Ontario Public Health Standards

Population Health Assessment and Surveillance Protocol, 2008

Foundational Standard Workshop
November 14, 2008

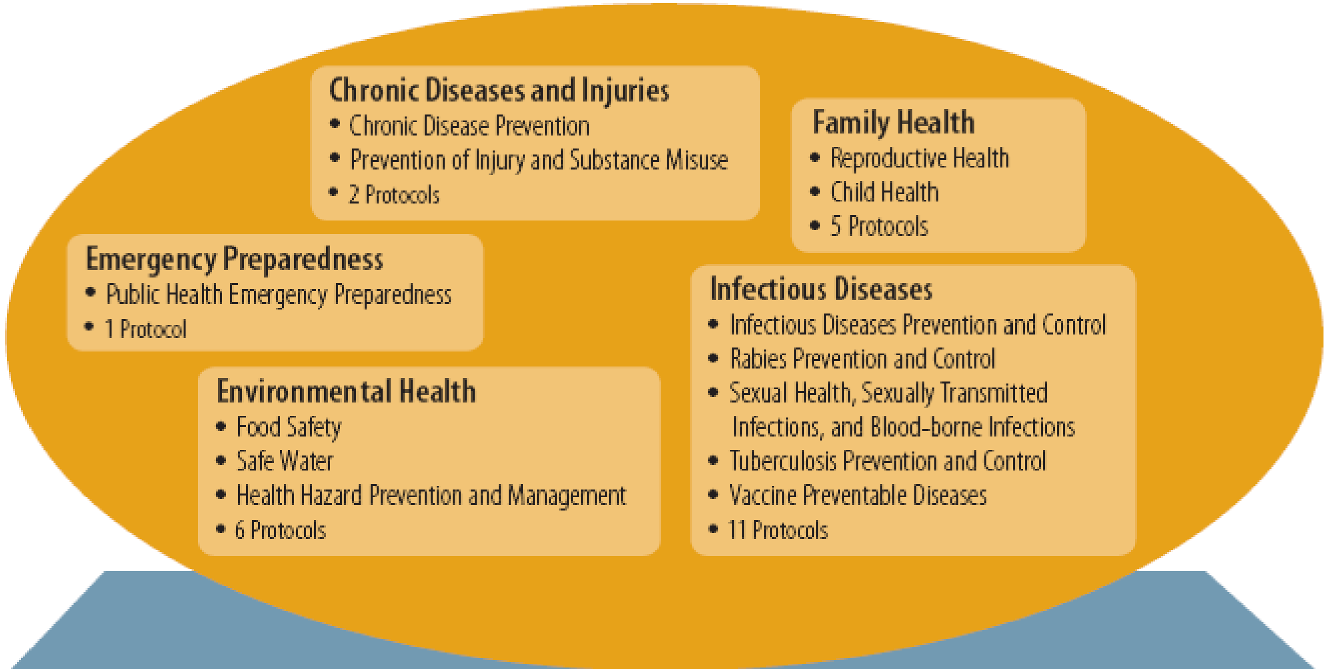
Ontario

Purpose

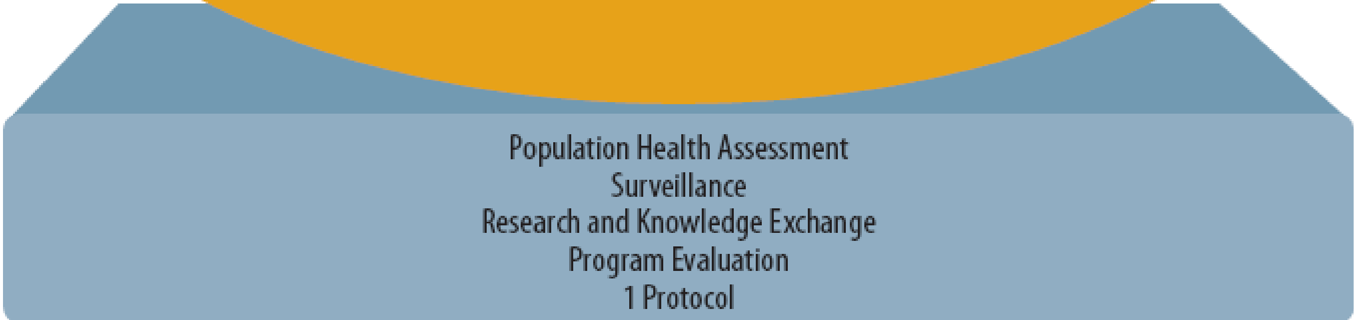
- The purpose of this presentation is to discuss the Population Health Assessment and Surveillance (PHAS) Protocol, 2008

OPHS "Atlas"

Program Standards and Protocols



Foundational Standard and Protocol



Principles

Legislative Authority for the Ontario Public Health Standards and Incorporated Protocols

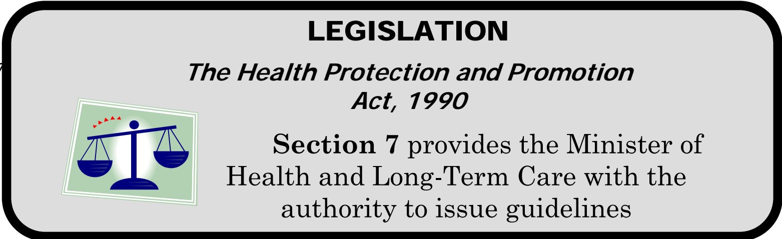
HPPA, Section 7

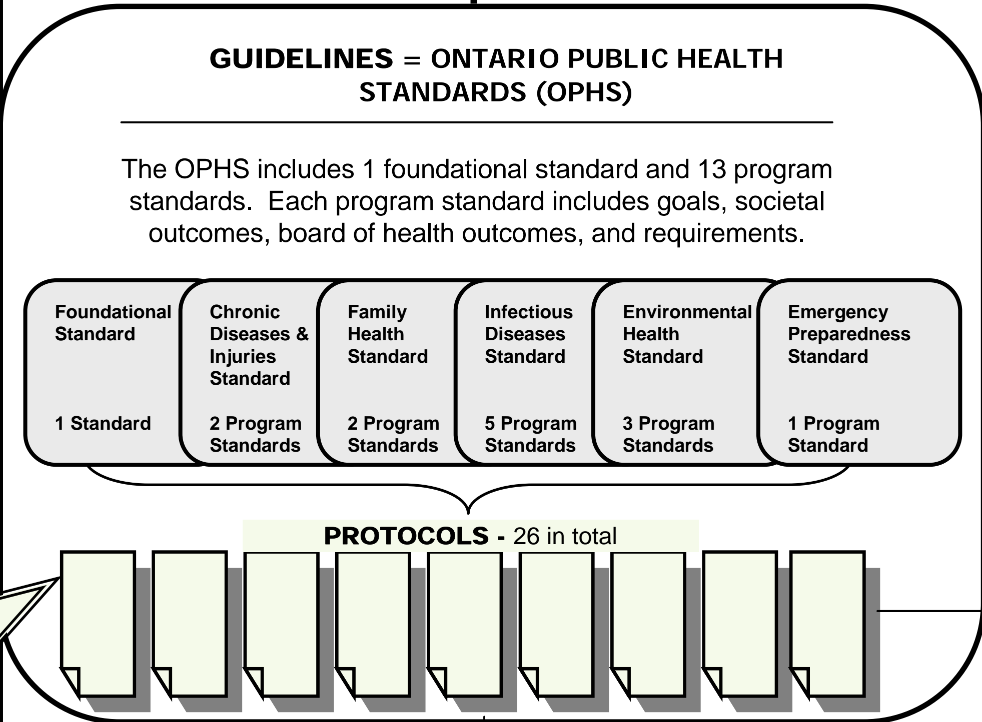
7 (1) – provides the minister the authority to issue guidelines
7 (2) – requires that guidelines are transmitted to boards of health
7 (3) – states that a guideline is not a regulation
7 (4) – clarifies that a guideline is subordinate to a regulation

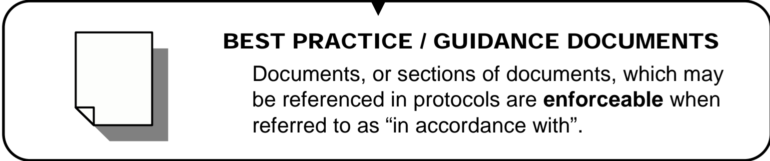
7 (5) – allows for the adoption of other documents by reference, in a guideline
7 (6) – specifies that a document incorporated by reference should be referred to as "amended from time to time"
7 (7) – states that a document comes into effect when the MOHLTC notifies boards of health and when it publishes a notice

Protocols - Protocols include detailed direction to assist boards of health to operationalize specific requirements in the OPHS.
26 protocols in total are included in the OPHS.

Enforceable







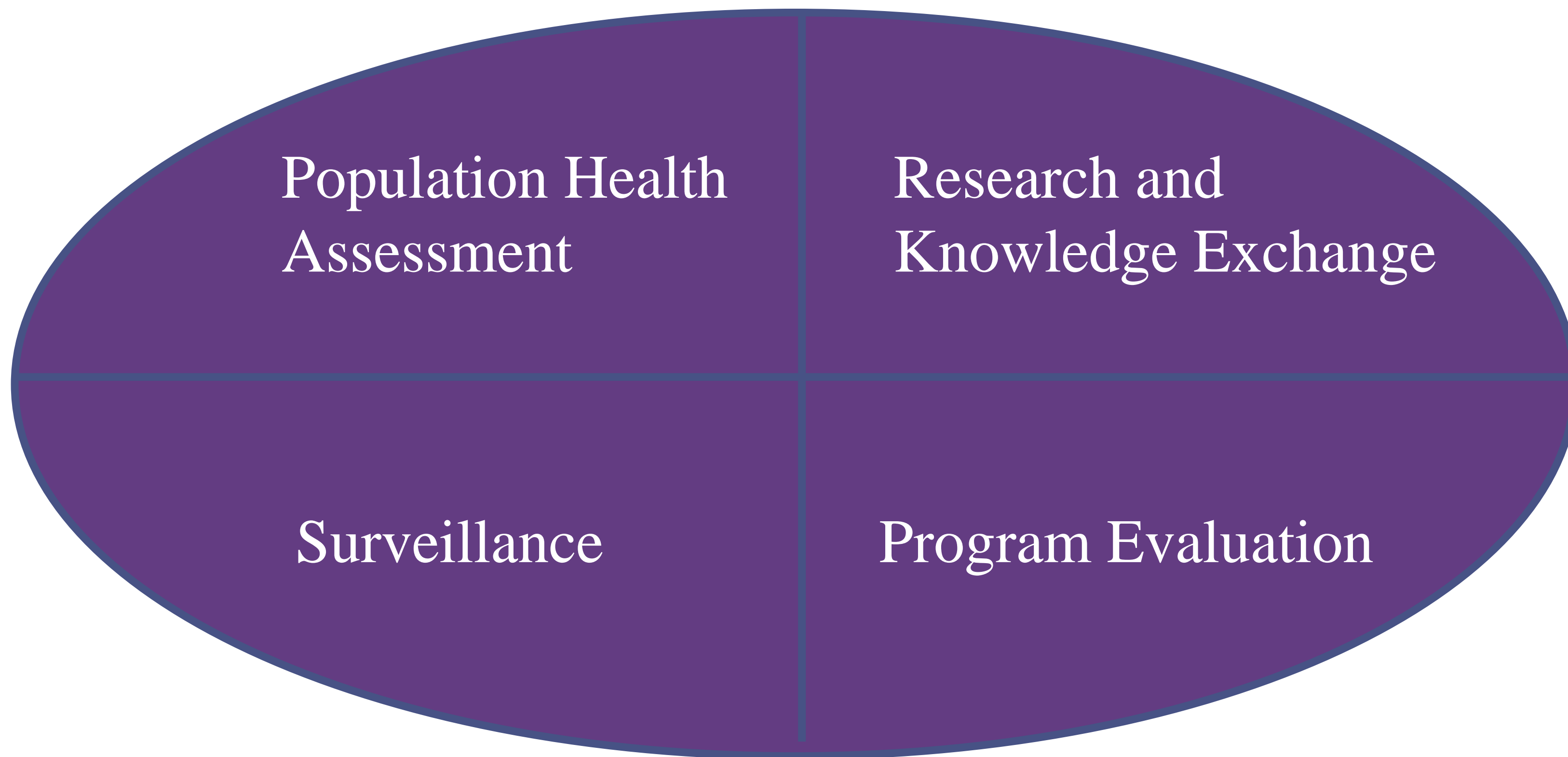
Not Enforceable

BEST PRACTICE / GUIDANCE DOCUMENTS

Documents, or sections of documents, which may be referenced in protocols are **not enforceable** when referred in such a manner as to indicate that they are being provided for guidance purposes only. An example of this would be where the document is referred to as being provided to the board of health for their "further information".

Foundational Standard

- The OPHS includes a Foundational Standard which is intended to acknowledge and reinforce the importance of foundational public health activities to under-pin the planning, delivery and evaluation of all public health programs and services – including each of the Program Standards in the OPHS



Population Health Assessment and Surveillance Protocol, 2008

- Operationalizes specific requirements in the Health Assessment and Surveillance Requirements of the Foundational Standard and all Program Standards Assessment and Surveillance requirements
- Provides boards of health with direction on applying and meeting requirements where standardization across the province is required

Linkages Across the OPHS

- As part of the OPHS Foundations and Foundational Standard, the requirements of the PHAS protocol should be applied across all of the OPHS
- The following Standards refer to the PHAS Protocol, 2008 *in name:*
  - Foundational;
  - Chronic Disease Prevention;
  - Prevention of Injury and Substance Misuse;
  - Reproductive Health;
  - Child Health;
  - Infectious Diseases Prevention and Control;
  - Rabies Prevention and Control;
  - Sexual Health, Sexually Transmitted Infections, and Blood-Borne Infections (including HIV);
  - Tuberculosis Prevention and Control;
  - Vaccine Preventable Diseases;
  - Food Safety;
  - Safe Water;
  - Health Hazard Prevention and Management; and
  - Public Health Emergency Preparedness.

Development of PHAS Protocol, 2008

- Protocol Development Team made up of:
  - Associate Medical Officer of Health;
  - Senior Management Staff (e.g. Directors and Managers);
  - Epidemiologists;
  - Data Analysts;
  - Program Evaluators;
  - Policy-makers;
  - Rural, Urban, and Sub-urban practice settings; and
  - Health Promotion and Health Protection areas of public health practice.

Protocol Development Process

- The Program Standards Technical Review Committee (TRC) felt that requirements in the Foundational Standard, alongside the health assessment and surveillance requirements, needed standardization and direction to operationalize requirements
- Several months of writing and revisions
- Consensus-based process
- Engagement of the field through Phase 1 Protocol consultation
- Employing a health equity lens throughout the process

Consultation Results

Overall Themes:

- Reporting and dissemination issues- prescriptiveness of the protocol in frequency of reporting and scope of dissemination
- Indicator and Data availability issues
- Ensuring linkages to other protocols

Content:

- Concern with Table 1 which outlines frequency of dissemination
- Reporting Issues: required audience and reporting formats unclear
- Further clarification requested on community partners and their roles
- Roles of provincial and federal agencies for support was requested

Consultation Results (cont'd)

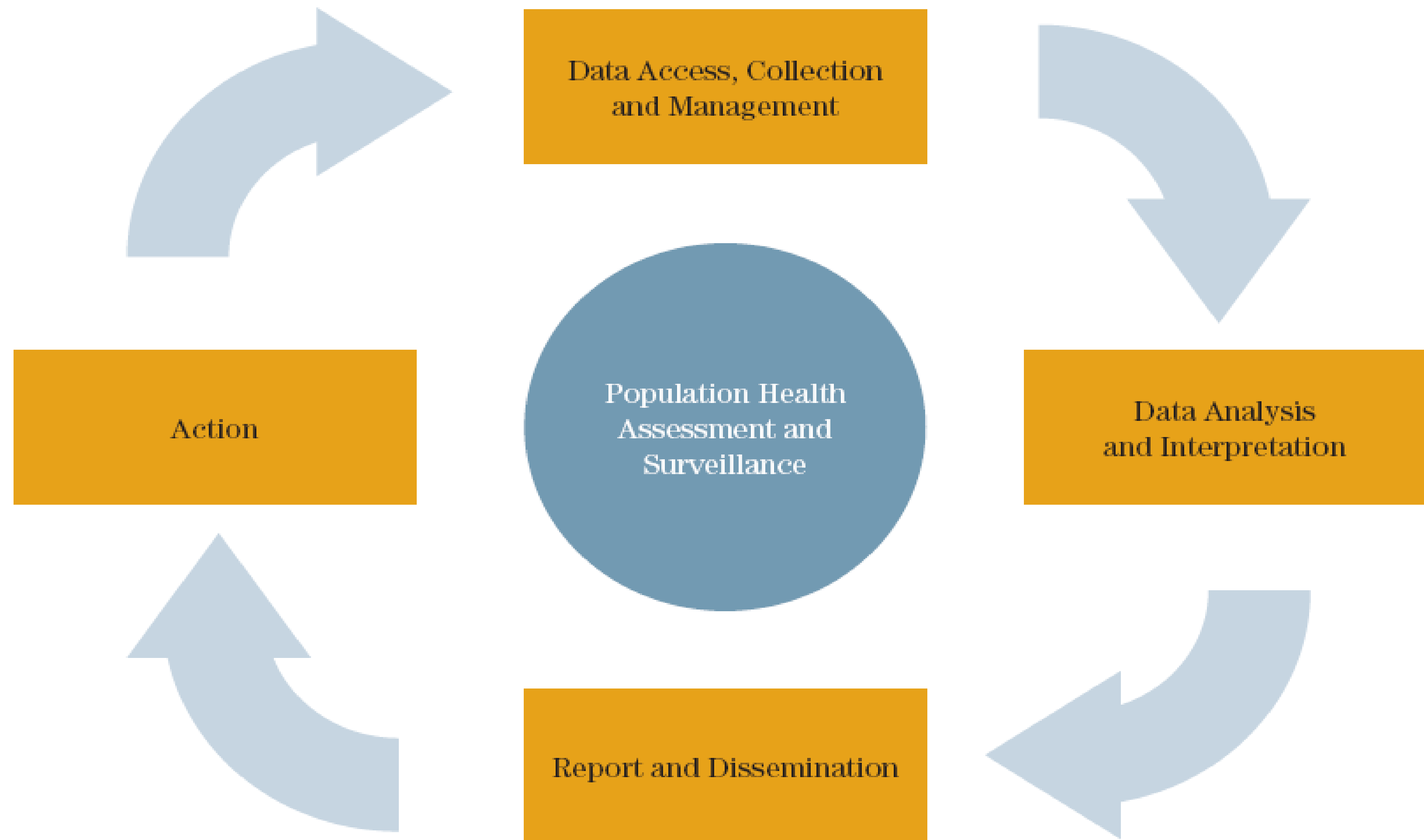
Potential Gaps:

- Requirement to report on topics where no indicators currently exist;
- Quality assurance practices missing from data analysis methodology descriptions;
- Data access and sharing agreements often an issue for board of health (CCHS, RRFSS);
- Relationships with other public health agencies not defined;
- Missing definitions of role of Situational Assessment, Program Assessment;
- Imbalance on quantitative methods - role of Qualitative methods;
- Requirements for data/information requests and end-user consultations with community partners; and
- Missed linkages to Nutritious Food Basket, NutriStep, Work Stress, Access to services, Health care providers, linkages to Infectious Diseases and Environmental Health protocols.

Consultations Results and Revisions

- Protocol feedback varied from too prescriptive or not prescriptive enough making it difficult to strike a balance between the two
- Resulted in reconvening the PHAS Protocol Development Team for several months to revise the protocol
- Revisions included:
  - Removal of data analysis frequency and report dissemination table;
  - Cross-referencing definitions and surveillance requirements with all other protocols upon their completion;
  - Implementing suggested changes re: language and expanded definitions;
  - Including reporting and dissemination themes;
  - Addressing indicator and standardization issues;
  - Improving wording and clarification;
  - Further clarifying linkages with the social determinants of health.

Population Health Assessment and Surveillance Cycle



1) Data Access, collection and management I

- The board of health shall access, collect, manage, and use data and information from multiple sources in order to undertake population health assessment and surveillance. This will include quantitative and qualitative data and information obtained through the following sources or methods, depending on the issue:
  - Public health information systems, and any other Ministry required systems that collect health assessment and surveillance data;
  - Administrative Databases;
  - Surveys;
  - Literature (peer-reviewed and/or other “grey” literature);
  - Policy and program documentation, including evaluation; and
  - Other primary data collection (qualitative or quantitative), as well as data and information from other local, regional, provincial, and national sources.

1) Data Access, collection and management II

- The board of health shall use standard definitions of variables and health indicators, to collect and access population health data and information

- The board of health shall employ rigorous and sound methods in accessing, collecting, and managing population health data and information including appropriate sampling, and reducing potential sources of bias and error to optimize data quality

1) Data Access, collection and management
Types of data required I

- Socio-demographic data: population by age, sex, education, employment, income, housing, language, immigration, culture, ability/disability, and cost of a nutritious food basket
- Mortality: including death by cause
- Morbidity: reportable diseases, other infectious diseases of public health importance, injury by hospitalizations and emergency department visits, and prevalence of chronic diseases
- Reproductive outcome: live births, stillbirths, pregnancy, birth weight, multiple births, gestational age, and congenital anomalies
- Growth and development

1) Data Access, collection and management
Types of data required II

- Risk factors: tobacco use, exposure to ultraviolet radiation, alcohol use and other substances, work stress, food handling practices, and infection prevention and control practices of inspected premises associated with risk of infectious diseases of public health importance
- Preventive health practices: immunization, oral health, physical activity, healthy eating, healthy weights, road and off-road safety, cancer screening, sexual practices, breastfeeding, preconception health, healthy pregnancies, preparation for parenting, positive parenting, and healthy family dynamics
- Physical environment factors
- Other relevant data and information regarding: attitudes, awareness, and knowledge; public health policies, programs and services; the legal and political environment; stakeholder perspectives; and program evaluation

2) Data analysis and interpretation I

- The board of health shall undertake monitoring, analysis, and interpretation of population health data on a systematic and timely basis based on patterns of exposure or outcome occurrence likelihood and/or possibility of change, availability of data, urgency of required action, and the consequences of decision-making

- The board of health shall analyze and interpret population health data to describe the distribution of health outcomes, risk factors, determinants of health, and other relevant information to assess the overall health of its population and consider the relationships among these elements

2) Data analysis and interpretation II

- The board of health shall, when analyzing health data and information:
  - Use quantitative and qualitative data analysis methods as appropriate to the issue;
  - Define the population of interest;
  - Document and provide analysis details: data sources, methods, assumptions, definitions, and limitations; and
  - Use the most currently available data.
- The board of health shall integrate data from multiple sources, to make recommendations for decision making

2) Data analysis and interpretation III

- The board of health shall synthesize data into a situational assessment as required

- The board of health shall identify priority populations to address the determinants of health by considering those with health inequities including: increased burden of illness; or increased risk for adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action

3) Reporting and dissemination I

- The Board of Health shall develop and maintain a locally appropriate plan for reporting and dissemination that would identify:
  - Characteristics of the data and information;
  - Intended audiences;
  - Frequency of reporting; and
  - Format of reporting (internal fact sheet; health status report; etc.).
- The board of health shall produce information products to communicate population health assessment and surveillance results. Information products must:
  - Be understandable and useable by the intended audience(s); and
  - Be timely in terms of issues, policy-making cycles, and seasonality to maximize visibility and impact.

3) Reporting and dissemination II

- The board of health shall distribute/ make available population health assessment and surveillance information products as appropriate to:
  - Public health professionals/practitioners and policy and decision-makers among board of health staff; governments (local, provincial and/or federal); and across the broader health system;
  - Community partners (e.g., social service, education and non-government agencies); and
  - The general public.
- The board of health shall disseminate information products at a timing and frequency determined by the following factors: patterns of exposure or outcome occurrence (including intervals within which meaningful change is detectable), likelihood and/or possibility of change, availability of data, and the urgency of required action

4) Action I

- The board of health shall use population health assessment and surveillance data and information to:

  i) Identify options for action, including but not limited to:

  - Continuation of existing policies, programs, or interventions;
  - Modification of existing policies, programs, or interventions;
  - Creation of new policies, programs, or interventions;
  - Launch of timely investigations and responses to exposures, potential or confirmed communicable disease outbreaks, non-communicable disease clusters, and emerging public health issues; and
  - Further investigations using evaluation and/or research methods as identified in the Foundational Standard

4) Action II

- The board of health shall use population health assessment and surveillance data and information to (cont'd):

  ii) Make decisions and set priorities; and

  iii) Implement and act on decisions.

- The board of health shall continually incorporate new data and information generated from this decision-making process into the population health assessment and surveillance cycle

Protocol Revisions-Evergreen Process

- The TRC recommended a formalized process be established to ensure that the OPHS and Protocols are reviewed and revised on an ongoing basis
- Processes and structures for the formalized OPHS and Protocols review are being considered (potentially to initiate in late 2009)
- Commitment made by MOHLTC:
  - OPHS will be reviewed after 5 years-revisions require ministerial approval (MOHLTC, MHP, MCYS)
  - Protocols will be reviewed every 2 years - *or as required*
- Any revision to Protocols will require CMOH approval
  - It is anticipated that revisions to some Protocols may be more frequent
  - Addition and/or removal of Protocols entails changes to OPHS
  - Changes in names of Protocol also entails changes to the OPHS
- It is anticipated that stakeholder engagement will be a component of the "evergreen" process - mirroring the approach to the development of the OPHS and Protocols
- The role of the Ontario Agency for Health Protection and Promotion is to be determined in the coming months

Appendix 1: Population Health Assessment and Surveillance Protocol Development Team

- Ms. Mary-Anne Pietrusiak, Co-Chair
- Ms. Karen Hay, Co-Chair
- Ms. Mary Lou Decou
- Ms. Effie Gournis
- Ms. Brenda Guarda
- Ms. Alanna Leffley
- Dr. Valerie Mann
- Ms. Isabelle Michel
- Ms. Karen Moynagh
- Dr. Elizabeth Rael
- Dr. Fran Scott
- Ms. Daniela Seskar-Hencic