned with regional improvement or redesign strategies OR reports evidence in the literature related to health system improvement and redesign.	Strong context specific and research evidence	
d. The proposed initiative cuts across several program areas and sites.	No, only 1 program/ sites.	More than one site OR more than one program	More than one program AND more than one site	Several (multiple) partnership within and outside health care system.	■
e. Proposed partnerships will contribute to system integration and improve patient care.	Anecdotal/ No evidence	Weak evidence	Good context specific or research evidence	Strong context specific and research evidence	

Pre-screening criteria
(Do not consider for 2008 process)

Pre-screening is the first step in the review of submissions. All submissions must meet the first 3 pre-screening criteria, and the 4th if it is applicable, in order to move on to the second stage of the process. Check Yes or No for each of the first 3 criteria. If there is no applicable concept paper or directional document, check off not applicable.

4. Consistent with WRHA mission, vision, values and strategic direction.

To view:	Please see:
WRHA mission, vision and values	http://www.wrha.mb.ca/about/mission.php
WRHA strategic direction	http://www.wrha.mb.ca/about/plan.php

5. Consistent with organizational priorities.

WRHA Organizational Priorities are:

- Access
- Aboriginal Health
- Patient Safety
- Workforce Safety and Wellness

6. **Consistent with provincial goals and strategies.**

Provincial goals:

5. Optimize the health status of all Manitobans.
6. Improve quality, accessibility and accountability of the health system.
7. Achieve a sustainable health system.

Provincial strategies:

6. Advance healthy living and public health, through strategic partnerships and re-alignment of resources.
7. Through partnerships, reduce health disparities for at risk populations defined by socioeconomics, ethnicity, geography and gender.
8. Lead innovation and system change through strategic partnerships.
9. Improve access and sustainability in health care delivery through strategic investment in resources.
10. Build an integrated primary care system.

7. Consistent with approved WRHA concept papers and directional documents (if applicable).

To view:	Please see: Web address or Appendix.
WRHA concept papers and directional documents	http://home.wrha.mb.ca/research/reports.php

Review criteria

4. Health Burden – The importance of the problem

Overview:
A submission should clearly state the problem it is meant to address. Health burden describes the impact that an illness or health condition has on individuals and the community. This category is also used to capture the importance of the problem to health system functioning.

For clinical initiatives, indicators such as incidence, prevalence, life expectancy and quality of life may capture health burden. Non-clinical initiatives will need to determine the best way to describe and provide evidence to support the problem they are addressing.

Tips:
i. Determine whether the problem the submission addresses is clearly stated.
ii. Sub-category d is designed to capture emerging or growing problems.
iii. For sub-category f, add and score any other factors that the proposal describes that are not captured by sub-categories b – f. You may add more than one.

Scoring:
i. For sub-categories b – f:
   1. **Anecdotal/No evidence** should be selected if the proposal provides no evidence, no source for the evidence, or anecdotal evidence where there is a reasonable expectation that good evidence would be available.
   2. **Weak evidence of impact** should be selected if the evidence presented is weak, or the evidence shows that the problem has a weak impact in this area.
   3. **Good context specific OR research evidence** should be selected if either good context specific OR research evidence is presented that shows that the problem has a significant impact in this area.
   4. **Strong context specific AND research evidence** should be selected if both strong context specific and research evidence is presented that show that the problem has a significant impact in this area.

ii. For more information about what constitutes strong and weak sources of evidence, please consult Potential Evidence Sources (Appendix A).

5. Health Gain – Proposed response to the problem

Overview:
Health gain can be thought of as the inverse of health burden. The submission should present evidence to show how the proposed initiative will impact the health of individuals and the community (clinical) or the organization and/or community (non-clinical), and why the intervention they have chosen is the preferred option.

Tips:

i. Determine whether the proposed initiative is clearly described. This should include a clear description of key activities and services to be provided.
ii. All proposals should describe alternatives considered. There should be evidence of an objective review of the literature including strengths and limitations of each alternative.
iii. Evidence presented for sub-categories d - f may include the number of people who are expected to benefit from the initiative, and what the evidence suggests the expected benefits will be.
iv. To determine a score for sub-category g, consider the evidence presented related to alternative solutions (sub-category c) and the expected impact of the initiative (sub-category d, e and f), emphasizing **context specific evidence**.

Scoring:
i. For sub-categories d through f:
   - 0 **Anecdotal/No evidence** should be selected if the proposal provides no evidence, no source for the evidence, or anecdotal evidence where there is a reasonable expectation that good evidence would be available.
   - 1 **Weak evidence** should be selected if the evidence presented is weak, or the evidence shows that the initiative will have a limited positive impact in this area.
   - 2 **Good context specific OR research evidence** should be selected if good context specific OR research evidence is presented that shows that the initiative will have a positive impact in this area.
   - 3 **Strong context specific AND research evidence** should be selected if both strong context specific and research evidence is presented that show that the initiative will have a positive impact in this area.

6. Accessibility

Overview:
Access is one of the WRHAs organizational priorities, and ensuring equitable access is an important criterion for all health initiatives. Access can be defined as the "provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health" (Health Canada, 2001). Barriers to access include both those that prevent participation in preventive, health promotion and assessment services and those that limit needed treatments. Wait times are but one component of access. Initiatives will be reviewed with a view to their impact on various population groups. Special consideration should be given to issues of access for groups facing health disparities.

Tips:

i. Barriers to access may be financial, geographic, linguistic, or cultural, and may affect initial access, quality of care, or health outcomes.

ii. Health disparities may be based on geography or population group (ethnicity/race, language proficiency, socioeconomic status, gender, sexual orientation, physical, psychological or cognitive disability).

iii. For sub-category c:
   - 0 **S**hould be selected if the proposal provides **no clear inclusion/ exclusion criteria** or if the criteria would **limit access,** especially for groups/individuals most in need.
   - 1 Should be selected if the inclusion/exclusion criteria do not completely reflect the best evidence available related to providing access for the groups most in need.
   - 2 Should be selected if the inclusion/exclusion criteria **promote access**, especially for groups/individuals most in need.
   - 3 Should be selected if the inclusion/exclusion criteria promote access, especially for groups/individuals most in need, and include a **monitoring strategy** to ensure that the inclusion/exclusion criteria are in fact appropriate on an ongoing basis.

Scoring:

iv. For sub-categories a and c:
   - 0 **Anecdotal/No evidence** should be selected if the proposal provides no evidence, no source for evidence, or anecdotal evidence where there is a reasonable expectation that good evidence would be available.
   - 1 **Weak evidence** should be selected if the evidence presented is weak, or the evidence shows that the initiative will have a weak impact on access or reducing health disparities.
   - 2 **Good context specific OR research evidence** should be selected if good context specific OR research evidence is presented that shows that the initiative will have a positive impact on access or reducing health disparities.
   - 3 **Strong context specific AND research evidence** should be selected if both strong context specific and research evidence is presented that show that the initiative will have a positive impact on access or reducing health disparities.

4. Appropriateness

Overview:
Appropriateness means the provision of the right kind of care, at the right time, in the right setting, for the right reasons. Effectiveness, efficiency and alignment with best practice guidelines (if available) should be considered. Consideration should be given to moving interventions as far upstream as possible; in other words, focusing on prevention and promotion where appropriate. Providing appropriate services may require finding a balance between the efficiency of the health care system and the needs of individual patients.

Tips:
i. For sub-category e, setting includes location, and other aspects of the physical and social environment.
ii. For sub-category f, time does not refer to time of day, but to the appropriate time in the progression of the disease, life span, etc.
iii. When scoring Appropriateness sub-categories, consider how the initiative balances health system improvement and redesign (including fiscal responsibility and safety of care providers) with the needs of individual patients (convenience of care, patient preference).

Scoring:
iv. To score sub-category a, consider whether:
- The initiative has an appropriate promotion and prevention *component*
- A health promotion or prevention approach would be more appropriate than what the initiative is describing

v. For sub-categories b and c (there may be no evidence available for innovations):
0 **Anecdotal/No evidence** should be selected if the proposal provides no evidence, no source for evidence, or anecdotal evidence where there is a reasonable expectation that good evidence would be available.
1 **Weak evidence** should be selected if the evidence presented is weak, or the evidence shows that the initiative will be minimally efficient or effective.
2 **Good context specific OR research evidence** should be selected if good context specific OR research evidence is presented that shows that the initiative will be moderately efficient or effective.
3 **Strong context specific AND research evidence** should be selected if both strong context specific and research evidence is presented that show that the initiative will be highly efficient or effective.

8. Consultation process

Overview:
In this context, consultation refers to providing opportunities for stakeholders (e.g. staff, patients/clients/consumers, caregivers and community members as appropriate) to have meaningful input into the development, or redesign, of a program or service. There is a growing body of evidence that suggests that collaboration throughout the planning process results in a stronger initiative.

Tips:

i. Who is appropriate to include in consultation activities will vary depending on the initiative.
ii. Consider whether all affected stakeholders have been consulted and to what extent their perspectives have been incorporated into the development and planning of the submission.
iii. Consider whether stakeholder participation has been built into the implementation of the initiative.

6. Innovation and partnership development

Overview:
Innovation is about doing things in new and different ways. A submission may be innovative or new to the WRHA, or may be proposing a new way of doing something that has never been tried anywhere. This category does not simply refer to technical innovations, but to new approaches to old problems (for example, initiatives that move intervention as far upstream as possible).

The most effective initiatives are those that are the result of genuine partnership between all relevant stakeholders. Partnerships can also contribute to better system integration and therefore improved patient care. They may be formed within the region (e.g. between programs) or with external agencies and organizations. Greater weight should be given to those initiatives that cut across a number of programs or that address more than one health risk or issue.

Tips:
i. To obtain a high score, an innovation should not only be new, it should be well thought out.
ii. While there may not evaluation research supporting the value of the innovation, program theory (the rationale for the different components of the initiative and how they are anticipated to affect desired outcomes) should be clear. These different aspects of program theory often do have an evidence base, even if they are combined in innovative ways for a particular submission.

Scoring:

i. To score sub-category e,
- **0** **Anecdotal/No evidence** should be selected if the proposal provides no evidence, no source for evidence, or anecdotal evidence where there is a reasonable expectation that good evidence would be available.
- **1** **Weak evidence** should be selected if the evidence presented is weak, or if the evidence suggests that the partnerships developed will contribute minimally to system integration and improved patient care.
- **2** **Good context specific OR research evidence** should be selected if good context specific OR research evidence is presented that shows that the partnerships developed will contribute to system integration and improved patient care.
- **3** **Strong context specific AND research evidence** should be selected if both strong context specific and research evidence is presented that show that the partnerships developed will contribute to system integration and improved patient care.

8. Evaluation

Overview:
There is increasing recognition of the importance of evaluation within the health system, as well-designed evaluation combines research rigour with decision-maker needs for timely, relevant, and context sensitive information.

Evaluation can be defined as "the systemic collection of information about the activities, characteristics and outcomes of programs to make judgments about the program, to improve effectiveness, and/or inform decisions about future programming" (Patton, 1997).

Performance measurement involves the tracking and monitoring of program outcomes using valid indicators or performance measures (Blalock, 1999). If collected reliably, performance measures can be an important source of data for answering some types of evaluation questions. However, evaluation is broader than performance measurement, and is able to address complex questions facing the healthcare system, contributing insights to such questions as "why are we seeing these results?" and "how best can we address this issue?"

Tips:

i. Consider whether the evaluation plan is complete.
ii. Is the evaluation plan realistic (e.g. Are timelines for outcomes realistic)?
iii. Does the plan include an implementation evaluation?
iv. For sub-category c, consider both a) how the evaluation plan was developed (was it in collaboration with stakeholders and users?); and b) whether it is based on current evidence from the knowledge translation literature (e.g. inclusion of facilitators to evaluation utilization, such as collaboration, and leadership commitment).

Appendix A – Priority Setting Criteria Reviewer's Template

Priority Setting Criteria Reviewer's Template

Pre-screening criteria:	Yes	No	N/A
1. Consistent with WRHA mission, vision, values and strategic direction			
2. Addresses one or more organizational priorities			
3. Consistent with provincial goals and addresses one or more provincial strategies			
4. Consistent with any relevant approved WRHA concept papers and directional documents			

1. Health Burden – What is the problem that this submission addresses, and why is it important?	0	1	2	3	N/A
h. The problem that this submission addresses is clearly stated.	Not stated	Stated but unclear	Somewhat clear	Very clearly stated	
i. There is evidence that the problem is important because of its impact on quality of life.	Anecdotal/ No evidence	Weak evidence of impact on QOL	Good context specific OR research evidence	Strong context specific and research evidence	
j. There is evidence that the problem is important because of the number of people impacted.	Anecdotal/ No evidence	Weak evidence of importance related to #s affected	Good context specific OR research evidence	Strong context specific AND research evidence	
k. There is evidence that the problem is important because the number of people impacted is increasing.	Anecdotal/ No evidence	Weak evidence of importance related to #s affected	Good context specific OR research evidence	Strong context specific AND research evidence	
l. There is evidence that the problem is important because of its impact on mortality rates.	Anecdotal/ No evidence	Weak evidence of impact on mortality rates	Good context specific OR research evidence	Strong context specific AND research evidence	
m. There is evidence that the problem is important because of other factors (please describe).	Anecdotal/ No evidence	Weak evidence of importance	Good context specific OR research evidence of importance	Strong context specific and research evidence	
n. Overall, this problem poses a significant health burden.	No health burden	Minimal health burden	Moderate health burden	Significant and increasing health burden	

2. Health Gain – Is this the best way, in this context, to address the issue	**0**	**1**	**2**	**3**	**N/A**
i. **The proposed initiative is clearly described.**	Not described	**Described but unclear**	**Somewhat clear**	**Very clear**	
j. Short and long terms objectives are clearly described.	**No short-term or long-term objectives.**	**Short and long-term objectives unclear.**	**Clear short and/or long-term objectives.**	**Clear short and long-term objectives.**	
k. Alternative solutions are described.	**No**	**One other alternative is described.**	**Two or more alternatives described, with some evidence of strengths and limitations.**	**Strong evidence of objective review of the literature.**	
l. There is evidence that the initiative will positively impact the health of individuals.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
m. There is evidence that the initiative will positively impact the health of the community.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
n. There is evidence that the initiative will positively impact the organization (WRHA).	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
o. There is evidence that the proposed initiative is the best solution to the problem in this context.	**Anecdotal/ No evidence**	**Weak evidence**	**Good evidence**	**Strong evidence**	
p. Overall, this solution will reduce health burden and have a positive impact on individuals/ community/ organization.	**No impact.**	**Minimal impact.**	**Moderate impact.**	**Significant**	

3. Accessibility	**0**	**1**	**2**	**3**	**N/A**
d. **There is evidence that the proposed initiative will have a positive impact on addressing known barriers to access.**	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
e. There is evidence that the initiative will have a positive impact on reducing health disparities, or provide enhanced access to vulnerable communities.	**Anecdotal/ No evidence**	**Weak evidence**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
f. The inclusion and exclusion criteria are appropriate.	**No clear criteria/ Limits access**	**Criteria do not reflect best evidence of need/ priority**	**Criteria will promote access to groups most in need**	**Criteria will promote access to groups most in need and includes a strategy to monitor appropriate-ness of criteria.**	

4. Appropriateness	0	1	2	3	N/A
h. **The initiative has an appropriate emphasis on health promotion and prevention.**	**No**	**Prevention and promotion could be strengthened**	**Prevention or promotion could be strengthened**	**Prevention and promotion appropriate**	
i. There is evidence that the proposed initiative is the most efficient alternative.	**Anecdotal/ No evidence**	**Weak evidence that it is the most effective**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
j. There is evidence that the proposed initiative is the most effective alternative.	**Anecdotal/ No evidence**	**Weak evidence that it is the most effective**	**Good context specific or research evidence**	**Strong context specific and research evidence**	
k. The proposed initiative is supported by "best practice" guidelines.	**Contradicts guidelines**	**Does not meet best practice guidelines**	**Generally meets best practice guidelines**	**Meets and/or exceeds best practice guidelines**	
l. The initiative provides service in the most appropriate setting for users and providers.	**Evidence suggests location is not the best**	**Weak evidence, Anecdotal/ No evidence**	**Some evidence**	**Strong evidence**	
m. The initiative provides service at the most appropriate time.	**Evidence suggests time is not the best**	**Weak evidence, Anecdotal/ No evidence**	**Some evidence**	**Strong evidence**	
n. Overall, this initiative is the most appropriate solution in this context.	**Definitely not the most appropriate**	**Somewhat appropriate**	**Mostly appropriate**	**Definitely the most appropriate**	

5. Consultation	0	1	2	3	N/A
d. There is evidence of appropriate consultation with affected staff and related programs.	**No consult'n**	**Limited consult'n but not all stakeholders included**	**Consult'n representative of all staff, staff perspective/ concerns partially addressed**	**Consult'n representative of all staff, staff perspective/ concerns fully addressed**	
e. There is evidence of appropriate consultation with patients/clients/residents/ families.	**No consult'n**	**Limited consult'n - not representative of all stakeholders**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns partially addressed**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns fully addressed**	
f. There is evidence of appropriate consultation with community.	**No consult'n**	**Limited consult'n - not representative of all stakeholders**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns partially addressed**	**Consult'n representative of all stakeholders - stakeholders perspective/ concerns fully addressed**	

6. Innovation and partnerships	0	1	2	3	N/A
b. The proposed initiative is an innovation, or takes a new approach.	No	Minimal innovation.	New to the WRHA	Cutting edge.	
f. The evidence/theory to support the innovation is strong.	Anecdotal/ No evidence	Weak evidence	Some theoretical basis OR good context specific or research evidence	Strong theoretical foundation and /OR strong context specific AND research evidence	
g. The initiative contributes to health system improvement and system redesign.	Anecdotal/ No evidence	Weak evidence	Is aligned with regional improvement/redesign strategies OR reflects evidence in the literature related to health system improvement and redesign.	Strong context specific and research evidence	
h. The proposed initiative cuts across several program areas and sites.	No, only 1 program/ site.	More than one site OR more than one program	More than one program AND more than one site	Several genuine partnerships within and without heath care system.	
i. Proposed partnerships will contribute to system integration and improve patient care.	Anecdotal/ No evidence	Weak evidence	Good context specific or research evidence	Strong context specific and research evidence	

7. Evaluation	0	1	2	3	N/A
b. Evaluation results or quality improvement initiatives support the development of this initiative.	No			Yes	
d. There is a plan to objectively evaluate the initiative.	No plan.	Weak evaluation plan	Strong plan, no funding	Strong plan and evaluation included in budget.	
e. The proposal outlines how evaluation results will be utilized.	No utilization plan	Utilization plan is not supported by stakeholders or KT evidence.	Utilization plan based on current KT research OR consult'n process	Utilization plan based on current KT research AND consult'n process	

Based on personal/professional knowledge and experience, I would say that this problem is:
___ Not at all important ___ Of minimal importance ___ Somewhat important ___ Very important

Based on personal/professional knowledge and experience, I would say that this proposal is:
___ Poor ___ Fair ___ Good ___ Excellent

Score Sheet

Pre-screening: If the answer is 'No' to any pre-screening criteria, do not continue the review process.

Review criteria:

Criteria	Sum of assigned scores (A)	Total possible score (B)
8. Health burden		7 – [Number of Not Applicable] x 3 =
9. Health gain		8 – [Number of Not Applicable] x 3 =
10. Accessibility		3 – [Number of Not Applicable] x 3 =
11. Appropriateness		7 – [Number of Not Applicable] x 3 =
12. Consultation		3 – [Number of Not Applicable] x 3 =
13. Innovation and partnerships		5 – [Number of Not Applicable] x 3 =
14. Evaluation		3 – [Number of Not Applicable] x 3 =
Total	Sum (A) =	Sum (B) =

Total score (sum A/sum B) x 100 = ☐

Appendix B - Potential evidence sources

GOOD SOURCES OF EVIDENCE	**CONTRIBUTION**	*WHERE TO START*
Systematic reviews, meta-analyses	Summarizes, according to strict, objective criteria results from all applicable studies	Request a literature search of reviews and meta-analyses from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
Results of expert consensus forums	Provides "cutting edge" thinking in situations where systematic research not available	Request a literature search of grey literature from the Health Sciences Libraries: http://www.umanitoba.ca/libraries/health/
Relevant MCHP reports	May provide other program relevant indicators; often provincial comparison available	MCHP website. Most reports available on line at: http://umanitoba.ca/medicine/units/mchp/
Well designed Program Evaluations	Combine research rigour with need for timely, context sensitive evidence	Contact specific programs, request consult from R & E regarding evaluation quality.
Well designed evaluations from other jurisdictions	Such findings from the grey literature often precede formal research activities	Direct contact with other RHAs. Request consult from Research and Evaluation Unit re: evaluation quality. Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
Synthesis of WRHA evaluation findings	Identifies themes emerging across region, not limited to one program	Contact R & E for information as to whether similar themes have emerged in other areas.
Concept papers, literature reviews commissioned by WRHA	Interprets current research for specific context, combines with critical review of research, other evidence	Check Insite for posted reports (Research and Evaluation pages), contact R and E to see if any related activities are underway. http://home.wrha.mb.ca/research/reports.php
Internal systematic literature review with contextual analysis	If done well, can integrate current research, other context-sensitive evidence	Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php Research and Evaluation Unit can provide guidance with literature review and can conduct review upon request from Senior Management.
WRHA Community Health Assessment	Region-wide analysis of provincially approved indicators; inter-RHA comparison	Available on WRHA website (Intra/Internet). This site also links to related reports, and will soon provide community area profiles. http://www.wrha.mb.ca/research/cha/index.php
Well designed community needs assessments	Can identify trends and issues not captured in information systems	Specific program area, CADs.
Results of quality improvement, activities	If well designed, can provide useful information on what works, doesn't work similar to	Consult specific program areas.

	program evaluation	
Performance measurement indicators	If valid, robust, non-gameable indicators, can provide comparison over time, provincial comparison	Can consult with R & E re: appropriate interpretation, use of indicators.
POOR SOURCES OF EVIDENCE	*RISKS*	*CONSIDER INSTEAD*
1 or 2 selected articles	"Decision-based evidence-making" – cherry picking of articles that are supportive of chosen initiative rather than a systematic review. May lack contextual evidence.	With assistance of Health Sciences Libraries search for meta-analyses or systematic review: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php If this is not available, consider undertaking a context-sensitive review under guidance of Research and Evaluation Unit.
Quick internet search	Hugely variable quality – may include "sponsored" research, lobby groups, etc.	Request a literature search the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
1 or 2 experts' opinion	Does not bring advantages of consensus forum described above; experts chosen may not be representative	Consensus conference findings. Request a literature search of grey literature from the Health Sciences Libraries: https://www.umanitoba.ca/libraries/units/health/secure//literatureresearch.ssl.php
1 or 2 case examples	Case examples may not be representative or frequent.	Systematic review of cases, client experiences
Poorly designed, "internal" program evaluations from within or outside the organization	May lack scientific rigour; may lack credibility (conflict of interest).	Have any evaluations reviewed by R & E
Media summaries	May not accurately represent research findings.	Systematic reviews; at minimum review original article

Glossary

Access: "The provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health" (Health Canada, 2001).

Appropriateness: The provision of the right kind of care, at the right time, in the right setting, for the right reasons.

Best practice guidelines: Agreed upon procedures that are believed to result in the most efficient and effective provision of a service (CAOT, 2005).

Consultation: Providing opportunities for stakeholders (eg. staff, patients/clients/ consumers, caregivers and community members) to have meaningful input into the development, or redesign, of a program or service.

Effectiveness: "The extent to which a specific intervention, procedure, regimen, or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population" (Last, 1995, p. 52).

Efficacy: "The extent to which a specific intervention, procedure, regimen, or service produces a beneficial result under ideal conditions. Ideally, the determination of efficacy is based on the results of a randomized controlled trial" (Last, 1995, p. 52).

Efficiency: "The effects or end results achieved in relation to the effort expended in terms of money, resources, and time. The extent to which the resources used to provide a specific intervention, procedure, regimen, or service of known efficacy and effectiveness are minimized" (Last, 1995, p. 52).

Evaluation: "The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming" (Patton, 1997, p. 23).

Health burden: Impact of illness or condition on individuals and the community.

Health gain: The impact of an intervention on the health of individuals and/or the community.

Health disparity: A "difference in health status between a defined portion of the population and the majority. Disparities can exist because of socioeconomic status, age, geographic area, gender, race or ethnicity, language, customs and other cultural factors, disability or special health needs" (Minnesota Department of Health).

Health Promotion: "The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their

everyday lives, rather than focusing on people at risk for specific diseases , and is directed toward action on the determinants or causes of health" (WHO, 1986).

Incidence – The number of new cases of a condition in a given population in a given period of time (Last, 1995).

> Eg. In 2006, the incidence of HIV in Canada was 2557. In other words there were 2557 new HIV cases reported in Canada that year.

Innovation: Innovation is about doing things in new and different ways.

Life expectancy – The average number of years a person of a given age is expected to live, if mortality rates remain unchanged (Last, 1995).

> Eg. A baby born in 2005 is expected to have a life expectancy of 80.4 years.
> Eg. In 1992, the life expectancy of a child born with cystic fibrosis was 32.9 years.

Partnership: A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal (American Heritage Dictionary).

Performance Measurement: The use of data to determine if a program is meeting its goals and objectives.

Prevalence – The number of people in a given population that have a specific illness or health condition at a point in time (Last, 1995).

> Eg. On Dec. 31, 2006, the prevalence of breast cancer in Winnipeg was 4437. In other words there were 4437 people with breast cancer in Winnipeg at this time.

Prevention

> **Primary Prevention:** "The protection of health by personal and communitywide effects" (Last, 1995, p. 130). For example, immunizing children.
>
> **Secondary Prevention:** "Measures available to individuals and populations for the early detection and prompt and effective intervention to correct departures from good health" (Last, 1995, p. 130).
>
> **Tertiary Prevention:** "Measures available to reduce or eliminate long term impairments and disabilities, minimize suffering caused by existing departures from good health, and to promote the patient's adjustment to irremediable conditions" (Last, 1995, p. 130).

Quality of Life – A person's "emotional, social and physical wellbeing, and their ability to function in the ordinary tasks of living" (Hayword Medical Communication).

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APPENDIX F. Questions to guide New Initiatives discussion

We would now like to move into reviewing each initiative. Because of time constraints we have less than 10 minutes per initiative so we have tried to be creative to allow as much time for you to learn from each other and discuss the initiatives, while making sure that we have time to consider all of the initiatives. To this end, the discussion will be very focused on 4 questions. We will do a go around for each question, allowing everyone to answer. There will be time for discussion after everyone has answered all 4 questions. The questions are:

- What is your total score?
- What, from your perspective are the strengths and weaknesses of this proposal? Please summarize in 30 seconds or less
- How important do you rate this problem?
- How confident are you that this is the best solution to the problem?

During this focused discussion, we encourage you to change your scores as we go along (using the red pens provided), to reflect any change that the discussion has made in your ratings. For each initiative, the average of the 4 individual scores will go forward to the executive team.

After all 4 questions are answered, discussion will focus on any strong points of disagreement that group members would like to discuss.

Just a few additional points:

- During the pilot we noticed that the rating of N/A was an issue that could consume a lot of time during discussion. For this reason, although its ok if you scored things N/A, we would like to ask you to not discuss N/A's today
-

We will start with [first initiative].

- What is your total score?
- What, from your perspective are the strengths and weaknesses of this proposal? Please summarize in 30 seconds or less
- How important do you rate this problem?
- How confident are you that this is the best solution to the problem?

After this discussion, ask "Are there any strong points of disagreement that you would like to discuss further?"

- If yes, say, we have about x minutes for discussion, and I will have to cut off the discussion at this point even if it is not complete
- If no, move on to the next submission

Concluding remarks

I'd like to take the last 5 minutes for a quick debrief. Overall, how did you find today's process?

APPENDIX G. On-line survey

New Initiatives Survey

Consent

* 1. INTRODUCTION

You are being invited to take part in a survey that is a research activity of the From Evidence to Action research project. The WRHA component of this research has been exploring strategies to increase use of evidence in health planning, and to develop priority setting processes that reflect appropriate use of evidence.

An invitation to participate in the survey is being sent to all WRHA staff who were involved in preparing a New Initiative submission this September, as well as members of the New Initiatives Review Committee. It is up to you to decide whether or not to take part. Before you decide, you need to understand the purpose of the survey.

PURPOSE OF THE SURVEY

The purpose of this survey is to assess the appropriateness and effectiveness of a) the new process developed for prioritizing New Initiatives and b) the tools developed to support the use of evidence in health planning and priority setting. Tools developed include:

The WRHA Draft Priority Setting Criteria
The Health Planner's Online Toolkit
The Health Planner's User's Guide
The Reviewer's Template
The Reviewer's Guide

The results of the survey will help in continued improvement of priority-setting activities related to health planning within the WRHA.

DESCRIPTION OF SURVEY PROCEDURES

This is a web-based survey. If you agree to participate, the number of questions that you answer is entirely up to you. Your participation is voluntary. You may refuse to answer any of the questions and are free to stop the survey at any point.

LENGTH OF SURVEY

The survey will take approximately 10 minutes to complete.

POSSIBLE BENEFITS, RISKS AND DISCOMFORTS

There are no foreseeable risks, discomforts or inconveniences for the participants in this survey. While there may not be direct benefits to you associated with completing

this survey, the results are anticipated to inform future New Initiatives and regional health planning processes.

CONFIDENTIALITY

Your privacy and confidentiality will be maintained throughout and upon completion of this study. Your name, age, sex, or other personal identifiers will not be collected as part of this survey. The investigators have no way of tracking the identity of the individuals who have responded to the survey.

The information gathered in the survey will only be used by the investigators for the purposes of research. All data is collected anonymously by www.surveymonkey.com. All data collected will be kept in password protected computer files. Data will be presented in a summarized way and identifiable results will not be presented.

QUESTIONS

If you have further questions about taking part in this survey, you may contact Ashley Struthers (Project Coordinator) at astruthers@wrha.mb.ca

CONSENT

By checking “I agree” in this section of the survey, you are giving your consent to be surveyed. It indicates that you understand the information that has been presented about the survey.

I have read and understood the above information, and I agree to participate. I understand that my participation is voluntary and that I can stop participation at any time without having to give a reason.

- ◯ I agree
- ◯ I do not agree

General information

New Initiatives Survey

2. I am a (check more than one if applicable):

- [ ] Senior manager
- [ ] Program director/Community Area Director
- [ ] Medical director
- [ ] Admin director/Finance
- [ ] New Initiatives Review Committee member
- [ ] Other

3. Did you participate (eg. by submitting a proposal, attending the New Initiatives planning day, reviewing submissions) in the New Initiatives process LAST YEAR (2007)?

- ◯ Yes
- ◯ No

Previous experience with New Initiatives

4. What were the strengths and limitations of LAST YEAR'S New Initiatives process (2007)?

5. Based on your experiences LAST YEAR, what formal/informal criteria were used to evaluate proposals and make decisions?

6. Thinking about LAST YEAR'S New Initiatives process (2007), how much do you agree or disagree with the following statements?

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The process last year was fair.	◯	◯	◯	◯	◯	◯
I felt confidence in the process last year.	◯	◯	◯	◯	◯	◯
Last year, the process was based on the strength of the evidence provided in the submission.	◯	◯	◯	◯	◯	◯
I clearly understood the process used to make decisions last year.	◯	◯	◯	◯	◯	◯

Comments:

New Initiatives Survey

Participation in this year's New Initiatives Process

7. Did you participate in THIS YEAR'S New Initiatives process by attending the Regional New Initiatives Planning Day and/or submitting or reviewing submissions?

- ◯ Yes
- ◯ No

This year's New Initiatives process

8. Did you attend the New Initiatives Regional Planning Day THIS YEAR (2008)?

- ◯ Yes, the whole day
- ◯ Yes, for part of the day
- ◯ No, I did not attend.

9. Thinking about THIS YEAR'S New Initiatives process (2008), how much do you agree or disagree with the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
I clearly understood the process used to make decisions this year.	◯	◯	◯	◯	◯	◯
I felt confidence in the process this year.	◯	◯	◯	◯	◯	◯
The process this year was fair.	◯	◯	◯	◯	◯	◯
This year, the process was based on the strength of the evidence provided in the submission.	◯	◯	◯	◯	◯	◯

Comments:

10. Overall, I would say that:

- ◯ THIS YEAR's New Initiatives process was better than last year's
- ◯ THIS YEAR's New Initiatives process was about the same as last year's
- ◯ LAST YEAR'S New Initiatives process was better than this year's
- ◯ I did not participate in LAST YEAR'S New Initiatives, so I cannot answer.

Familiarity with WRHA Draft Priority Setting Criteria

New Initiatives Survey

11. Are you familiar with the WRHA DRAFT PRIORITY SETTING CRITERIA? These criteria were developed by the Resource Allocation Committee to guide the decision-making process and included pre-screening and review criteria (Health burden, Health gain, Access, Appropriateness, Innovation and partnerships, Consultation and Evaluation).

- ◯ Yes
- ◯ No

The WRHA Draft Priority Setting Criteria

12. The WRHA DRAFT PRIORITY SETTING CRITERIA include four pre-screening criteria. In order to move on to the review stage of the process, it was intended that all submissions must meet the first 3 pre-screening criteria, and the 4th if it is applicable. The pre-screening criteria are:

1. Consistent with WRHA Mission, Vision, Values & Strategic Directions
2. Consistent with Organizational Priorities
3. Consistent with Provincial Goals and Strategies
4. Consistent with approved WRHA concept papers and directional documents (if applicable).

Overall, how much would you say that you agree or disagree with the following statement:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unsure
The pre-screening criteria as outlined above are an important first step in the review of New Initiative submissions.	◯	◯	◯	◯	◯	◯

Please explain your response and provide any suggestions or comments related to the pre-screening criteria.

New Initiatives Survey

13. Seven review criteria were developed to be used by reviewers to rank submissions and determine priorities. For each of the following review criteria, please select how much you agree or disagree that it is USEFUL AND APPROPRIATE to guide the review of submissions to the New Initiatives process:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unsure
Health Burden	◯	◯	◯	◯	◯	◯
Health Gain	◯	◯	◯	◯	◯	◯
Access	◯	◯	◯	◯	◯	◯
Appropriateness	◯	◯	◯	◯	◯	◯
Consultation process	◯	◯	◯	◯	◯	◯
Innovation and partnerships	◯	◯	◯	◯	◯	◯
Evaluation	◯	◯	◯	◯	◯	◯

Please provide any suggestions or comments related to the review criteria.

Did you prepare a submission?

14. Did you participate in developing a final submission to the New Initiatives process THIS YEAR?

◯ Yes

◯ No

Using the priority setting criteria in submissions

15. In the submission that you prepared, did you provide evidence in some or all of the categories outlined in the WRHA DRAFT PRIORITY SETTING CRITERIA (Health burden, Health gain, Access, Appropriateness, Innovation and partnerships, Consultation and Evaluation)?

◯ Yes, I addressed each of the criteria.

◯ Yes, but I did not address every criteria.

◯ No, I did not address any of the criteria.

Did not use criteria

New Initiatives Survey

16. Which of the following explain why you did not include evidence in some or all of the WRHA DRAFT PRIORITY SETTING CRITERIA categories in the preparation of your submission (please check all that apply)?

- [ ] I was not aware of the WRHA Priority Setting Criteria when I prepared my submission
- [ ] I did not have time
- [ ] The information about the priority setting criteria and associated resources came too late
- [ ] I wasn't sure how to find and/or use appropriate evidence
- [ ] Another staff person completed the New Initiatives template
- [ ] In previous years we were advised to keep the submissions short
- [ ] The criteria did not fit my proposal
- [ ] I needed more orientation to what was expected
- [ ] The Manitoba Health New Initiatives template is not consistent with the criteria
- [ ] I did not believe that including evidence would make any difference to the final result
- [ ] Other (please specify)

The Health Planners' Online Toolkit

The Health Planners Online Toolkit is intended to provide a single point of access to good sources of evidence to help support the development of New Initiative submissions, and other health planning activities. It is based on the WRHA Draft Priority Setting Criteria. The Toolkit is available online at http://home.wrha.mb.ca/research/hpt/index.php

17. Please select the answer that best reflects your experience with the HEALTH PLANNERS ONLINE TOOLKIT.

- ◯ I have never used the Health Planners Online Toolkit.
- ◯ I have used the Health Planners Online Toolkit to prepare a submission.
- ◯ I have used the Health Planners Online Toolkit for another purpose. Please describe below:

The Health Planners' Online Toolkit

New Initiatives Survey

18. Based on your experiences with the HEALTH PLANNERS ONLINE TOOLKIT, please answer the following questions.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Online Toolkit improved my understanding of what evidence is.	○	○	○	○	○
The Online Toolkit helped me to understand the Priority Setting criteria.	○	○	○	○	○
The Online Toolkit was easy to use.	○	○	○	○	○
The Online Toolkit helped me to find the evidence that I needed to prepare my submission.	○	○	○	○	○

19. What aspects of the format and content of the HEALTH PLANNERS ONLINE TOOLKIT did you find useful/not useful?

20. Please provide any suggestions for how the ONLINE TOOLKIT could be improved:

Online Toolkit

21. Which of the following explain why you did not use the ONLINE TOOLKIT in the preparation of your submission (please check all that apply)?

- ☐ I was not aware of the Online Toolkit
- ☐ I did not have time
- ☐ The information about the toolkit came too late
- ☐ Another staff person completed the New Initiatives template
- ☐ I needed more orientation about how to use the toolkit
- ☐ I didn't believe that using the Online Toolkit would make any difference to the final result
- ☐ The Toolkit was too difficult to understand
- ☐ I could not find the toolkit on line
- ☐ Other (Please explain)

The Health Planners User's Guide

New Initiatives Survey

The User's Guide was designed to support the development of submissions to the New Initiative, and other health planning processes. It describes appropriate sources of evidence for health planning, provides explanation of the WRHA Draft Priority Setting Criteria and provides guidance on the type of evidence that could be used to support each criteria. It is similar to the Online Toolkit, but in a printable format.

22. Please select the answer that best reflects your experience with the HEALTH PLANNERS USER'S GUIDE.

- ◯ I have never used the Health Planners User's Guide
- ◯ I used the Health Planners User's Guide to prepare a submission.
- ◯ I have used the Health Planners User's Guide for another purpose. Please describe below:

The Health Planners User's Guide

23. Based on your experiences with the HEALTH PLANNERS USER'S GUIDE, how much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The User's Guide improved my understanding of what evidence is.	◯	◯	◯	◯	◯
The User's Guide helped me to understand the Priority Setting criteria.	◯	◯	◯	◯	◯
The User's Guide was easy to use.	◯	◯	◯	◯	◯

24. What aspects of the format and content of the HEALTH PLANNERS USER'S GUIDE did you find useful/not useful?

25. In considering the content and ease of use of the USER'S GUIDE, please provide any suggestions for improvement.

User's Guide

New Initiatives Survey

26. Which of the following explain why you did not use the USER'S GUIDE in the preparation of your submission (please check all that apply)?

- [ ] I was not aware of the User's Guide
- [ ] I did not have time
- [ ] The information about the User's Guide came too late
- [ ] Another staff person completed the New Initiatives template
- [ ] I needed more orientation to what was expected
- [ ] The User's Guide was too difficult to understand
- [ ] I didn't believe that using the User's Guide would make any difference to the final result
- [ ] Other (please specify)

Reviewers Group

27. Were you a member of the New Initiatives REVIEW GROUP this year (2008)?

- ◯ Yes
- ◯ No

Reviewer's Template

The Reviewer's Template was developed to assist members of the Review Committee to score each New Initiative submission. It is used to come up with a total score for each submission.

28. Based on your experience with the REVIEWER'S TEMPLATE, how much do you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Reviewer's Template was easy to use.	◯	◯	◯	◯	◯
The rating system was credible.	◯	◯	◯	◯	◯
The overall score generated for each proposal seemed sensible.	◯	◯	◯	◯	◯
The Reviewer's Template helped to evaluate the strength of the evidence that each proposal put forward.	◯	◯	◯	◯	◯
The Reviewer's Template contributed in a significant way to a fair priority setting process.	◯	◯	◯	◯	◯

New Initiatives Survey

29. What aspects of the REVIEWER'S TEMPLATE did you find useful/not useful?

30. Please provide any suggestions for how the REVIEWER'S TEMPLATE could be improved.

The Reviewer's Guide

The Reviewer's Guide is a supplement to the Reviewer's Template. It provides further explanation to assist reviewer's in scoring submissions to the New Initiatives process.

31. Please select the answer that best reflects your experience with the REVIEWER'S GUIDE.

- ◯ I have never used the Reviewer's Guide.
- ◯ I used the Reviewer's Guide to review a submission.
- ◯ I used the Reviewer's Guide for another purpose. Please describe below:

The Reviewer's Guide

32. Based on your experience with the REVIEWER'S GUIDE, how much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not sure
The Reviewer's Guide helped me to understand the review criteria.	◯	◯	◯	◯	◯	◯
The Reviewer's Guide helped me to understand how to assign scores.	◯	◯	◯	◯	◯	◯
The Reviewer's Guide provided appropriate guidance for the realities of decision-making.	◯	◯	◯	◯	◯	◯
The Reviewer's Guide was easy to use.	◯	◯	◯	◯	◯	◯

33. What aspects of the format and content of the REVIEWER'S GUIDE did you find useful/not useful?

New Initiatives Survey

34. Please provide any suggestions for how the REVIEWER'S GUIDE could be improved:

Reviewer's Guide - Not used

35. Which of the following explain why you did not use the REVIEWER'S GUIDE to review submissions? Please check all that apply.

- [ ] I was not aware of the Reviewer's Guide
- [ ] I did not have time to use the Reviewer's Guide
- [ ] I needed more orientation to what was expected
- [ ] The Reviewer's Guide was too difficult to understand
- [ ] I didn't need to use the Reviewer's Guide because the scoring template was self-explanatory
- [ ] Other (please specify)

Overall impact: Submissions

36. The Priority Setting criteria and associated tools changed the way I prepared my New Initiatives submission.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree
- ◯ Don't Know/Did not use

Please explain:

37. What challenges do you think remain in promoting the use of evidence in health planning and priority setting within the WRHA?

New Initiatives Survey

38. What suggestions do you have regarding how the health planning process could be further improved?

39. Do you have any final thoughts or suggestions related to health planning processes in the region?

Overall impact: Reviewers

40. What impact, if any, do you think the changes to the New Initiatives process implemented this year have had?

41. What challenges do you think remain in promoting the use of evidence in health planning and priority setting within the WRHA?

42. What suggestions do you have regarding how the health planning process could be further improved?

43. Do you have any final thoughts or suggestions related to health planning in the region?

Focus Group Participation

New Initiatives Survey

44. This survey is only one strategy we are using to gather information on ways to improve the New Initiatives and other priority setting processes. Would you be interested in participating in a focus group that would explore improvements to the New Initiatives process and other strategies to improve use of evidence in WRHA planning?

- ◯ Yes
- ◯ No

Because this survey is anonymous, and we have no way of determining who indicates interest, could you please email researchandevaluation@wrha.mb.ca in order that you can be included on the list of potential participants for focus groups.

Thank you

Thank you very much for taking the time to participate in our survey.