

LONG TERM PLANNING

SUMMARY

1. Key Issues for new Health Units to Join

- ?? Cost
 - need to show utility, supportive health unit culture
 - what do you use instead
- ?? Internal resources, staff
- ?? Flexibility, may not meet all health unit needs
- ?? Workbook, training material

2. Unmet needs of RRFSS Partners

- ?? Data analysis, dissemination / better data mining
- ?? Sample size increase or decrease
- ?? Provincial sample
- ?? Sub-populations
- ?? Data availability to all RRFSS partners
- ?? Questions on sensitive issues, e.g., sexual health
- ?? Training manual
- ?? Coordinator
- ?? Syntax files on web site
- ?? More funding
- ?? Better estimates on module time
- ?? HIU access
- ?? Central coordination for special projects
- ?? Response rates
- ?? Different types of modules
- ?? Youth

3. Challenges for 37 Health Units

- ?? Commitment from all health units
- ?? Logistics, teleconferencing
- ?? Decision-making
- ?? ISR needs lead time
- ?? May take longer to get data
- ?? Contacting all health units for data access
- ?? Flexibility decrease
- ?? Not all health units have Epi, appropriate staff
- ?? Weighting

Benefits

- ?? Profile
- ?? Provincial sample more attractive to external agencies (PHB) – sell \$
- ?? People to share work
- ?? HIUs involved

- ?? Data quality
- ?? More talent

4. Sustainability

- ?? Central coordination/coordinator
- ?? External agencies buy data or questions
- ?? ISR, HIUs, CCO does some analysis
- ?? Lower cost
- ?? More streamlined decision-making
- ?? *Disseminate data, utility beyond health units – niche of emerging issues
- ?? Long term contracts
- ?? Consider additional organization for data collection
- ?? Provincial funding
- ?? Annual workshop
- ?? Expand sample provincially with existing health units, identifying buyers
- ?? Rotating core
- ?? Outside Ontario
- ?? PHERO, CJPH
- ?? Groups of health units combining for data analysis

5. Priorities

- ?? MOH buy-in (aIPHa)
- ?? Dissemination
- ?? Funding
- ?? Coordinator
- ?? Demonstrating utility

DETAILED

1. Key Issues for new Health Units to Join

- ?? Cost vs investment - because information is needed, culture in health units, what are you using instead?
- ?? Need direct link between RRFSS data and use of information. Have to sell board of health because of 50:50 funding.
- ?? Other sources of data, e.g., CCHS?
- ?? Cost – no new money, where does it come from, how to take from a variety of programs
 - ISR too expensive? reductions now after set up
 - in-kind time of health units not considered in \$40,000, cost per interview
- ?? Flexibility – diversity among health units. May not meet the needs of all health units, e.g., physical activity, nutrition
- ?? Lack of a workbook, training material, support for those coming in – need for mentors
 - time gap if you don't come in at right time for orientation
- ?? Cost – to spend money, it has to do a lot
 - realistic understanding of what RRFSS can do
- ?? Need to demonstrate how RRFSS can be used – program evaluation
- ?? Internal resources – who does it, capacity
- ?? Mechanisms within health units to disseminate, communicate

- ?? Learning curve
- ?? Cost
- ?? Staff time

2. Unmet needs of RRFSS Partners

- ?? Toronto in particular – sample size, may have to wait a year
- ?? Sub-populations
- ?? Data on public domain e.g., internet
- ?? Data availability to participating health units
 - Roadblock*
 - too much bureaucracy, need permission and have to be specific
 - code of conduct vs “our” data
 - wide open like BRFSS, state gets data first (annually)
 - ISR will make data public after 1 year after technical documentation
 - tax dollars
 - issue that information may be released before they have had a chance to analyze
- ?? Questions on sensitive issues, e.g., sexual orientation
- ?? Health unit specific issues
 - resources to develop
 - working with Working Group
 - getting it on the questionnaire
- ?? Teenagers – some youth questions by proxy
- ?? Pleased to see adjustments to sample size, time of interview – less \$ for those who want less
- ?? Larger sample size for some
- ?? Training manual to new partners, orientation – when to use weighting
- ?? Better data mining, more leadership
 - look beyond health units, external agencies involved
 - collaboration between neighbouring health units
- ?? Structured access to syntax files on web site
- ?? Coordinator – looks for \$
- ?? Additional funding, common funder
- ?? Provincial sample – more attractive to external partners, e.g., detecting effect of tobacco taxes
- ?? Regional estimates
- ?? Central coordination for special projects
- ?? Partnerships with external agencies to do special projects
- ?? External agencies to add modules for \$, CAMH, Canada Health Monitor
 - bring groups together
- ?? Central analysis
- ?? Province-wide coverage
- ?? Module timing – amount of time they take – helps decide which to choose
- ?? Health Information Unit access/ - process?
 - data analysis
- ?? Different types of modules
 - similar to BRFSS set-up?
- ?? Response rates
- ?? Data analysis and dissemination to public, staff

- ?? Module development, e.g., sexual health
- ?? Sub-populations, e.g., parents
- ?? Sensitive questions – use research by CCHS
- ?? Sample size increase?

3. Challenges for 37 Health Units

- ?? Commitment needed from all to provide resources, would strain others if they don't meet commitment
 - infrastructure needed within health unit suggestion
 - a group of health units combine to do analysis, processes
 - next year may be feasible to have different sample sizes
- ?? May be more difficult for an individual health unit to get a specific module on
 - usually other health units join in
- ?? Health units with an Epi vacancy or no Epi
 - may need to do basic analysis for health units
 - problem is unequal work commitment
- ?? Weighting for provincial sample
- ?? Working Group functions – 21 members, difficult to get through agenda
 - process would need to be streamlined
- ?? ISR can expand to more health units as long as they have lead time
- ?? Teleconferencing between 37 health units
 - restructuring – regional?
- ?? Flexibility may decrease, e.g., fewer optional modules, data may not come monthly, infrastructure
- ?? If ISR can't handle – another agency may be involved
- ?? Is it realistic?
- ?? Reaching consensus
- ?? Teleconferencing
- ?? ISR capacity
- ?? Longer times for your data, questions?
 - problem with having ISR doing development, processing, collection – not enough resources
- ?? Contacting all health units for data access
 - graphs showing all health units with no labels
 - Suggestion* – regional groups
 - infrastructure of Working Group
- ?? Logistics of dealing with 37 health units
- ?? Not all health units have Epis, or someone similar to designate
 - if committed, can find someone
- ?? Decision-making process
- ?? Demand on capacity
- ?? ISR needs lead time

Benefits

- ?? Profile, usefulness to provincial government \$
 - not sure about provincial involvement

- province may not want provincial data
- ?? More people to share work potentially
- ?? Provincial sample – attractive
- ?? Another level of collaboration
- ?? Would Health Information Partners be more likely to do data analysis?
- ?? Data quality
- ?? Get \$ from Public Health Branch
- ?? Comparisons between provincial, others
- ?? More talent feeding in – theoretically better sharing of work load
- ?? Better buy-in from external groups, maybe work with Ontario Health Monitor, TUPS (Health Canada) CAMH to reduce duplication
- ?? Provincial sample – more external agencies interested
- ?? Increase visibility – all of Ontario
- ?? May help with funding – more saleability, without giving up control
- ?? More people to share costs of coordinator, other
- ?? More useful to the Ministry
 - would like access without having to ask, tip off topic

4. Sustainability

- ?? Central coordination
- ?? ISR giving more than just data - frequencies, cross-tabs (cost, but cheap)
- ?? Cost - can we lower cost with more health units
- ?? Enablers – to lower cost; time, sample size
- ?? Promote RRFSS through publications, e.g. like BRFSS at-a-glance
- ?? Selling questions?
 - sponsor survey rather than selling questions
- ?? External \$, bring cost down
- ?? Infrastructure – coordinator, analyst
- ?? Bring Ministry in – sacrifices flexibility
- ?? More streamlined decision-making by Advisory Group- gives up some flexibility
- ?? Disseminate data, improve access
 - more automated access
 - demonstrate utility, decision-making compendium
 - develop more useful data products, e.g., graphical techniques
- ?? Longer term contracts
- ?? Demonstrated utility beyond other data sources
 - identify emerging issues beyond CCHS, e.g., West Nile virus
 - RRFSS niche – is emerging issues
 - maybe let go of some core because of CCHS
- ?? Better linkages with ALPHA to get MOH buy-in
- ?? Allow other agencies to do data collection
- ?? Other agencies to do analysis, e.g. HIUs, CCO
- ?? Provincial funding
- ?? Coordination, centralization (coordinator)
- ?? Continue annual workshop
- ?? Continue bottom-up approach
- ?? Usefulness beyond health units – RRFSS niche is emerging issues
- ?? More rigor – more resources into validation, data quality issues

- ?? Develop a quality assurance template – steps
- ?? Increasing flexibility
 - lower core leaving more room for options
 - allow larger sample with fewer questions
- ?? External agencies may buy data or questions
- ?? Plan over time – existing health units expanding to all health units to have a more saleable Product, other health units may buy in later, reduces \$ to all
 - may be only enough to get a provincial sample
 - identify buyers, e.g., OTRU
 - BRFSS model of groups doing presentations to present their questions, all vote
- ?? RRFSS niche – may take CCHS questions off if you can ensure CCHS will continue.
“Emerging issues niche? If so, our processes need to support it
- ?? Rotating core
- ?? Submit proposal to groups such as the Research unit at the Ministry for funding – short term funding
- ?? Consider expansion outside Ontario
- ?? Demonstrate usefulness
- ?? Visibility – PHERO – even small updates, wide dissemination

5. Priorities

- ?? Data utilization, dissemination
 - CJPH, PHERO
- ?? Coordination
- ?? Funding, connection with
- ?? Dissemination products
- ?? Process of prioritizing
- ?? Working Group burnout
- ?? Coordinator
- ?? Demonstrating utility
- ?? Involving alPHa
- ?? MOH buy-in
- ?? Issue of Early Childhood survey bringing some health units in, sustainability. Back to 15?
- ?? Need more staff, resources to support participants