THE ACCOUNTABILITY CYCLE: MAKING IT WORK


Manitoba
MANITOBA HEALTH
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## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Introduction</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>What is the core content of these guidelines?</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Establish Expectations</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>What is meant by “expectations”?</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>What is the approach to establishing expectations?</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>What are the characteristics of good expectations?</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Suggestions for developing expectations</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Strategic planning</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Policy development</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Program planning</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>The challenge of establishing expectations</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Measure, Monitor and Report</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>What is meant by measure, monitor and report?</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>What is the approach to measure, monitor and report?</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>What is the strategy for putting performance measurement in place?</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Step 1: assign responsibility</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Step 2: set expectations</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Step 3: select and/or develop measures</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Step 4: design the methodology</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Step 5: collect and report</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Step 6: use the information</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>The challenge of performance measurement</td>
<td>21</td>
</tr>
</tbody>
</table>
THE ACCOUNTABILITY CYCLE: MAKING IT WORK

Section 4 Evaluation and Feedback 23

What is meant by evaluation and feedback? 23
What is the approach to evaluation and feedback? 23
Suggestions for assessing, adapting & applying
Assessing information 24
Adapting information 26
Applying information 28
The challenge of evaluation and feedback 30

4 The Accountability Cycle at Work 31

List of tables and figures

Tables
1 Examples of health system expectations 7
2 Benefits matrix 15
3 Performance measurement dimensions 19
4 Information assessment tool 26
5 Worksheet for adapting to the audience 27
6 Grid to synthesize data 27

Figures
1 Accountability model 4
2 Spheres of influence 16
3 Capacities for use of research 24

References and Resources 35

Appendix A. How a bill becomes law: Federal and Manitoba 39
Appendix B. Additional Information/Tools 43-66

THIS MANUAL COULD NOT HAVE BEEN COMPLETED WITHOUT THE COMMITMENT OF THOSE INVOLVED. WE THANK THE PEOPLE FROM THE REGIONAL HEALTH AUTHORITIES AND MANITOBA HEALTH WHO PARTICIPATED IN THE DEVELOPMENT, REVIEW AND REVISIONS. YOUR GENUINE INTEREST MADE IT POSSIBLE.
1. INTRODUCTION

Welcome to a resource manual for achieving accountability. This resource manual is consistent with and acts as an informal guideline for *The Accountability Framework for the Health System in Manitoba* (the "Framework") found in "Achieving Health System Accountability 2009: Getting There Together" (AHSA). Its purpose is to promote on-going, sustainable accountability practices and continuous quality improvement in the health system.

The Accountability Model (Figure 1) is also from the AHSA. The three arrows are the basis of the Framework and the foundation of improved planning, informed decisions and ultimately, improved health system performance.

The Framework includes a distinction between different levels of responsibility categorized as Governance, Strategic Directions, Management and Operational.

**Governance:** establishes the legislation and policies that are the “rules” of the system. For example, The Canada Health Act (a federal expectation), The Regional Health Authorities (RHA) Act (provincial expectation) and Board policies (health authority expectations) are governance level expectations.

**Strategic Directions:** establishes policies, priorities and planning consistent with governance direction. The federal government’s H1N1 response, Manitoba Health’s stated priorities, and Health Authorities’ strategic planning are examples of strategic direction in the system.
Management: takes strategic direction and develops structures, processes, policies and priorities to manage the system. Manitoba Health’s funding policies, Health Authorities’ annual health plans, and community organizations’ priorities for service delivery are examples of management level expectations.

Operational: takes direction from the management level to establish objectives, make resource allocations and establish roles and responsibilities to carry out the functions of the health system. For example, the federal government provides direct service to First Nations communities, Manitoba Health has direct responsibility for Selkirk Mental Health Centre and Health Authorities are responsible for delivery of core services to their residents.

WHAT IS THE CORE CONTENT OF THE RESOURCE MANUAL?

Sections titled Establish Expectations; Measure, Monitor and Report; and Evaluation and Feedback are based on the Accountability Model and on the Framework. The intent of each section is to facilitate a general understanding of the principles of accountability and a specific understanding of each segment of the cycle by:

- promoting an understanding of relevant concepts and terminology
- establishing a recognizable context to which the information applies
- suggesting applicable tools and processes in a variety of formats

Establish Expectations Establishing expectations is a common activity along the entire continuum of the health system. From legislation to program objectives, expectations drive what happens on a day to day basis in the civil service, Health Authorities, facilities, community programs and among the consumers of health services. The people who work in the system are governed by professional standards and human resource policies. The people receiving services in the health care system gain reassurance from clinical practice guidelines, scope of practice regulations and quality policies. The general public needs to know the basic guidelines for when to go the emergency department, what to expect from a personal care home, and how to know if they qualify for a service.

Measure, Monitor and Report Measuring, monitoring and reporting are well-established activities and functions in our health system. The activities required for identifying measures, planning and carrying out monitoring, and preparing the resulting information for reporting are more commonly referred to as a performance management strategy. There is staff dedicated to preparing financial reports, utilization reports, inspecting facilities and tracking quality indicators. The provincial government publishes performance measures on the internet and Health Authorities distribute their Annual Reports.

Evaluation and Feedback Evaluation and feedback activities should logically follow a performance management process, but too often this step is left to chance or not done at all.
The sometimes overwhelming amount of data and qualitative information that results from monitoring is not as useful as it should be when left in its “raw” form. Without synthesis and analysis, it is less likely to be useful. When resources are consumed to provide information that isn’t useful, there is waste in the system.

**Using This Resource Manual**

This is not a step by step style of presentation. While the manual is organized so that the beginning of the cycle is *establishing expectations*, each section can stand alone for its individual purpose. Accountability work may begin with the development of an “expectation”, but it may also begin with monitoring reports that need to be sorted, analyzed and presented to senior management for a year-end report. Start where the task lies, but remember they are all linked.

Additional information includes:
- illustrations of the accountability cycle in use
- an extensive reference list
- completed tools in Appendix B

Any referenced websites were confirmed to be active as close to publication as possible.

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**SOME WAYS TO USE THE MANUAL**

*I need to develop a presentation for a planning committee that demonstrates the need for...*

The Evaluation and Feedback chapter discusses how best to organize and present data for uptake by your audience.

*I need to revise a policy to include a monitoring process and performance indicators*

Both Establishing Expectations and Measure, Monitor and Report will have useful information and references for that task.

*I have been asked to plan a program evaluation.*

All three chapters have helpful information and references for developing the objectives of the evaluation, planning for data collection and reporting on results. The reference section includes sources of more information about program evaluation.
2. ESTABLISH EXPECTATIONS

WHAT IS MEANT BY “EXPECTATIONS”?

An expectation is as basic as “eat your vegetables” or as complicated as an international nuclear non-proliferation treaty. Legislation, strategic goals, policies and program objectives state the way things should be. Expectations guide actions, set out strategies and usually assign or suggest responsibility for the results. As such, expectations at all levels of accountability need to be clear, measurable, and based on reliable and valid information.

This chapter is about the art and science of establishing expectations.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>EXAMPLES OF HEALTH SYSTEM EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>Federal</td>
</tr>
<tr>
<td>Governance</td>
<td>Canada Health Act</td>
</tr>
<tr>
<td>Strategic</td>
<td>Primary Care Strategy</td>
</tr>
<tr>
<td>Management</td>
<td>Health care for First Nations</td>
</tr>
<tr>
<td>Operational</td>
<td>Program delivery guidelines</td>
</tr>
</tbody>
</table>

WHAT IS THE APPROACH TO ESTABLISHING EXPECTATIONS?

For the purpose of this manual, “expectations” will refer to strategic plans, policies, and program/service objectives that are the responsibility of the different levels of government, health authorities, health care providers and other partners in the system. “Establishing Expectations” emphasizes the importance of having clear and well-developed expectations to:

- promote quality, safety, and competence through application of well-researched structures and processes
  
  *Ex: Clinical Practice Guidelines for the treatment and management of Type 2 diabetes have been adapted to educational materials for people at risk for or with diabetes*
• ensure compatibility and avoid conflict with related strategies, polices, standards or guidelines
  Ex: On-call policies at a PCH must be compatible with existing staffing policies

• promote common understanding by defining commonly used terms and detailing the steps in required processes
  Ex: Clear definitions of the criteria used to establish qualifications for any given service ensures equitable assessment of all applicants

• ensure expectations are appropriate to the level of mandated responsibility.
  Ex: Departmental policies related to Health Authority processes should be specific about intended outcomes and avoid operational details.

WHAT ARE THE CHARACTERISTICS OF GOOD EXPECTATIONS?

A good expectation is a statement of something that is needed. An expectation should state something that can be measured, observed, tested or demonstrated. It must be attainable and/or feasible and it must express a single thought so it is not misunderstood.

Applying these concepts is an iterative process. The realistic “test” may cause a revision of the specificity of the expectation or the resources required for it to be feasible.

SMART
The concept of SMART objectives is familiar and entirely applicable to setting all types of expectations. The SMART concepts should be applied appropriately to the level of expectation you are developing. A governance level expectation will have a different quality of specificity than an operational expectation. For example, the measurement of a strategic priority will be much more population focused than the measurement of a program objective.

SMART expectations are:

Specific/clear: the statement needs to be concise, express a single thought, written so that it cannot be misunderstood. It is often helpful to include what it is NOT intended to cover to help manage the expectations. Define terms and know what “achieved” or “complied with” will look like.

Measurable: must be verifiable by inspection, analysis, measurement or demonstration. The plan for measuring the requirement should be included in the documentation.

Attainable/Achievable: must be technically feasible and for all but the most general of goals, achievable within current budgets, schedules and resources. And/or,

Agreed upon: the people who are experienced, skilled and involved in the development of the expectation can agree on its purpose, wording and scope.
Realistic: the expectation must make sense within its context. The expectation should be based on the best understanding of the environment, resources, and skills that are required.
And/or,

Relevant: there should be a clear explanation of why this expectation is important. Include a description of the facts, assumptions and previous decisions that led to its development. Show how it is linked to and consistent with other similar expectations and how it supports existing values, mission statements, strategic plans, etc.

Timely: while not always applicable to have a time limit on expectations (legislation, for example, may be relevant for decades) it is important to keep time in mind in terms of review and updating language, information, etc. Some expectations may be intended to be short-term or time-limited and should be stated clearly and tracked. Timely could also refer to the appropriate timing of the expectation.

SMART EXPECTATION CHECK LIST

- the expectation is a priority
- everyone involved knows that it includes them specifically
- everyone involved understands it
- the statements are free from jargon
- all terms are defined
- measurements identified to answer questions such as “how much”, “how many”, “who benefited” and “what changed”
- someone else has done it successfully
- it is theoretically possible
- there is a realistic chance of having the necessary resources (human/time/money)
- the opportunities and limitations are known and considered
- everyone knows who will be doing the work
- everyone involved will have or can get the skills they need to do it well
- the source of funding is known
- responsibility is assigned

SUGGESTIONS FOR DEVELOPING EXPECTATIONS

Strategic Planning

Why? To clearly define an organization’s purpose, goals and objectives for a given period of time and to determine a plan to achieve the goals, including how to best direct resources and how success will be measured.
THE ACCOUNTABILITY CYCLE: MAKING IT WORK

When? The timing depends on the stability of the organization and its environment. The literature suggests anywhere from a yearly process to every five years. Circumstances, such as the completion of a major project, major changes in the organizations purpose, or initiation of a new program may be appropriate times to initiate a planning process.

How? A typical strategic plan will include the following elements:

- **Mission**: purpose of the organization
- **Goals/Objectives**: specific aims
- **Situation Analysis**: an environmental scan and analysis.
- **Strategy formulation**: after information is analyzed, identify specific strategies.
- **Implementation**: articulate strategies as policies or action plans and identify required funding and resources.
- **Control**: develop systems to monitor and evaluate the strategy, to measure performance and to respond with appropriate action to ensure success.

The selection of a strategic planning model depends largely on the size and maturity of the organization and the preferences of the participants.

Who? Not everyone needs be involved in all phases of the planning process, but everyone should be informed of results with opportunity to ask questions and get clarification. The process should encourage a sense of ownership of the plan while building consensus. In general, consider the following participants for each task:

- **planning the process**: management team of the project or organization
- **vision, values, mission discussion**: staff and board members
- **understanding the context**: all staff and board members
- **review of internal/external conditions**: program/professional staff for external, add administrative staff for internal
- **strategic options and goals**: professional staff and board
- **implementation and control**: management team with input from staff

**Policy Development**

Why? To guide how decisions are made, to strengthen an organization’s accountability and provide consistency. Policies are basic to quality assurance and improvement processes.

Many organizations have unwritten policies that also guide decisions and behaviour. Different interpretations and applications of unwritten policies can result in inconsistencies and inefficiencies that are hard to identify and fix.

When? Policy development is indicated when:

- there is confusion about how to proceed with basic work functions
- the organization needs to be protected from legal liability
• there is a need to ensure compliance with legislation or government policies
• there is a need to protect staff and/or clients
• there is a need to ensure equitable processes and behaviour

How?
The following are characteristics of good policies and procedures:

• sufficiently researched and written in clear, concise and simple language
• relevant to the organization’s real needs, not adapted from others
• will not overlap or contradict other policies
• statements address the rule, not how to implement the rule
• should be available to all they apply to
• authority should be clear

A plan for communication, involvement of stakeholders, training if applicable, and monitoring/follow up should be put into place as part of the policy development process.

Who?
Policy development involves a set of skills most likely found in a team approach. For consistency, central responsibility should be assigned for administrative functions such as approval, review and revision processes.

Program Planning
Why?
Program planning at the operational level sets the expectations for service delivery, from resource use to changes in health status for consumers.

When?
Needs for new programs or revisions to existing programs are suggested by:

• strategic planning
• evaluations and program reviews
• community health assessments
• changes in resource availability
• response to public demand

How?
Basic elements of planning help ensure a solid foundation. Each program plan should:

• be strongly associated with the organization’s overall mission and strategic plan
• be designed for consumer benefit
• confirm that it is relevant and useful to clients
• coordinate with other programs in the system
• identify and moderate negative impacts on existing programs
• develop key indicators of success (see Chapter 3)
• include a plan for program monitoring, review and improvement (see Chapter 4)

Who?
Program planning, like strategic planning, should be a team effort involving the organization, internal and external partners and potential users of the program.
THE CHALLENGE OF ESTABLISHING EXPECTATIONS

When non-compliance has formal consequences:
Compliance can be an all or nothing concept which is sometimes unrealistic in a complex, social and political system such as health.

When change impacts the ability to comply:
Resource availability (ex: human or fiscal) is neither static nor predictable.

When planning is inadequate:
Given the often serious consequences when expectations are not met, taking care to develop them well is extremely important.

When expectations have a public interpretation:
Consumer satisfaction is based on how well an experience meets expectations. Mediating solutions to unmet expectations, either through discussion or change to policies or programs, helps to manage expectations.

Well developed policies and procedures will eliminate or minimize many of these challenges. If they persist, a policy review may be warranted.

See Appendix B: Tools for additional information on establishing expectations.
3. MEASURE, MONITOR AND REPORT

WHAT IS MEANT BY MEASURE, MONITOR AND REPORT?

Measure, Monitor and Report is the section of the Accountability Model that represents identifying measures, planning and carrying out monitoring, and gathering the resulting information for use by decision-makers. Its purpose is to support improved governance, strategic planning, management and operations of the health system.

WHAT IS THE APPROACH TO MEASURE, MONITOR AND REPORT?

A performance management strategy is one tool available to encompass the components of measuring, monitoring and reporting. It is:

“... a management tool intended to provide decision makers and management with concrete data and information on which to make sound decisions and improve performance by measuring how well an organization, program, etc. is achieving its planned results measured against defined goals, standards or criteria” (Treasury Board of Canada, 2000).

The following performance management guiding principles apply:
- It is developmental and should be subject to evaluation and modification.
- It is a process, not an end in itself.
- It should encourage improvement and not be punitive.
- It should be based on clearly defined goals, expectations, and/or desired outcomes.
- Reports should be credible and timely.

Some of the more common purposes for performance management are:
- Continuous Quality Improvement
- Customer service
- Program performance
- Planning
- Reporting on accomplishments and challenges

WHAT IS THE STRATEGY FOR PUTTING PERFORMANCE MANAGEMENT IN PLACE?

Performance management needs champions and committed leadership to be sustainable. Performance management also requires people with content and measurement expertise.
The basic steps are:

- Step 1: Assign responsibility
- Step 2: Set expectations
- Step 3: Select/develop measures
  - context
  - purpose
  - criteria for measures
  - selecting the measures
- Step 4: Design the methodology including schedules and timelines
- Step 5: Collect and report on data, and
- Step 6: Use the information for making decisions (Evaluation and Feedback section)

Manitoba’s health system has prescribed reporting processes in place such as budgeting/estimates, annual reports, health plans, community health assessments, and funding-specific monitoring requirements. While some reporting processes have flexibility built in, in many situations the expectations, measures, methodology and/or reporting are directed.

Consider using this process to review and improve existing performance measures.

**STEP 1: Assign Responsibility**
A performance management strategy is challenging and requires not only supportive leadership, but acceptance and engagement from all involved. It requires extensive time and effort and is most efficient when the process is integrated into daily activities. Clearly defining roles and assigning responsibilities is a key component of any performance management strategy.

**STEP 2: Set Expectations**
This step is about determining, in general, what needs to be measured and why. Typically, the following background information should be considered:
- goals, desired results, anticipated benefits
- beneficiaries, users and/or audience (reach)
- main activities meant to achieve the results
- acceptable levels of performance (targets, internal or external comparisons)
- preliminary measurement focus (ex: behavior change, utilization, expenditures, health outcomes)

Several tools found in the literature help to organize this information such as:
- results chain
- logic model
- benefits matrix
TABLE 2
BENEFITS MATRIX

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFORT</td>
<td>What did we do?  How much?  How many?  Who?  When?</td>
</tr>
<tr>
<td>EFFECT</td>
<td>Did we do enough?  How many participated?  Were we efficient?  Was access improved?</td>
</tr>
</tbody>
</table>

STEP 3: Select and/or Develop Measures
To select the most appropriate existing measure, or to develop a new measure, begin by determining the context and purpose then consider the measurement criteria. This is a cyclical process.

Context: Governance/Strategic measures of expectations refer to government or regional strategic priorities, goals, issues of governance and accountability or changes in social conditions such as health status, safe neighborhoods and education.

Management measures refer to behavioral changes of individuals and of the system, such as awareness, acceptance, capacity and action.

Operational measures refer to monitoring the inputs, outputs and results of operations, such as efficiencies, quantities, quality and timeliness.

THE CONTEXT OF MEASUREMENT

Strategic
- Manitoba Finance: Reporting to Manitobans on Performance: 2005 Discussion Document. Measures include:
  - estimated numbers of Manitobans living with diabetes
  - self-reported health status
  - life expectancy

Management
- program reviews such as the Palliative Care Drug Program
- recommendations from Accreditation Canada
- results of recruitment and retention strategies

Operational
- annual financial and statistical reporting
- monthly cash flow reporting from cost centres
Another way of considering context is “spheres of influence” (Figure 2 below). This refers to what control or influence an organization’s actions have over measured outcomes:
- Strategic actions will have indirect influence on high level outcomes such as changes in social conditions.
- Management actions will have direct influence over results, but not complete control. Other factors (individual choices, staff turnover) also influence results.
- Operational actions will have direct control over the results (ex: utilization, efficiency). Managers are accountable for results at the operational level.

**FIGURE 2**
**SPHERES OF INFLUENCE**

*PM — PERFORMANCE MEASUREMENT*
*EVAL - EVALUATION*
Purpose: Ultimately, the purpose of performance management is to support accountability. The immediate “why” of managing performance can be summarized with the following list:

- Continuous quality improvement
- Reporting requirements (financial & statistical)
- Improve program performance
- Improve customer service
- Inform planning
- Inform about accomplishments and challenges

Any discussion of the purpose of performance management should include consideration of the expectations of the authority requesting/requiring the information and the impact on those responsible for responding.

**PRACTICAL IMPLICATIONS**

<table>
<thead>
<tr>
<th>REQUESTING AUTHORITY</th>
<th>PURPOSE</th>
<th>IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
<td>financial and statistical reporting • funded initiatives (e.g., Baby First, Aboriginal Head Start)</td>
<td>prescribed monitoring, reporting schedule and format measurement capacity issues</td>
</tr>
<tr>
<td>Provincial Government</td>
<td>inform about accomplishments and challenges • reporting to the public</td>
<td>challenges reporting the information requested with the data available</td>
</tr>
<tr>
<td>MH</td>
<td>inform Planning • Health Plan Reporting</td>
<td>including sufficient information</td>
</tr>
<tr>
<td>HA Board</td>
<td>CQI • monitor progress on strategic priorities</td>
<td>resource requirements for on-going reporting</td>
</tr>
</tbody>
</table>

Criteria for measures: To promote the selection of feasible and valid measures, first consider the context, purpose and the practical concerns that were initially recognized. Then apply the following criteria to assist in choosing measures.

Measures should be:

- **Linked to goals/strategies:** measurement should focus on what is important to know to be effective and efficient
- **Focused on results:** “What changed?” is the key question
- **Relevant and useful to support decisions:** decision-makers see the usefulness of the measurement process and tools, information is balanced between success and challenges
• **Reliable and valid:**
  the measure should provide consistent data over time, should measure what needs to be measured, and come from unbiased sampling and tools

• **Understandable:**
  lay people can see how the data illustrate the concepts under consideration, data collection forms are appropriate for respondents and users

• **Comparable to a standard (internal or external):**
  the data can be compared to (for example) baseline data, targets, standards of care or other validated sources of information to demonstrate change or progress, and

• **Economical to gather:**
  selected measures may require expensive surveys, data storage and analysis may require new/upgraded technology, measurement activities in general may require additional staff, resources and time away from other duties.

**Selecting the measures:** There are a variety of data sources and resources available to assist in the identification, selection and/or development of measures.

For the more strategic issues, relevant and valid measures have been reported for other purposes. For example, the measure of Potential Years of Life Lost (PYLL) is often included as an indicator of the impact of accidents, illnesses or chronic conditions. It can also be used to compare rates with other jurisdictions to illustrate system performance. It may also help to answer questions about a region’s health disparity in context with other measures.

Just like a research project or a program evaluation will benefit from “multiple lines of inquiry” (several sources and methods of data collection), performance measurement will benefit from more than one measure to illustrate performance. In some cases, that might mean selecting or developing measures to cover a broad spectrum of health and health system issues.

A familiar tool that is based on this idea of multiple lines of inquiry is the Performance Measurement Dimensions (Table 3, p. 19) that has been in use in Manitoba for several years (Performance Measurement Framework, 2002).
### TABLE 3
PERFORMANCE MEASUREMENT DIMENSIONS

#### DIMENSION: POPULATION HEALTH

<table>
<thead>
<tr>
<th>Well Being</th>
<th>Functional Status</th>
<th>Health/Social Conditions</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures of physical, social, mental and spiritual well-being</td>
<td>Measures of functional limitations that arise as a consequence of health of social problems</td>
<td>Measures of injury and disease morbidity, social dysfunctions and associated risk conditions</td>
<td>Measures of overall and disease specific mortality</td>
</tr>
</tbody>
</table>

#### DIMENSION: DETERMINANTS OF HEALTH AND SOCIAL WELL BEING

<table>
<thead>
<tr>
<th>Health Behaviours</th>
<th>Socio-Economic Conditions</th>
<th>Environmental Factors</th>
<th>Personal Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural risk factors associated with health/social problems</td>
<td>Social and economic factors linked to health status and social well-being</td>
<td>Physical environmental conditions linked to health status and social well-being</td>
<td>Social supports and family/community life factors that influence health and well being</td>
</tr>
</tbody>
</table>

#### DIMENSION: GOVERNANCE

<table>
<thead>
<tr>
<th>Stewardship</th>
<th>Leadership</th>
<th>Accountability</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting goals/priorities clarity of roles and functions, responsibility for organization</td>
<td>External &amp; internal relations, link to community, appropriate members</td>
<td>Sufficient &amp; necessary information for financial &amp; performance review, accountability relationships with service providers</td>
<td>Efficient and effective board function, self-assessment</td>
</tr>
</tbody>
</table>

#### DIMENSION: HEALTH SYSTEM PERFORMANCE

<table>
<thead>
<tr>
<th>Population Focus</th>
<th>Accessibility</th>
<th>Safety</th>
<th>Work Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current and future needs &amp; expectations of clients, community, populations, &amp; changes in the environment are anticipated and responded to</td>
<td>Required services are easily obtained by clients &amp; the community in the most appropriate setting</td>
<td>Unsafe acts in the care system’s delivery of services &amp; organizational structures are prevented and mitigated</td>
<td>Optimal individual client and organizational health and outcomes are provided in the work environment</td>
</tr>
</tbody>
</table>

#### Client-Centred Services

<table>
<thead>
<tr>
<th>Client-Centred Services</th>
<th>Continuity of Services</th>
<th>Effectiveness</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and services are respectful and responsive to needs, preferences, culture and values of individuals, families and communities.</td>
<td>Coordinated and consistent care/intervention/actions provided across the continuum of services over time.</td>
<td>Services, interventions or actions are based on the evidence from the current and evolving state of knowledge and achieve the desired outcomes</td>
<td>Resources are allocated to achieve optimal outcomes with minimal waste and effort</td>
</tr>
</tbody>
</table>

#### DIMENSION: HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Utilization</th>
<th>Human Resources</th>
<th>System Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, sex, and other analytical characteristics of the population</td>
<td>Monitoring information: who, what, when, where and how much</td>
<td>Professional and administrative resources available to meet service needs. Includes skills and engagement</td>
<td>Leadership, resources, critical thinking, skills &amp; knowledge, attitude</td>
</tr>
<tr>
<td>Fiscal</td>
<td>Information Technology</td>
<td>Physical Structure &amp; Equipment</td>
<td>Other</td>
</tr>
<tr>
<td>Expenditures, revenues, debt</td>
<td>Hardware, software, technical uses</td>
<td>New construction, diagnostic and treatment equipment</td>
<td></td>
</tr>
</tbody>
</table>

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Page | 19
STEP 4: Design the Methodology
A discussion of data collection methods may not be critical if the selected measures are part of existing monitoring activities. It may be necessary to select or develop measures that are unique to the task. It may also be necessary to expand existing measurement activities.

There are several considerations which may include:
- using qualitative and/or quantitative data
- using ongoing and/or periodic methods (utilization information, CCHS surveys)
- collecting data from all, or systematic sampling
- statistical limitations due to sampling and/or design
- limitations due to inconsistent recording, vague definitions, and unreliable technology

In addition, the resources (both human and fiscal) that are available to support the methodology must also be considered. An unrealistic data collection plan will not be sustainable.

STEP 5: Collect and Report
As a communication tool, a performance report should stimulate discussion. It can and should provide managers, staff and stakeholders with the opportunity to reflect on what has worked and what has not. It is a process of learning and adjusting that refines the performance management strategy.

Reporting on performance:
- The purpose and context of the measurement will suggest both the scheduling and potential audience for reports
- When results include information from individuals, it is important to validate the findings with those individuals before they are reported
- The initial reporting task is to analyze the results
- Results should be understandable and clearly linked to the purpose of the measurement.

There are some reports that must follow the requirements as set out in legislation, regulation, policy or guidelines (ex: audits). In other situations there are no set rules for reporting and as such each organization needs to craft and create tailor made reporting mechanisms that work for their organization and suit their needs.

The following are a few examples of reporting tools commonly used in Manitoba:
- Digital dashboards
- Performance scorecards
- Performance stories
- Indicator reports
- Health plans
Annual reports
Community health assessment
Accreditation Canada reports
Bed maps
Progress reports
Project specific monitoring forms

**REPORTING MECHANISMS**

**Strategic**
- Manitoba Finance: Reporting to Manitobans on Performance (indicator reports)
- Manitoba Health’s Annual Report (published)
- RHA Annual Reports (published)

**Management**
- Audit reports
- Community health assessments
- Senior Management reports to RHA boards (digital dashboards, performance stories)

**Operational**
- Vacancy rates per division for senior management meetings (indicator reports)
- Consumer satisfaction survey results in newsletters (project specific)

**STEP 6: Use the Information**
The time, resources, thought and effort put into a performance management strategy are lost if the resulting information is not put to use. This step leads back to Step 1, assigning roles and responsibilities. The responsibility for presenting the information to the appropriate audience and demonstrating how it could be used in decision-making should be part of the plan from the beginning.

"Traditional reporting provides information on how much money is spent in a particular area. Performance reporting can help us determine what results have been achieved from the investment of that money" (Manitoba Finance).

**THE CHALLENGE OF PERFORMANCE MANAGEMENT**

**Identifying outcomes and ascribing causality.** Given the complexity of the health system, multiple partnerships and few theories linking outputs to outcomes, it is difficult to
explain why something happened or what to do to make improvements. The health system speaks of broad goals and mandates while measurement requires a level of specificity that makes agreement on what is necessary to measure difficult.

**Cost of information:** Information is not free and management is reluctant to divert money from program operations to measurement. A common solution has been to monitor select indicators and administrative data. Unfortunately, information can be lost in the aggregating process and the temptation is to measure what is most measurable, instead of what is most important.

**Supportive culture:** Performance measurement requires specific skills and technological capacity that may not be available. It is seen as expensive and it is difficult to agree on appropriate measures. People who support and promote measurement are necessary components of a successful measurement strategy.

See Appendix B: *Tools* for additional information on measuring, monitoring, and reporting.
4. EVALUATION AND FEEDBACK

WHAT IS MEANT BY EVALUATION AND FEEDBACK?

Evaluation and feedback is making the information we have collected useful to the people who need it. The content of this section is a synthesis of a body of literature describing models, strategies and tools under various names such as Knowledge Exchange, Knowledge Transfer and Knowledge Brokering. Similar and supporting information is found by examining Evidence-Base Decision Making materials and Organizational Improvement strategies.

The performance measurement strategy in the previous section places emphasis on understanding the purpose and context of the chosen measures. Ultimately, performance measurement, in whatever form it takes, is providing evidence for making decisions. Whether the decisions are for improvement, expansion, deletion, funding, recruitment, and/or maintenance, they will likely be better if based on reliable evidence.

Data and information that has been collected needs to be organized and described in a way that makes sense to its audience. Then the audience interprets the organized data and information in light of their own context and attitudes. Finally, the audience will make judgments about the relative merits of the information, how it has been interpreted and how it can be best communicated to senior managers, programs, clients, facilities or community. The process of evaluation and feedback converts results into messages that will “change hearts and minds” (D. Pencheon, 2008), resulting in a better health care system based on objective and reliable information.

A note about evaluation
The term “evaluation” of information in an accountability relationship refers to a process of analysis and judgment. This term differs from “Program Evaluation”, which is a specific term/methodology for systematic social research designed to assess the efficiency and/or effectiveness of our interventions.

A program evaluation would follow the entirety of the accountability model, not just the Evaluation and Feedback component. A program evaluation would include establishing expectations by determining what is to be evaluated and why, measuring, monitoring and reporting on results of data collection, and evaluating the synthesized information to provide feedback on the program under consideration.

WHAT IS THE APPROACH TO EVALUATION AND FEEDBACK?

The Canadian Health Services Research Foundation (CHSRF) suggests four dimensions of capacity (see Figure 3) that support an organization’s use of research. For purposes of this chapter, “research” has been expanded to “information”, which is used here to include all
relevant sources, both internal and external. The model illustrates the approach this chapter will take.

**FIGURE 3**
**CAPACITIES FOR THE USE OF RESEARCH**

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**Fundamentals of Evaluation and Feedback**
To take full advantage of data and information that is collected within the health system, there should be a basic capacity for performance measurement. Not all parts of the health system will have equivalent skills or technology, but each should still be able to give some priority to information gathering, analysis and use. This includes ensuring there are appropriate resources and opportunities for learning essential skills.

The previous chapter, *Measure, Monitor and Report*, discussed the first concept of the Fundamentals of Evaluation and Feedback model - “acquiring”. This chapter discusses the concepts of assessing, adapting and applying information:

- **Assessing**: Can the organization assess the quality, reliability, relevance and适用性 of the information?
- **Adapting**: Can the organization present the information to appropriate audiences (including decision-makers) in a useful format that synthesizes key issues?
- **Applying**: Does the organization have the skills, structures, processes and corporate culture to promote the use of evidence in decision-making?

**SUGGESTIONS FOR ASSESSING, ADAPTING AND APPLYING**

**Assessing Information**
Reliability. Reliability refers to the consistency and precision of information. Examining reliability helps to ensure the usefulness of the information and to assess its potential risks.
For example:
- a standardized tool for measuring community capacity will result in more consistent information than casual interviews
- monitoring forms that include specific definitions and instructions will help different people record the same data in the same way
- to compare costs from one facility to the next, the formulas and assumption that result in a “cost” must be the same

Using the results of a reliable source of information increases the likelihood of more accurately informing the decision-making process.

Validity. A valid measure is one that measures what it is intended to measure. This has particular relevance when thinking about indicators that will be proxies for complex or theoretical measures such as risk of chronic disease or “good health”. For example, recent research suggests that the hip/waist ratio may be a more valid indicator of heart health risk and obesity than the Body Mass Index (BMI).

The concept of “validity” also refers to the subsequent meaning given to information. Information has Content validity when there is evidence that it is relevant and representative of the issue/event, etc. Community Health Assessment reports have content validity. Generalizable validity allows the information to legitimately be applied beyond the current context. Results from The Canadian Community Health Survey have generalizable validity. Consequential validity describes the social consequences of the assessment. Reports that provide engaging reasons to quit smoking would have consequential validity.

Timeliness. D.M.Griffith (2005), in his guide to managing information, proposes a principle of timeliness that refers to the need for information:

“Information is only required when decisions have to be made”

In other words, timely information is that which is directly related to a current need, not reported simply because it is available.

“Outdated” is often stated as a reason for not using a particular report, research finding or set of performance measures. Information that is highly variable in relative short time frames or is sensitive to changes in situations or environments is likely to be outdated sooner than more stable information such as health status or provincial population statistics. The issue is usefulness, not a ‘best before” date. If the information is sufficiently up to date for its purpose, then it is timely.

Relevance Without relevance to your audience(s) and the specific decisions that are up for discussion, the evidence might be a “hard sell”. Demonstrate how the evidence is linked to and consistent with audience values, potential benefits prior decisions, etc.
This table provides a format to consider the value and challenges of information sources.

### TABLE 4
#### INFORMATION ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>FACTORS INFORMATION</th>
<th>Reliability</th>
<th>Validity</th>
<th>Timeliness</th>
<th>Relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anecdotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Adapting information**

“People change what they do less because they are given analysis that shifts their thinking, than because they are shown a truth that influences their feelings” (NHS, 2008).

Knowledge Exchange practitioners know that impressions are as important to evidence uptake as facts. As mentioned earlier, hearts must be changed, not just minds. Consider the needs of your audience(s) when preparing the information for presentation and communication.

**Audience considerations.** The sample below is useful for stimulating the discussion of how best to present the information to a variety of audiences and for a variety of needs. While no audience will be homogenous, it should be possible to make some generalizations.

- **Level of detail**
  - planners and providers want more detail to identify opportunities for change and improvement
  - policy makers want a higher level of aggregation to understand larger trends
  - stakeholders may want data to form their own conclusions without interpretation by presenters
  - consumers/the public want information they can access easily and understand (i.e., written in non-technical language with a minimum of jargon)

- **Audience needs**
  - identify decisions that the audience owns or influences: financial, policy, program, approvals, for example
  - consider how audience characteristics such as gender, age, education, or political affiliations will affect their interpretation of the evidence
  - determine current level of knowledge and the need for more detail
✓ determine if the audience has made a decision already, and how the evidence may be able to open discussion
✓ consider who the messenger should be – who would be most acceptable to the audience

**TABLE 5**
**WORKSHEET FOR ADAPTING TO THE AUDIENCE**

<table>
<thead>
<tr>
<th>AUDIENCE: NAME OF INDIVIDUAL OR GROUP</th>
<th>RELATIONSHIP TO THE INFORMATION</th>
<th>PRIMARY AREAS OF CONCERN</th>
<th>KEY DATES IN DECISION-MAKING PROCESS</th>
<th>PREFERENCES EXPRESSED BY AUDIENCES</th>
</tr>
</thead>
</table>

Synthesizing multiple sources of information. There is such a thing as too much information, but there are advantages to having multiple sources with different perspectives to support good decisions. This process determines the most useful information and ensures that a valid mix of perspectives are included.

In those instances where several sources of data are available, the following grid can help to lay out which data answers which question and also help to decide how relevant the data is to each question. For space’s sake, there is only one question.

Synthesis will be influenced by an analysis of potential audiences. The more known about the audiences, the more likely the evidence can be adapted into relevant themes for the decision-makers.

**TABLE 6**
**GRID TO SYNTHESIZE DATA**

<table>
<thead>
<tr>
<th>SOURCES</th>
<th>QUESTIONS</th>
<th>REQUIRED</th>
<th>NICE TO KNOW</th>
<th>DON’T NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td>monitoring data</td>
<td>How have waiting times for ____ been reduced?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>regional data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>provincial data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Communicating the message. Research shows that the best way to achieve uptake once you have determined the information you will present is to tailor the message to the type of evidence it is and how it will be used.

Type of evidence:
- credible facts and data: easily accessible, accurate, trusted source
- findings and conclusions with limited strength of evidence that inform discussion and suggest further investigation
- evidence that supports action and is directly related to the audiences decision-making needs, providing recommendations, advice or suggested actions

Use:
- Indirect use: changes in knowledge, awareness or attitude. For example, the evidence has informed a political debate.
- Direct use: changes in behaviour, changes in policies, programs, practice, patient care and outcomes.
- Tactical use: evidence is used to validate or defend a position already taken or taken for other reasons.

Here are some suggestions for consideration when planning the content of a presentation (see Talking Quality website):
- People can handle a limited amount of information at a time. Research suggests that people can hold from five to nine items in short term memory.
- A lot of information doesn’t necessarily result in better decisions. People may say they want more information than they have, but research shows that decisions do not improve as a result.
- People are more likely to act on information that has been put into context and allows for judgments of “good” and “bad”. If the presenter doesn’t provide context, the easiest to evaluate information will be used, despite its relative importance.

Applying information
Given the most reliable, valid and eye-catching presentation/message that is possible within resources, time, and available information, the eventual uptake of information depends largely on the willingness and capacity of the audiences to work with evidence. An organization needs to have the skills, structures, processes and corporate culture to promote the use of evidence in decision-making before it will be used appropriately.

This “corporate culture” of evidence use is supported by four components (The Informed Decisions Toolbox, University of California Berkeley, Kaiser Permanente and the Oregon Health Sciences University):

- **Strategic** Evidence-based management practices must be in place to focus on strategically important issues facing the health system. Evidence must be seen by managers as a core strategic priority of the system. When the strategic component is
missing and efforts at evidence based management are not directed at strategic priorities, there is little effect on the system.

- **Structural** This refers to the overall structures in place to support the use of evidence and include designated committees, task forces, or individuals identified and responsible for implementing and disseminating evidence-informed decision making. Without a structure in place, there is little system-wide use of evidence; however ad hoc use is possible.

- **Cultural** Leaders who encourage the use of evidence create an environment which supports and rewards this behaviour. Without on-going leadership the practice tends to fade away.

- **Technical** This is the extent to which people have access to the necessary tools, knowledge, skills and training to seek out information from a variety of sources.

The more of these components that are in place, the more solid the system of evidence based decision-making will be. It is beneficial to start with a genuine belief in the value of evidence.

Managers and executives in the health care field participated in a research project on the use of evidence for decision-making (Dobbins, DeCorby, & Twiddy, 2004). Findings include:

- The more familiar the source, format and/or authors, the more credibility is assumed.
- There needs to be a balance between the frequency of reporting and the amount of information included.
- The evidence needs to be clearly aligned with each recommendation.
- There isn’t always enough time to find, read, and think about evidence.
- Evidence must be relevant to the needs of the users (directly related to their needs).
- Evidence should be provided in a reliable and consistent fashion (knowing what to expect is valued).
- Provide options for customizing how the evidence will be received (hard copy, electronic, details, summaries, just the conclusions – all useful for different circumstances).

The most effective way to ensure the use of evidence in decision-making is through a collaborative process between the providers of information and the users. There should be an exchange of ideas so that providers (such as research staff, regional planners, program managers, community developers) help audiences (including executives, managers, boards, staff, consumers) build capacity to use evidence while at the same time, users build provider capacity to produce relevant and useful information.
THE CHALLENGE OF EVALUATION AND FEEDBACK

The primary challenge is to foster an organizational culture of evidence use. This is particularly challenging in our complex health system when decisions are often required quickly.

In crisis management mode, or when system demands dictate, information may be required to validate decisions made for other reasons. Just as some performance measures are mandated by legislation or policy without systematic selection, some decisions will be made without the preferred analytical processes.

Another reality of the health system is the limited supply of human and financial resources. While a plan for greater efficiencies and more cost effective interventions would benefit from resources devoted to information analysis and dissemination, there is significant competition for scarce resources.

See Appendix B: Tools for complete tools and additional information on evaluation and feedback.

THIS MANUAL COULD NOT HAVE BEEN COMPLETED WITHOUT THE COMMITMENT OF THOSE INVOLVED. WE THANK THE PEOPLE FROM THE REGIONAL HEALTH AUTHORITIES AND MANITOBA HEALTH WHO PARTICIPATED IN THE DEVELOPMENT, REVIEW AND REVISIONS. YOUR GENUINE INTEREST MADE IT POSSIBLE.
THE ACCOUNTABILITY CYCLE AT WORK

ILLUSTRATIONS
ANNUAL HEALTH PLAN GUIDELINES

1. SUBMISSION

**ESTABLISHING EXPECTATIONS**

The Annual Health Plan Guidelines sets/revises expectations for submission, including due dates and content.

**EVALUATION & FEEDBACK**

HAs are contacted to submit missing schedules, information

**MEASURE, MONITOR, REPORT**

The Health Plans submission is reviewed for compliance.

1. CONTENT

**ESTABLISH EXPECTATIONS**

The process for expanding and/or establishing a new Telehealth site is included in the Guidelines. The negotiations are between MBTelehealth and the HAs.

**EVALUATION AND FEEDBACK**

Expansion sites are prioritized and decisions to proceed are based on an HAs approved capital costs and ability to self-fund operating costs

**MEASURE, MONITOR & REPORT**

Information flows between the HAs and MBTelehealth to establish, for example, the correct reporting of capital and operational funding needs for both expansions and new initiatives
ACCOUNTABILITY MONITORING

1. PROCESS

ESTABLISHING EXPECTATIONS

HAs are expected to comply with relevant Manitoba Health policies and directives, and to be responsible for implementing and reviewing their board policies.

EVALUATION & FEEDBACK

The reports are recorded and reviewed, and the Deputy Minister is advised of the results.

2. CONTENT

ESTABLISH EXPECTATIONS

Initial monitoring included activities, department policies and HA policies related to board governance expectations.

EVALUATION AND FEEDBACK

The success of this monitoring process to date has resulted in plans to add additional expectations and an audit process to further confirm compliance.

MEASURE, MONITOR & REPORT

The HAs report on compliance with policies and management of theirs on an annual monitoring form which is signed by the CEO and Board Chair and sent into the department.

MEASURE, MONITOR, REPORT

A monitoring spreadsheet is kept for each year’s results to track progress in compliance and any variances in how compliance is achieved.
COMMUNITY HEALTH ASSESSMENT

1. EVALUATION OF THE OUTCOME

ESTABLISHING EXPECTATIONS
At the end of the previous 5 year cycle, a commitment was made to evaluate the outcome of the CHAs. Initial planning included the validity of the indicators and how the information is eventually used.

RESULTS
Results will be used to improve the next 5 year cycle in terms of content requirements, processes and support for broader use.

ESTABLISH EXPECTATIONS
During the planning phase of each 5 year cycle, committees work to establish required quantitative indicators for the next report & suggestions for qualitative data gathering through community engagement.

EVALUATION AND FEEDBACK
The quality, usefulness and ease of acquiring the indicators from the previous cycle are evaluated to determine improvements to the next.

MEASURE, MONITOR & REPORT
Data collection will include literature reviews, environmental scans, interviews, questionnaires and content analysis.

2. CONTENT

EVALUATION & FEEDBACK
Each HA is provided with provincial and federal health statistics and establish their own process for collecting and reporting on the community level data.
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APPENDIX A

HOW A BILL BECOMES A LAW

(FEDERAL)

Prepared by Inba Kehoe,
Government Documents, Stauffer Library, Queen's University

The following guide will explain the process by which a typical government initiated bill becomes law. This guide provides an overview of the Federal Legislative Process. Adapted from "The Federal Legislative Process in Canada".

NOTE: To become law, a bill must first be introduced in either the Senate or the House of Commons. It must then pass through various stages in each House: first, second and third reading. Then it must receive Royal Assent.

A. DEFINITIONS

- **Public Bills**
  These are proposals for laws that will affect the public in general. Most public bills are introduced by Government Ministers. Bills sponsored by the Government are numbered from C-1 to C-200 in order of presentation. If they are introduced first in the Senate, they are numbered starting S-1.

- **Private Bills**
  These are limited in scope: they concern an individual or group of individuals only. They confer a right on some person or group, or relieve them of a responsibility.

B. POLICY PROPOSAL

Most legislation originates with the Government. Policy proposal requiring legislation is submitted to Cabinet by Minister(s).

C. CABINET

- Policy proposal is considered by the appropriate Cabinet committee and recommendations are made to the Cabinet.
- If Cabinet approves, the responsible Ministry issues drafting instructions to the Legislation Section of the Department of Justice.
- Draft bill is prepared in two official languages and approved by the responsible Minister.
- Draft bill is presented to Cabinet for approval.
- If approved it is ready to be introduced in Parliament.
D. PARLIAMENT

- **FIRST READING**
  
  First reading in either the Senate or the House of Commons. Bill is printed.

- **SECOND READING**
  
  Second reading in the same House of Parliament. Members debate and vote on the principle of the bill. The House may decide to refer the bill to a legislative, standing or a special committee, or to Committee of the Whole.

  - **CONSIDERATION IN COMMITTEE**
    
    Consideration by the appropriate parliamentary committee (clause-by-clause study of the bill). Committee can summon witnesses and experts to provide it with information and help in improving the bill.

  - **REPORT STAGE**
    
    Committee reports the bill to the House clearly indicating any amendments proposed. House considers amendments and votes for or against them.

- **THIRD READING**
  
  Debate and vote on bill as amended.

  **NOTE:** Once bill has been read 3 times in the House, it is sent to the Senate for its consideration.

E. ROYAL ASSENT

- Bill is presented to the Governor General for assent.
- Governor General may assent to Bill in the Queen's name, withhold assent or reserve assent.
- When Bill is given Royal Assent it becomes law.

F. IN FORCE

- **Statute is in force:**
  
  o upon Royal Assent, or
  o when it is proclaimed by the Governor General, or
  o on a day specified in the act

- **Different sections may come into force at different times**

Government of Canada web site July, 2010

http://dsp_psd/pwg.gc.ca
HOW LAWS ARE MADE: MANITOBA

LAWS, BILLS, ACTS AND STATUTES

In order for the Legislative Assembly to enact a law, a Bill must be prepared. Bills are proposed laws. If passed by the Assembly and given Royal Assent, they become part of the law of the Province. Once part of provincial law, Bills are known as Acts or Statutes.

1. NOTICE

Notice of a Bill’s intended introduction must appear in the Notice Paper one day prior to the introduction day.

2. INTRODUCTION AND FIRST READING

The Sponsor of a Bill (an MLA) moves that a Bill be read a first time and introduced in the House. The motion is not debatable, but the MLA may offer a brief explanation of the Bill’s purpose.

3. SECOND READING

During this stage, the Bill is debated and either accepted or rejected. This is the most important stage, since adoption of a second reading motion means the Legislative Assembly approves the principle of the Bill.

4. COMMITTEE STAGE

A Bill passing Second Reading is referred to a Standing, or Special Committee (comprised of Members selected from both sides of the House) or to a Committee of the Whole House (comprised of all Members.) Usually after consultation with Opposition House Leaders, the Government House Leader determines the Committee that will examine a Bill.

Since the public has the opportunity to have direct input into the law making process, the committee stage is important. Members of the public may present oral and written submissions concerning proposed Bills. After the public has been heard from, the sponsor of the Bill and the Opposition Critics may make opening statements. The Committee then proceeds to a clause-by-clause consideration of the Bill. At this time, amendments may be proposed and considered.

Persons wishing to make an oral presentation can register through the Clerk’s Office at 945-3636.

Please refer to Fact Sheet #5 How Standing Committees Operate for details on Committee registration and presentations.
5. REPORT STAGE

At this stage, the House considers a Bill that has been considered by a committee, and reported - with or without amendments - to the House. At this time, Members may propose further amendments to specific Bill clauses. The sponsor moves concurrence and third reading after any amendments have been disposed of.

6. CONCURRENCE AND THIRD READING

The sponsor of the Bill moves that the Bill "be now concurred in and read a third time and passed." At this point, the Bill is debatable and amendments may be proposed to apply a 6-month hoist, present a reasoned amendment, or refer the Bill back to Committee. At this stage, debates are usually brief, in part since most Concurrence and Third Reading motions are moved in the final days of session. Adoption of a Concurrence and Third Reading motion signals passage of a Bill.

7. ROYAL ASSENT

To become law, a Bill that passes all stages in the House must receive Royal Assent from the Lieutenant Governor. In the Lieutenant Governor's absence, the Administrator of the Province (The Chief Justice of the Court of Appeal, or another Judge of that Court) performs this task.

What happens during this ceremony?

The Speaker reads the address to the Lieutenant Governor and a Table Officer reads the titles of the Bills in English and French. The Clerk then announces that the Lieutenant Governor has granted Royal Assent.

Is the Bill effective immediately?

Although a Bill receives Royal Assent, it does not mean that it comes into effect immediately. It may come into effect on the date of Royal Assent, 60 days after the ceremony, on a specific date named in the Bill, or on a date to be set by order of the Lieutenant Governor in Council as set out in the coming into force provision of the Bill.

How many times a session does the Royal Assent ceremony occur?

The ceremony may occur several times during a session, the last time being immediately before the end of session.
APPENDIX B

ADDITIONAL INFORMATION/TOOLS
1. BASIC STRATEGIC PLANNING MODEL

VISION

MISSION

STRATEGY (PRIORITIES AND GOALS)

CONTENT
Environment
Barriers
Support Mechanisms

PROCESS
Objectives
Tactics
Measures

TEAM PROCESS
2. FOUR COMMON STRATEGIC PLANNING MODELS

Model One: “Basic” Strategic Planning
Typically, this model is used by small, busy organizations and conducted largely by senior management. It follows the format of:
1. Identify purpose (mission statement)
2. Select the goals needed to meet the mission
3. Identify specific approaches or strategies that must be implemented to reach each goal
4. identify specific action plans to implement each strategy
5. monitor and update the plan

Model Two: Issue-based (goal based) Planning
Organizations which start with the basic model above, often move to this model for a more comprehensive type of planning
1. Do an internal/external assessment of strengths, weaknesses, opportunities and threats – SWOT analysis (see_____ for illustration)
2. Identify and prioritize major issues/goals
3. Design major strategies to address issues/goals
4. Update vision, mission, and values (may do this first)
5. establish action plans (objectives, resource needs, roles and responsibilities for implementation)
6. document the strategic plan
7. develop a yearly operating plan
8. develop and authorize a one budget
9. conduct one year’s operations
10. monitor, review, evaluate and update strategic plan document

Model Three: Alignment Model
The purpose of this model is to align the organizations resources with its mission. It is useful if the organization is experiencing internal efficiency issues or if it needs to fine tune strategies to find out why they aren’t working.

1. planning group outlines the mission, programs, resources and required support
2. identify what is working well, and what needs adjustment
3. identify how the adjustments need to be made
4. include adjustments as strategies in the strategic plan
Model Four: Scenario Planning

This is an approach to be used with other models of strategic planning in order to encourage strategic thinking and to help identity strategic issues and goals.

1. select several external forces and imagine related changes which might influence the organization (e.g., changes in legislation, demographics, environment)
2. for each changed force, identify three different organizational scenarios which might happen due to the changes (use best case, worst case, and OK case)
3. suggest strategies to respond to changes
4. start to identify common considerations in each scenario
5. select the most likely external changes over the next three to five years and select the most reasonable strategies to respond to them.

One other model is mentioned in several sources that is a change from the linear models described above. An “Organic” planning session has the following general steps:

1. clarify and articulate the organization’s cultural values
2. articulate the group’s vision for the organization
3. on a regular basis (e.g., quarterly) discuss what processes are needed to arrive at the vision and what the group will do about the processes
4. the group needs to learn to conduct its own values clarification over time
5. be very, very patient
6. focus on learning and less on method
7. the group will need to decide how to present the plan to stakeholders who may expect a more linear format.

From managementhelp.org/plan_dec
3. GENERIC STRATEGIC PLANNING FRAMEWORK

Strategic Outcome Areas

How ___ contributes to mission/vision

Mission | Vision

(Date) Priorities

a) b) c) d)

These priorities will be the focus of ___ to achieve the following outcomes

Management Outcomes

Outcome #1 | Outcome #2 | Outcome #3

Performance Measures

• • • • • • • • • • • •
4. SWOT ANALYSIS MODEL

 adapted from Novamind website 
 June 7, 2010-06-08 
 www.novamind.com
5. POLICY WRITING TIPS

Keep it Simple: A policy is not a law and shouldn't be written in legalese. It should be understandable to a diverse audience.

Select words carefully:

- 'shall' means compliance
- 'should' or 'may' means one may choose to follow policy, but they don't have to;

Use fewer words (avoid redundancy):

- "C. Purpose: The purpose of this policy is...."
- "C. Purpose: This policy is ....." (preferable)

or,

- "All faculty and staff shall..."
- "Faculty and staff shall..." (preferable)

Keep it General: A policy cannot be written that will take precise account of all possible situations. Its provisions need to be general enough and clear enough to be applied to unanticipated circumstances.

Keep it Helpful: A policy should tell the reader why it exists (perhaps a government or Board of Directors mandate), to whom it applies, when and under what circumstances it applies, and its major conditions or restrictions. A policy should also make reference to any previous policies so as to establish the historical and legal context of the current policy.

From University of Idaho, University Policies: uidaho.edu/uipolicy
This page is a reminder to refer to the above guide whenever possible. It has been developed in the Manitoba context and provides excellent information.

TABLE OF CONTENTS

INTRODUCTION

DEFINITIONS

PART A: LEADING AND MANAGING POLICY DEVELOPMENT
  1. Leadership Direction and Support
  2. Human Resources
  3. Infrastructure Support

PART B: POLICY PROCESS ATTRIBUTES
  4. Issue Identification
  5. Issue Analysis
  6. Generating Solutions
  7. Consultation
  8. Performance Measurement

PART C: POLICY PRODUCT ATTRIBUTES
  9. Purpose.
  10. Evidence
  11. Options
  12. Logic
  13. Consultation
  14. Presentation

SOURCES OF INFORMATION
7. PROGRAM PLANNING AND DEVELOPMENT LOGIC MODEL:
HOW IT FITS WITH ACCOUNTABILITY MODEL

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>WHAT WE DO</th>
<th>WHO WE REACH</th>
<th>ASSUMPTIONS</th>
<th>EXTERNAL FACTORS</th>
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<th>SHORT TERM</th>
<th>MEDIUM TERM</th>
<th>LONG TERM</th>
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<td>AWARENESS</td>
<td>KNOWLEDGE</td>
<td>ATTITUDES</td>
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<td>ACTION</td>
<td>BEHAVIOR</td>
<td>PRACTICE</td>
<td>DECISION-MAKING</td>
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<td>CONDITIONS</td>
<td>SOCIAL</td>
<td>ECONOMIC</td>
<td>CIVIC</td>
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<td>IMPACTS</td>
<td>ENVIRONMENTAL</td>
<td>HEALTH</td>
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<tr>
<th>PARTNERS</th>
<th>INPUTS</th>
<th>SITUATION</th>
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<tbody>
<tr>
<td>WHAT WE INVEST</td>
<td>WHAT WE DO</td>
<td>INTENDED OUTCOMES</td>
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<tr>
<td>PRIORITIES</td>
<td>WHO WE REACH</td>
<td>PRACTICES</td>
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</tbody>
</table>

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<thead>
<tr>
<th>ESTABLISH EXPECTATIONS</th>
<th>MEASURE, MONITOR, REPORT</th>
<th>EVALUATION AND FEEDBACK</th>
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</thead>
</table>
8. BASIC LOGIC MODEL
FOR PLANNING AND EVALUATION

WHERE WE WANT TO GO:
VISION
MISSION
GOALS
OBJECTIVES

HOW WE GET THERE:
STRATEGIES
PRIORITY POPULATIONS
COMPONENTS
PROGRAMS
SERVICES
ACTIVITIES
INPUTS

WHAT WE WILL MONITOR
WHO, WHAT, WHEN,
WHERE, HOW MUCH, WHY
& RESOURCES

OPERATIONAL MEASURES

WHAT WE DID
INPUTS
OUTPUTS
PARTNERSHIPS
COSTS

WHERE WE ACTUALLY GOT:
ACTUAL RESULTS:
- HIGH LEVEL
- INTERMEDIATE
- DIRECT
PROCESS ACHIEVEMENTS,
CLIENT CHANGES,
DELIVERABLES, ETC.
UNEXPECTED OUTCOMES
IMPACTS/EXTERNAL EFFECTS

OPERATIONAL & MANAGEMENT LEVEL MEASURES

HOW WE WILL KNOW WE GOT THERE:
MEASURES OF
ANTICIPATED OUTCOMES
- HIGH LEVEL
- INTERMEDIATE
- DIRECT
UNEXPECTED OUTCOMES
IMPACTS/EXTERNAL EFFECTS

THIS WAY FOR PLANNING

THIS WAY FOR EVALUATING
9. RESULTS CHAIN

WHERE WE ARE  

CURRENT CONDITIONS  

(STRATEGIC)

STRATEGIES & POLICIES  

(CORPORATE SERVICES)

(MANAGEMENT)

REACH  

(OPERATIONAL)

RESOURCES  

ACTIVITIES

EFFECT OF OUR ACTIONS

INDIRECT INFLUENCE

DIRECT INFLUENCE

WHERE WE WANT TO BE

HIGH LEVEL OUTCOMES  

INTERMEDIATE

DIRECT OUTCOMES  

OUTPUTS

CONTROL

WHERE WE WANT TO BE

HIGH LEVEL OUTCOMES

INTERMEDIATE
## 10. BENEFITS TABLE

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>QUALITY</th>
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</thead>
<tbody>
<tr>
<td><strong>EFFORT</strong></td>
<td><strong>What did we do?</strong></td>
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<tr>
<td></td>
<td><strong>How much service did we deliver?</strong></td>
</tr>
<tr>
<td><strong>EFFECT</strong></td>
<td><strong>Is anyone better off (#s)?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>How much change for the better did we produce?</strong></td>
</tr>
</tbody>
</table>

This is a reproduction of a table found at the website for the ‘Results Accountability Implementation Guide’ at [www.raguide.org](http://www.raguide.org). The following are additional topics that are addressed at the site:
- Purpose and how to use the guide
- Basic ideas
- Starting and sustaining the work
- Identifying populations
- Choosing results
- Selecting indicators
- Creating baselines
- Identifying what works and creating a strategy
- Developing an action plan and budget
- Implementing and monitoring the plan
- Identifying performance measures
- Selecting performance measures
- Using performance measure to improve performance
11. EXAMPLES OF PERFORMANCE MEASURES

INPUT MEASURES:
Financial and non-financial resources that are used to produce outputs *(things)*.

Examples:
- money/budget allocation
- number of beds
- staff and staff time
- volunteers and volunteer time
- equipment and supplies
- number of student spaces
- postage
- travel time

number of clients
number of vaccinations
number of applications
hours of training
years of schooling
time it takes to do something
cost of materials
rental costs

Tips:
- Can it be measured?
- Is it clear?
- Is it easy to collect?
- Does it relate to outputs?
- Is it consumed or used up?
- Does it show/reflect a demand for service?

OUTPUT MEASURES:
Units of services provided, products provided or people served by government or government funded programs, regional health authorities, etc. A count of the goods and services produced.

Examples:
- number of treatments given
- number of graduates
- number of sessions
- number of materials distributed
- number of people served
- types of responses to requests

number of miles driven
number of hours per service
number of courses
number of blood tests
number of service requests
number of vaccinations given

Tips:
- Does it show how much was done *(NOT how well or how efficiently)*?
- Is the measure clear?
- Is it product or service oriented
- Does it relate to inputs?
- Does it show quantity or volume?
COST (EFFICIENCY) MEASURES:
Measures the cost, unit cost, or productivity associated with a given output or result. It can also be looked at as a ratio of things done to attempt to show how cost-effective it is to do an activity.

Examples:
- cost per client for counselling
- cost per day per client
- meals on wheels/home care
- cost of vaccination/cost of care
- rate of hourly pay/processing time
- land ambulance/flight

Tips:
- Does it compare items on a per unit basis?
- Does it tell you something about effectiveness or productivity?
- Does it help make decisions about the program?
- Does it tell you something to help improve the program?

QUALITY MEASURES:
Measures of excellence, reflects effectiveness in meeting the expectations of program recipients and/or stakeholders. Measures are associated with dimensions such as:
- Reliability
- Accuracy
- Courtesy
- Competency
- Responsiveness
- Completeness

Examples:
- % of clients rating program or service as good/excellent for:
  - response to complaints
  - timely service
  - empathy
  - complete service
  - Service demonstrated compliance with professional standards
- consistent performance
- credibility
- reasonable hours, location
- respectful treatment

Tips:
- Are processes to measure quality built into program/service delivery?
- Are the measures developed by all team members?
- Are efforts made to do more than ask “are you satisfied?”

OUTCOME MEASURES:
Measures the impact that program effort has. The desired result of the program, activity or service. They let you know that you are coming closer to your goals, can show that you have made a difference, can show that things have improved.
Examples:

**Direct outcomes:**
- increased awareness of negative effects of alcohol
- sobriety maintained for 3 months
- clients demonstrate skills in use of home insulin test
- caregivers get respite with new home care services

**Intermediate outcomes:**
- improved employment status for clients of alcohol treatment
- education results in reduction in diabetes ER visits for program clients
- respite services result in reduction in need for additional home care services

**High Level outcomes**
- clients maintain sobriety for five years
- delay in onset of diabetes complications
- more people aging in safe home environment

**Tip:**
Outcome measures should relate to why the program or service exists; what benefits are desired.

**Reminder:**
It does not exist to provide employment (input), to pass out pamphlets (output), to provide cheaper service (cost), or to meet professional standards (quality).
12. TYPES OF MEASURES

STRATEGIC (high level) measures look at “big” information such as population health and reflect measures of health and well being, and of illness, disease and disability within the population. This includes determinates of health and well-being reflecting non medical determinates such as personal behaviours, housing conditions environmental factors and others. The values of these measures change slowly (over many years) and are collected infrequently and often irregularly. They describe conditions but are influenced by so many factors that they are poor indicators of effects of specific short term actions or strategies in isolation.

MANAGEMENT (intermediate) measures are more directly influenced by the actions, funding and policies. These measures examine health and social service system performance reflecting measures of system performance such as effectiveness, efficiency and quality which are useful to the all health system stakeholders (health authorities, provincial programs, professional bodies and the Department of Health) Values of these measures are more sensitive to change than the high level measures and their external influences are easier to isolate and track.

OPERATIONAL (direct) measures are inputs, outputs, direct (short-term) outcomes of activities, resource allocations and service delivery. These are the contextual factors reflecting measures of the current operating environment including factors such as demographics, community capacity, client expectations and others. Direct measures describe the results that were expected and their values are under the control of management. They are often sufficient to answer questions about programs and services, particularly when collected systematically as part of a monitoring plan, and key to the operations/service delivery decision making process.
## 13. DATA COLLECTION SOURCES AND METHODS

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
</table>
| PROGRAM, SERVICE ADMINISTRATIVE SYSTEMS AND RECORDS | • contain a wealth of information about program, process and people  
• the information is organized so that it can be easily manipulated and extracted | • may not contain accurate, up-to-date information  
• may not contain data corresponding with what is being measured  
• expensive to set up when new information management systems are needed |
| INTERVIEWS | • inexpensive  
• flexible | • potential to influence answers  
• response rate for mail & telephone may be low  
• travel costs for in-person interviews can be high |
| FOCUS GROUPS | • helpful in revealing interactions and relationships between various initiatives  
• may uncover insights on the rationale behind common perceptions and reactions | • may not put participants at ease to discuss persona beliefs and attitudes  
• data generated in a focus group tend to be quick responses, instead of considered answers |
| COMPARATIVE STUDIES | • a powerful way of collecting data for comparative purposes | • finding reasonable comparative groups, structuring valid studies and analyzing data is time and money intensive |
| EXPERT PANELS | • can provide opinions and recommendations on an initiative or approach  
• low-cost and fast | • opinion may offer very little useful insights  
• experts can tend to hold a particular view or opinion that may affect their perception of a program or approach |
| QUESTIONNAIRES AND SURVEYS | • large feedback base  
• can cover a range of subjects  
• respondent can provide considered answers | • low response rate  
• risk of using a non-responsive sample  
• can be costly |
| SYSTEMIC LITERATURE REVIEW | • quick, inexpensive and up-to-date  
• existence of current data bases  
• access to a pool of international expertise | • quality of systematic review may vary |
| CASE STUDIES | • more holistic analysis  
• consideration of the inter-relationships among the elements of a particular situation | • complex method of data organization  
• difficult to draw general conclusions |
| EXTERNAL ADMINISTRATIVE SYSTEMS AND RECORDS | • timely and cost-efficient  
• avoids duplication | • data availability and applicability |

From Strategic Management Branch, Comptrollership and Administration Sector, Industry Canada
## 14. PERFORMANCE MEASUREMENT DIMENSIONS TABLE

### DIMENSION: POPULATION HEALTH

<table>
<thead>
<tr>
<th>Well Being</th>
<th>Functional Status</th>
<th>Health/Social Conditions</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures of physical, social, mental and spiritual well-being</td>
<td>Measures of functional limitations that arise as a consequence of health of social problems</td>
<td>Measures of injury and disease morbidity, social dysfunctions and associated risk conditions</td>
<td>Measures of overall and disease specific mortality</td>
</tr>
</tbody>
</table>

### DIMENSION: DETERMINANTS OF HEALTH AND SOCIAL WELL BEING

<table>
<thead>
<tr>
<th>Health Behaviours</th>
<th>Socio-Economic Conditions</th>
<th>Environmental Factors</th>
<th>Personal Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural risk factors associated with health/social problems</td>
<td>Social and economic factors linked to health status and social well-being</td>
<td>Physical environmental conditions linked to health status and social well-being</td>
<td>Social supports and family/community life factors that influence health and well being</td>
</tr>
</tbody>
</table>

### DIMENSION: GOVERNANCE

<table>
<thead>
<tr>
<th>Stewardship</th>
<th>Leadership</th>
<th>Accountability</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting goals/priorities clarity of roles and functions, responsibility for organization</td>
<td>External &amp; internal relations, link to community, appropriate members</td>
<td>Sufficient &amp; necessary information for financial &amp; performance review, accountability relationships with service providers</td>
<td>Efficient and effective board function, self-assessment of effectiveness and impact</td>
</tr>
</tbody>
</table>

### DIMENSION: HEALTH SYSTEM PERFORMANCE

<table>
<thead>
<tr>
<th>Population Focus</th>
<th>Accessibility</th>
<th>Safety</th>
<th>Work Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current and future needs &amp; expectations of clients, community, populations, &amp; changes in the environment are anticipated and responded to collaboratively</td>
<td>Required services are easily obtained by clients &amp; the community in the most appropriate setting</td>
<td>Unsafe acts in the care system’s delivery of services &amp; organizational structures are prevented and mitigated</td>
<td>Optimal individual client and organizational health and outcomes are provided in the work environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client-Centred Services</th>
<th>Continuity of Services</th>
<th>Effectiveness</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and services are respectful and responsive to needs, preferences, culture and values of individuals, families and communities.</td>
<td>Coordinated and consistent care/intervention/actions provided across the continuum of services over time.</td>
<td>Services, interventions or actions are based on the evidence from the current and evolving state of knowledge and achieve the desired outcomes</td>
<td>Resources are allocated to achieve optimal outcomes with minimal waste and effort</td>
</tr>
</tbody>
</table>

### DIMENSION: HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Utilization</th>
<th>Human Resources</th>
<th>System Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, sex, and other analytical characteristics of the population</td>
<td>Monitoring information: who, what, when, where and how much</td>
<td>Professional and administrative resources available to meet service needs. Includes skills and engagement</td>
<td>Leadership, structures, resources, critical thinking, skills &amp; knowledge, attitude</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Fiscal</th>
<th>Information Technology</th>
<th>Physical Structure &amp; Equipment</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures, revenues, debt allocation</td>
<td>Hardware, software, technical, uses</td>
<td>New construction, renovations, diagnostic and treatment equipment</td>
<td></td>
</tr>
</tbody>
</table>
15. NOTES ON KNOWLEDGE TRANSFER

Key Principles for Planning

- What is the message?
- Who is the audience?
- How will the message be transferred? (see below)
- With what expected impact (evaluation)

Evidence of transfer method effectiveness (from systematic reviews)

“Generally effective”
- Education Outreach: Trained professional meeting with providers in their practice setting
- Interactive Education: small group workshops with ample opportunity to participate
- Reminder Messages: notes on requisition forms, desk blotters with list of risk factors
- Interventions designed to overcome barriers: a process is used to identify barriers to good practice and to develop strategies to overcome/avoid/eliminate the barrier.

“Variable effectiveness”
- Audit & Feedback: summarized information (ex, clinical performance) with recommendations
- Opinion Leaders: use of individuals with a high profile in their discipline or practice
- Client-led Intervention: when the client (patient, consumer, etc.) provides information meant to influence the intervention

“Generally ineffective” (on its own)
- Lectures: when audience passively receives information
- Educational Materials: distribution of material

“No evidence of effectiveness”
- Electronic Communication: use of internet or intranet including websites, email, we casts, chat rooms, list serves, etc.
- Media: use of television, newspapers, magazines, billboards, etc to increase awareness of change behaviour.

### 16. INFORMATION ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>ASSESSMENT INFORMATION</th>
<th>RELIABLE</th>
<th>VALID</th>
<th>TIMELY</th>
<th>RELEVANCE</th>
<th>MULTIPLE USES</th>
<th>IMPLICATIONS</th>
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17. GRID TO SYNTHESIZE DATA

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<th>QUESTIONS</th>
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<td>DATA SOURCES</td>
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adapted from Yorke, C. Synthesizing Information: Strategies
18. Tool for Adapting Information to the Audience

<table>
<thead>
<tr>
<th>AUDIENCE: NAME OF INDIVIDUAL OR GROUP</th>
<th>INVOLVEMENT IN DATA COLLECTION</th>
<th>PRIMARY AREAS OF CONCERN</th>
<th>KEY DATES IN DECISION-MAKING PROCESS</th>
<th>PREFERENCES EXPRESSED BY AUDIENCES</th>
<th>REQUIRED REPORT(S) DATE AND TYPE</th>
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19. PRESENTING AND USING RESULTS WORKSHEET

PLANNING

<table>
<thead>
<tr>
<th>KEY QUESTIONS</th>
<th>WHOSE QUESTION?</th>
<th>WHAT WILL BE DONE WITH THE ANSWER</th>
<th>WHAT DATA IS NEEDED TO ANSWER IT?</th>
<th>WHO WILL COLLECT THE DATA AND HOW?</th>
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USING THE DATA

<table>
<thead>
<tr>
<th>WHAT IS THE DATA?</th>
<th>WHAT IS THE ANSWER?</th>
<th>WHAT DECISIONS RESULTED?</th>
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(adapted from 1997 Program Evaluation Toolkit)
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<th>AUDIENCE</th>
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<th>FORMAL PRESENTATION</th>
<th>MEDIA RELEASE</th>
<th>PUBLIC MEETING</th>
<th>STAFF MEETING</th>
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Adapted from: