North West **LHIN**

Priority Setting in the LHINs: A Practical Guide to Decision-making

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Ontario
Local Health Integration Network

Table of Contents

1.0 Executive Summary

Local Health Integration Networks (LHINs) are mandated to plan, integrate and fund health services across the continuum of care whilst engaging communities in setting local health service priorities. In addressing this mandate, LHINs are faced with making decisions about how best to meet community health needs in the context of competing system goals, multiple stakeholder interests and limited resources. This document describes a priority setting framework to help LHINs:

- Align resources strategically with *system goals* and *community needs*
- Reach publicly defensible decisions based on *evidence* and *community values*
- Facilitate constructive *stakeholder engagement* around better meeting system and / or organizational objectives within the constraint of limited resources
- Fulfill their *public accountability* for the use of public health service resources.

The priority setting framework incorporates economic principles of 'value for money' and ethical principles of fair process. It includes 16 priority setting criteria linked explicitly to LHIN strategic aims, values and performance goals and key process elements designed to facilitate transparent, evidence-guided, and fair priority setting decisions. This document provides an overview of the priority setting framework and an Implementation Toolkit. The toolkit is available in the appendix and also as an accompanying spreadsheet file for local adaptation and use. All related documents can be found on the LHIN priority setting SharePoint site:
N:\B. Administration\Administration\Conferences and Workshops\Priority Setting Workshops\February 20 2009 Priority Setting Workshop\February 20 Workshop Material

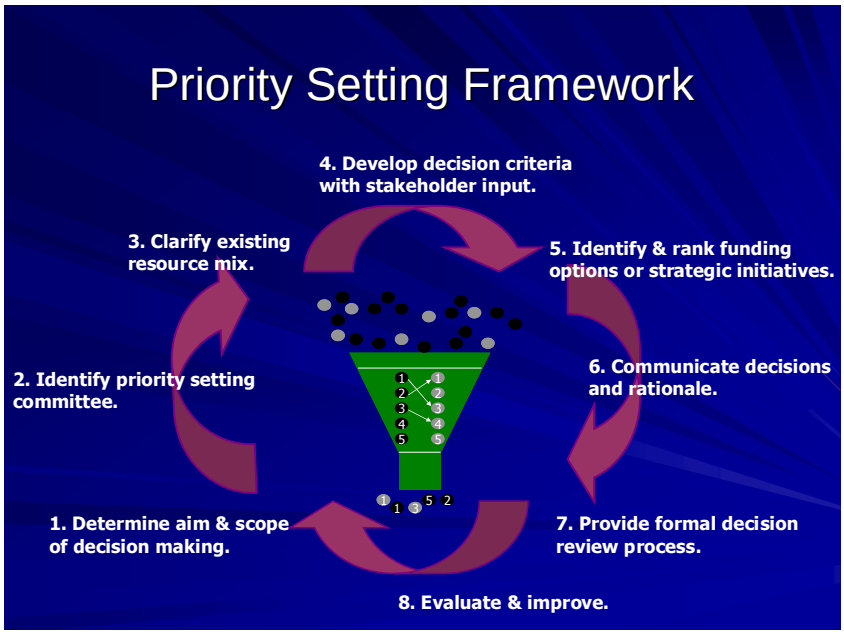
1.1 Introduction

Drawing on economic principles of value for money and ethical principles of fair process, a priority setting framework was developed and tested over an 18 month period (Appendix A). The overall goal was to develop a strategic, evidence-based and fair approach to priority setting that would aid decision-making and be adaptable to different LHIN contexts and decisions. The final framework is described here. The framework should enable LHINs to determine what strategic initiatives and service proposals should have the 'first call' on new resources and to identify and prioritize resource re-allocation options allowing 'freed up' resources to be shifted into priority areas for investment. While the process should be coordinated 'in house', the framework highlights key opportunities for constructive stakeholder engagement, which involves consolidating the evidence and value-base of decisions, facilitating system-level coordination and buy-in, and enhancing overall fairness of the priority setting process.

2.0 PRIORITY SETTING FRAMEWORK

2.1 Overview

The LHIN priority setting framework applies economic and ethical priority setting principles by nesting the economics of making trade-offs to optimize benefits with limited resources *within* the ethics of a fair priority setting process (Appendix B). The Implementation Toolkit describes how these economic and ethical principles can be operationalized in eight overlapping stages, which are highlighted in the following figure (Appendix C).



The priority setting framework is comprised of two main elements: decision criteria and decision processes.

2.1.1 Decision Criteria

The decision criteria link LHIN decisions to local and health system strategic directions, values and performance goals. The criteria are used to assess and rank funding options or strategic initiatives, explain LHIN decisions to stakeholders, and ensure a consistent and publicly defensible rationale for LHIN decisions. Based on a review of MoHLTC and LHIN documents and the broader priority setting literature, four overarching criteria domains and criteria were developed. The Implementation Toolkit provides detailed definitions for each criterion (Appendix C.2a), a criteria weighting tool (Appendix C.2b), a criteria-based proposal scoring tool (Appendix C.2c), and a business case template (Appendix C.2d). These criteria and tools can be adapted for local implementation based on the aim and scope of the priority setting process, the LHIN's strategic goals and environment, and local community values and needs.

STRATEGIC FIT Alignment with: IHSP and/ or ASP, Provider System Role (mandate and capacity)
POPULATION HEALTH Contribution toward improvements in: Health Status, Prevalence, Health Promotion/Prevention
SYSTEM VALUES Contribution toward fulfilling: Client-focus, Community Engagement, Efficiency (operational), Equity, Innovation, Partnerships
SYSTEM PERFORMANCE Contribution toward improvements in: Access, Integration, Quality, Sustainability

*The 'system values' domain is meant to provide a mix of local and potential system wide attributes.

2.1.2 Decision Processes

International experience with priority setting has demonstrated the importance of fair processes to establish the legitimacy of priority setting decisions. This is because priority setting involves value-based decisions affecting a range of stakeholder interests. The LHIN priority setting framework operationalizes key principles of fairness and aligns these with the LHINs' legislated mandate. Fair process elements include: stakeholder input on decision criteria, criteria-based decision-making, an effective communication plan, formal decision review process, and an evaluation strategy. These elements establish a basis for constructive stakeholder engagement, a mechanism for reaching publicly defensible decisions, and a pragmatic demonstration of public accountability for the use of limited resources. The Implementation Toolkit provides advice on how to implement these key process elements (Appendix C.1), including a proposed workplan and timeline (Appendix C.3).

2.1.3 Expected Outcomes

The LHIN priority setting framework should help LHIN staff to meet the practical challenge of priority setting within a complex system and with limited resources in a systematic, consistent, and strategic way. The framework facilitates *strategic alignment of priority setting decisions* by linking decision criteria explicitly with health system goals and community health needs, establishes a transparent basis for making *evidence-guided and value-based decisions*, enables shared ownership between the LHIN, providers, and the community through meaningful and *constructive stakeholder engagement*, and provides a mechanism to demonstrate the LHIN's *public accountability for the use of public resources*. The decision review and process evaluation components anchor the LHIN's activity within a broader commitment to organizational learning and system collaboration, which contributes to ongoing quality improvement and strengthens the defensibility of LHIN decisions in the eyes of the Ministry, system partners, and the public.

3.0 CRITICAL SUCCESS FACTORS

Drawing on experience with the LHINs and elsewhere, a number of success factors are outlined in the following table.

(a) Strong executive leadership coupled with board endorsement

(b) Sound project management

(c) Stakeholder engagement, including HSPs and the community

- e.g., input on criteria, external participation on priority setting committee, feedback on decisions

(d) Clear and consistent communication between LHIN and provider organizations

- including: details on priority setting goals, criteria, processes, and decisions as well as explicit rationale for such decisions

(e) Clear roles and responsibilities

- particularly between senior management and priority setting committee

(f) Organizational learning and application of lessons learned in future processes

Appendix A. Cross-LHIN Priority Setting Initiative

Over 18 months, a cross-LHIN Working Group chaired by Gwen DuBois-Wing (CEO, North West LHIN) worked closely with two external researchers – Drs. Jennifer Gibson and Craig Mitton – to develop a priority setting framework for the LHINs based on economic and ethical principles. The overall goal was to develop a strategic, evidence-based, and fair approach to LHIN priority setting that facilitated decision-making in practice and was adaptable to different LHIN contexts and decisions.

The workplan involved 4 phases:

- **Phase I: Development** – A draft priority setting framework was developed in Fall/Winter 2007 and circulated to the LHINs in January 2008. An orientation to the framework was held for LHIN staff by videoconference on March 10, 2008.

- **Phase II: Implementation** – Three LHINs piloted the framework over May-November 2008. The North West and Champlain LHINs piloted the framework in their Urgent Priorities Funding process. The Central West LHIN piloted it in their Aging at Home funding process.

- **Phase III: Evaluation** – An evaluation of the three pilots was launched in November 2008 to identify good practices and opportunities to improve local LHIN practices, to specify refinements to the framework, and to determine how the framework might be used in future funding initiatives. The evaluation involves an on-line survey with health service providers and interviews with LHIN staff and board members. This phase will be completed by the early April 2009.

- **Phase IV: Refinement** – A Priority Setting Workshop with all LHINs was held on February 20, 2009 in Toronto to review evaluation findings, identify common decision-making challenges across all LHINs, discuss practical solutions to these challenges, and explore refinements to the framework based on local experience. A Final Report, including the refined framework, a practical toolkit to guide local implementation of the framework (including practical strategies to address common issues or challenges), and advice on how individual LHINs can continue to update and refine the framework over time, will be circulated to participating LHINs in Spring 2009.

Appendix B: Guiding Principles – Economics & Ethics

The LHIN priority setting framework draws on international experience with using an economics approach called program budgeting & marginal analysis (PBMA) and an ethics approach called accountability for reasonableness (A4R). These approaches have commonly been applied independently. By contrast, the LHIN priority setting framework is comprehensive of both approaches, i.e., it provides guidance on how to achieve 'value for money' using a fair priority setting process.[1]

1. Economics principles

PBMA draws on economic principles of *opportunity cost* (i.e. the benefit lost by not investing in the next best alternative use of available resources) and *the margin* (i.e. the next unit of cost and the next unit of benefit). Together, these concepts suggest that decision-makers should re-allocate resources at the margin to get the best overall benefit within available resources. PBMA offers a criteria-based and evidence-guided technique for making explicit trade-off decisions. With PBMA, resources released through efficiency improvements and service reductions are shifted directly into service growth areas to meet organizational objectives. It also provides a 'way of thinking' about economics in a management context: that is, unless opportunity cost and the margin are considered in resource decisions, 'benefit' (however defined) is unlikely to be optimized for the given resources.[2]

2. Ethics principles

A4R describes five key principles of a fair priority setting process (see table below).[3] Developed in the context of real-world priority setting processes, A4R describes an open and transparent priority-setting process that engages stakeholders constructively, ensures publicly defensible decisions, and supports decision-makers' accountability for managing limited resources. It has been used to guide priority setting in healthcare organizations nationally and internationally.

RELEVANCE	Decisions should be based on reasons (i.e., evidence, principles, values, arguments) that fair-minded people can agree are relevant under the circumstances.
PUBLICITY	Decisions processes should be transparent and decision rationales should be publicly accessible.
REVISION	There should be opportunities to revisit and revise decisions in light of further evidence or arguments, and there should be a mechanism for resolving disputes.

[1] Gibson JL, Mitton C, Martin DK, Donaldson C, Singer PA. 2005. Ethics & economics: Does program budgeting and marginal analysis contribute to fair priority setting? *Journal of Health Services Research & Policy* 2006; 11(1):32-37.

[2] Mitton C, Donaldson C. *The Priority Setting Toolkit: A Guide to the Use of Economics in health Care Decision Making*. London: BMJ Books, 2004; Mitton C, Donaldson C. Doing health care priority setting: principles, practice and challenges. *Cost-effectiveness and Resource Allocation* 2004; 2(3).

[3] Daniels N, Sabin JE. *Setting Limits Fairly: Can we learn to share medical resources?* Oxford: Oxford University Press, 2002; Gibson JL, Martin DK, Singer PA. Priority setting in hospitals: fairness, inclusiveness, and institutional power differences. *Social Science & Medicine* 2005a; 16:2355-2361.

EMPOWERMENT	There should be efforts to optimize effective opportunities for participation in priority setting and to minimize power differences in the decision-making context.
ENFORCEMENT	There should be a leadership commitment to ensure that the first four conditions are met.

Appendix C: Implementation Toolkit

1. Implementation Guide

Below we offer some practical advice on how to implement each step of the priority setting framework. The steps align with the figure presented above.

Stage 1. Defining the aim and scope of the priority setting exercise

The first step is to determine the aim and scope of the priority setting activity. Determining the aim and scope of the activity is critical at the outset as this will have an impact on who sits on the priority setting committee (see Stage 2 below), what external stakeholders need to be engaged, and what criteria will underpin the process. Possible applications of the priority setting framework include:

- *New LHIN funding (e.g., MOHLTC strategic investments – Aging at Home):* Funding would be allocated based on a ranked list generated from assessment of the relative value of proposals according to relevant filters and decision criteria.
- *Health Service Integration Proposals (HSIPs)*: HSIPs would be prioritized according to relevant filters and decision criteria.
- *LHIN Budget Allocation (e.g., annual/multi-year, in-year)*: Based on the HSPs' inputs, the LHIN would identify and assess both investment and resource release opportunities. Trade-offs could be made within and across sectors to optimize LHIN and broader health system goals.
- *Emergency Response (e.g., Public Health Crisis)*: LHINs may face the challenge of making difficult decisions in the face of a public health crisis, whether an infectious disease epidemic or pandemic or similar public health emergency. Principles of fairness and public accountability are as important in these situations as in everyday situations – indeed, they are probably more important.

At this point, it is also critical to clarify *who* will be involved in the priority setting process, *what* roles and responsibilities they will have, and *how* accountability for the process will be ensured. For example, in a strategic exercise, the Board will typically have a role in determining the goal of the process, informing the development of relevant decision-making criteria, and providing high-level strategic oversight. Some organizations have drafted a memorandum of agreement between the Board and senior management specifying their respective roles. The role of priority setting committee should also be clear at the outset – will its role be primarily advisory or will it have a more active role in making priority setting decisions?

Stage 2. Establishing a priority setting committee

The priority setting committee is charged with systematically reviewing and prioritizing options using an explicit set of criteria and making recommendations to LHIN senior management. A well constituted committee should include both planning and funding portfolios. Multiple perspectives supports the goal of having all *relevant* reasons considered in setting priorities and ensures no one perspective or set of interests can dominate the decision-making. In some cases, it may be appropriate to engage a broader mix of health care providers, clinicians, or community members in the formal priority setting committee either as expert advisors or as members. An appropriate balance between inclusiveness and decision-making effectiveness is clearly necessary – too many people can make decision-making cumbersome, too few people can make decision-making insufficiently informed or leave some constituencies feeling disenfranchised. The key is in ensuring that all relevant stakeholders have an opportunity for their input to be brought to the decision making table. Thus, stakeholders should be made aware of the full range of opportunities available to them for contributing to or participating in the overall priority setting process. Experience from the LHIN pilots reinforces the importance of strong project management. A project manager should be identified to lead the day-to-day operational roll out of the priority setting process, including coordination of the priority setting committee.

Stage 3. Mapping existing resource mix

Health systems are complex and interdependent. It is important to have a clear picture of: a) what services are offered, how they are administered, and by whom, and b) a resource map of current activity and expenditure across (or within) HSPs and service areas under consideration. The resource map provides a starting point for coherent priority setting and resource re-allocation. In many instances the available information will only allow for financial reporting of budgeted (or contracted) services. While this provides a minimum level of information, ideally the existing mix of resources should be linked to a set of identifiable outcome measures. It is the link between resource inputs and performance outputs that fosters thinking about whether the existing mix is appropriate, and if it is not, where areas for service re-design should be considered. A further advantage of resource mapping is that it can identify gaps in critical data or differences in activity measurement and reporting across organizations. Given this information, the LHIN can adopt a more targeted approach in its data collection and resource mapping efforts.

Stage 4. Developing decision criteria with stakeholder input

Decision criteria are used to evaluate options systematically, explicitly, and with respect to relevant considerations under the circumstances. The priority setting framework proposes a set of 16 criteria, which LHINs can adapt to their context (see Appendix C.2a - Criteria Definitions). In adapting the criteria, consideration should be given to ensure that they: i) make sense in the local context (i.e., strategic situation, healthcare environment, client population, and community values), and ii) align with the aim and scope of the priority setting process. Criteria should be mutually exclusive, clearly defined, and, if appropriate, spelled out in terms of sub-criteria. It is important that the criteria be specified *a priori* and, if possible, weighted to reflect their relative importance. In addition, each criterion should have specified data/information requirements. If criteria are not explicitly weighted, the absence of such weighting implies equal weights across the criteria, which may or may not reflect the underlying values of those involved in setting priorities. Experience shows that the criteria development phase offers an important opportunity for constructive stakeholder engagement and buy-in. Some organizations have circulated a draft set of criteria to external stakeholders (e.g., HSPs, community) for comment; others have involved stakeholders directly in drafting the criteria. LHINs should be prepared to devote time

to define locally relevant decision criteria. It is important for the public defensibility of decisions that an explicit link can be made back to the evaluation criteria as well as any other relevant filters/screens that may have been applied. In some priority setting situations, it may be necessary to deviate from the agreed-upon weights. For example, a Ministry direction may require a LHIN to re-focus its planning or funding objectives with implications for how much weight ought to be given to some criteria over others. While it may be reasonable to change criteria weights mid-way through a planning or funding process, these changes should be explicit and transparent and the new weights ought to be applied consistently and systematically. Criteria "work" best if they are built into decision support tools. The priority setting framework includes three criteria-based tools: a criteria weighting tool, a proposal scoring tool, and a business case template (see Appendix C.2b-d). These tools are also provided in an accompanying Excel spreadsheet for local adaptation and use. These tools should be seen as an aid to decision-making not as decision-making tools per se. By facilitating the systematic collection of information and evaluation of project proposals against an agreed set of priority setting criteria, these tools contribute to reaching publicly defensible priority setting decisions.

Stage 5. Identifying and evaluating options

The priority setting committee is responsible for evaluating all project proposals against the criteria. The criteria-based scoring tool can help to ensure that the evaluation is systematic, consistent, and defensible. The result is a ranked list of project proposals from greatest to least alignment with the priority setting criteria. In general, the highest ranked submissions are understood to have priority access to institutional resources, i.e., if new resources become available, the higher ranked submissions would have "first right" to these resources, or if there is a need to cut program budgets to facilitate resource re-allocation within a fixed funding envelope, the higher ranked submissions might be given first consideration for protecting their existing budgets. In the case of a budgeting exercise, there would be two ranked lists of options: one for investment options and the other for disinvestment (or program re-design) options. To fund items on the first list, resources would need to be released from the second list in order of relative priority. In assessing options, it is important to have a clear understanding of the interplay between senior management and the priority setting committee as senior management may bring to the decision table additional criteria or considerations the committee is not necessarily privy to. Experience from the LHIN pilots showed that, while the priority setting committee would conduct the bulk of the evaluation, it may be helpful to have senior management input in completing Step #1 (Compliance Screen) and to have senior management complete Step #4 (System Readiness Screen) (see Appendix C.2c).

The aim and scope of the priority setting process and the specified criteria will determine to large extent what data and information is needed to make decisions. There are multiple data and information sources that may be relevant to inform the priority setting process. Examples include:

- Ministry and/or LHIN data,
- recent findings from research (e.g., outcomes studies, economic evaluations, health technology assessments),
- provincial or national policies/guidelines,
- environmental scan data,
- local utilization data, and
- informal input from relevant sources (i.e., narrative information).

Often health care decision-makers struggle with not having enough or the right data to make evidence-based decisions. Expert opinion can be a valuable source of information to fill some of the gaps. However, no matter how much or how little evidence is available, members of the priority setting committee are responsible for generating publicly defensible recommendations about local priorities and resources. Thus, where evidence is lacking, recommendations based primarily on 'expert' opinion should be identified explicitly and should be validated wherever possible by emerging evidence. LHINs should be clear with about their expectations about the 'evidence-base' provided in business case submissions. Experience from the LHIN pilots showed that it may be necessary to direct some resources toward levelling the playing field across provider organizations, whereby smaller organizations might require additional training or support in data collection, analysis, and business case development.

Stage 6. Communicating decisions and rationale

Stakeholders will be in a better position to accept allocation decisions if they can clearly see that the decisions are based on relevant reasons under the circumstances. This means that the rationale must be publicly accessible and clearly reflect how the decision is defensible in light of the priority-setting criteria and available data/information. The LHIN pilot evaluations showed that transparency is a critical and perhaps defining element of a fair priority setting process in the eyes of stakeholders. It is important to remember that transparency is not just about the transmission of information to stakeholders; it is also about keeping people engaged and invested constructively in the priority setting process. This might include specific training and information sessions, use of SharePoint resources, or the use of multiple communication vehicles, including public town hall meetings.

Communications should focus on building stakeholders' understanding of:

- the aim of the priority-setting process,
- the scope and necessity of priority setting at this time and in the present healthcare environment,
- the criteria that will be used to set priorities,
- the priority setting process itself (i.e., who will make decisions, how stakeholders can participate, how the process will unfold, what outcomes may result), and
- the rationale for funding decisions.

Communications should also be explicit about "must-dos" (e.g., MOHLTC directives) or other working assumptions (e.g., funding thresholds) that will limit the degrees of freedom in the decision-making context. It is clear that the more information that is provided to the HSPs in as many ways as is feasible within constrained resources is preferable. In the LHIN pilot evaluations, HSPs indicated a strong interest for feedback on their proposals and for an explicit rationale for funding decisions.

Stage 7. Providing formal decision review process

A formal decision review process is key mechanism for engaging stakeholders constructively around making difficult decisions and for resolving disputes. Prior to final recommendations being made, the priority setting committee should validate initial recommendations with relevant stakeholders. A fixed period of time should be set for the decision review process. At minimum, those individuals or groups who submitted proposals should have an opportunity to a revision request. In some cases, it may be appropriate to consider a third party decision review

committee or to task the senior leadership team with reviewing requests. Decision-makers are sometimes concerned that a decision review process may escalate conflict between stakeholders and decision-makers. Experience shows however that this is not likely to be the case if:

- the decision review process is open and transparent, and
- there are explicit decision review criteria to assess revision requests (e.g., new data/information, correction of material errors in the original decision, or procedural inconsistencies with a material impact on the decision outcome).

A priority-setting process that is responsive in this way has been described favorably by decision-makers as part of the spirit of inquiry that characterizes the learning organization. It may also play a critical role in building and sustaining confidence in the priority-setting process among decision makers and stakeholders.

Stage 8. Evaluating and improving the priority setting process

Evaluation strategies should be developed to ensure continued quality improvement and organizational learning. The evaluation can involve one-on-one interviews or focus group work with a broad range of stakeholders affected by the LHIN priority setting activity. An evaluation strategy could examine, for example:

- how fair the process was perceived to be in the eyes of key stakeholders (e.g., was it transparent, were decisions based on relevant reasons, were there opportunities for constructive decision review, were efforts taken to mitigate power differences among participating stakeholders?)
- whether proposals that have been implemented have delivered according to anticipated outcomes (e.g., were health or other gains realized, were the allotted resources adequate, were anticipated risks mitigated successfully?)
- how well the process performed in relation to local indicators of success, e.g., improved staff satisfaction with the priority setting exercise compared to previous exercises.

A formal evaluation can provide important insight into how the process can be improved. This can be accomplished in a number of ways: (a) before priority setting, by identifying opportunities for improvement in past priority setting and building these improvements into the present priority-setting exercise; (b) during priority setting, by monitoring the priority-setting process to assess alignment with fair priority setting and to allow mid-course corrections; or (c) after priority setting, by conducting a formal evaluation to capture lessons for future priority-setting exercises. The evaluation can involve one-on-one interviews, focus group work, and/or survey of a broad range of stakeholders affected by the priority setting activity. Experience shows that the principles of accountability for reasonableness provide a useful conceptual framework to identify good practices (i.e., fit with the principles) and opportunities for improvement (i.e., gaps). The Implementation Toolkit provides an Evaluation Checklist, which may be helpful in designing, monitoring, and evaluating the overall fairness of the priority setting processes locally (Appendix C.4). In some cases, it may make sense to have a third party evaluate the priority setting process. Having evaluated the process, it is important for the organization to report back on the findings, particularly to those individuals who participated in the evaluation, and to identify what steps the organization is proposing to take in order to improve the process (i.e., address the gaps).

2. Decision Support Tools

a) Criteria Definitions

This sheet provides a set of domains and criteria that can be used as a starting point for individual LHINs to adapt to their local context.

Domain	Criteria	Definition
Strategic Fit	Alignment with IHSP and/or ASP	Degree of impact on advancing IHSP and/or ASP goals and priorities.
	Alignment with provider system role	Extent to which program/initiative is consistent with the provider(s) mandate and capacity compared to other providers in Ontario or the local health system.
Population Health	Health status (clinical outcomes & QOL)	Impact on clinical outcomes for the patient/client, including risk of adverse events, and/or impact on physical, mental or social quality of life, as compared to current practice/ service.
	Prevalence	Magnitude of the disease/condition that will be directly impacted by the program/initiative as measured by prevalence (i.e., # of individuals with the condition in the population at a given time).
	Health promotion & disease prevention	Impact on illness and/or injury prevention and promotion of health and well-being as measured by projected longer term improvements in health and/or likelihood of downstream service utilization reduction.
System Values	Client-focus	Extent to which program/initiative meets the health needs of a defined population and the degree to which patients/clients have a say in the type and delivery of care
	Partnerships	Degree to which appropriate level of partnership and/or appropriateness of partnerships will be achieved in order to ensure service quality enhancement, optimal resource use, minimal duplication, and/or increased coordination.
	Community Engagement	Level of involvement of target population and other key stakeholders in defining the project and planned involvement in evaluating its impact on population health and key system performance.
	Innovation	Impact on generation, transfer, and/or application of new knowledge to solve health or health system problems; evidence of evaluation plan and application of leading practices.
	Equity	Impact on the health status and/or access to service of recognized sub-populations where there is a known health status gap between this specific population and the general population as compared to current practice/ service.
	Efficiency (operational)	Extent to which program/initiative contributes to efficient utilization of clinical, financial, and human resources capacity to optimize health and other benefits within the system.

Domain	Criteria	Definition
System Performance	Access	Extent to which program/initiative improves timely access to appropriate level of health services for defined population(s) in the local health system.
	Quality	Extent to which program/initiative improves safety, effectiveness, and client experience of health service(s) provided.
	Sustainability	Impact on clinical, financial, and human resources capacity over time.
	Integration	Extent to which program/initiative improves coordination of health care among health service providers to ensure continuity of care in the local health system and provision of care in the most appropriate setting as determined by patient/client's needs.

b) Criteria Weighting Worksheet

The Criteria Weighting Tool can be used to identify weights for each criterion. While some LHINs may choose not to weight their criteria, criteria weighting has three main advantages: a) it acknowledges and makes explicit the differential importance of criteria relative to funding or planning objectives, b) it limits the impact of subjective value judgments in evaluating planning or funding options, and c) it contributes to greater consistency across evaluators in applying the criteria.

Different methods can be used to determine criteria weights:

1. **Aggregation Method**: LHIN staff, providers and other stakeholders complete the worksheet (see below) on an individual basis. Points allocated by respondents are then averaged to generate a weight for each criterion and inserted into the 'weights' column of the worksheet.
2. **Consensus Method**: LHIN staff, providers and stakeholders meet together and work on a consensus basis to come up with a set of criteria weights at the group level. These weights would then be inserted into the 'weights' column of the worksheet.
3. **Combination Method**: LHIN staff, providers, and other stakeholders complete the table on an individual basis. Individual weights are aggregated, noting areas of significant agreement/disagreement in weights. Where there is significant agreement, these weights are inserted into the ‘weights’ column of the worksheet. Where there is significant disagreement, the consensus method can be used to reach agreement on weights or on a decision procedure to settle disagreements (e.g., voting).

The Aggregation Methods is best-suited to situations where there is already a solid base of consensus among participants or where the LHIN is interested in knowing whether there are any significant differences between the LHIN and/or stakeholder groups on criteria weights. The Consensus and Combination methods are preferable in situations where value-based disagreement is expected in weighting of criteria and/or

where achieving consensus is identified as an important outcome by the LHIN and its stakeholders.

Criteria Weighting Worksheet

Instructions: Allocate 0-20 points for each criterion to a total of 100 points across all criteria listed.

Domain	Criteria	Points
Strategic Fit	Alignment with IHSP and/or ASP	
	Alignment with provider system role (mandate & capacity)	
Population Health	Health status (clinical outcomes & QOL)	
	Prevalence	
	Health promotion & disease prevention	
System Values	Client-focus	
	Partnerships	
	Community Engagement	
	Innovation	
	Equity	
	Efficiency (operational)	
System Performance	*Access* to appropriate levels of health care services.	
	Quality of care and service provision.	
	Sustainability of the Ontario health care system.	
	Integration and coordination of health care among health services providers in the LHIN	
	Total:	100

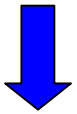
c) Proposal Scoring Tool

OVERVIEW:
Project proposals are assessed in 4 steps. In Step 1, project proposals are screened for their compliance with relevant laws, regulations, and contractual agreements. Only compliant project proposals move forward. In Step 2, each eligible project proposal is evaluated against predetermined decision criteria and given an overall benefit score based on the available evidence and rationale. Project proposals are ranked according to their overall benefit score. If desired, proposals can then be assessed according to cost-benefit. In Step 4, high-ranked proposals are screened for system readiness prior to final funding allocations. Steps 1 and 4 may be conducted by senior management whereas steps 2 and 3 could be carried out by the priority setting committee.

STEP 1. Compliance Screen
Project proposals are assessed to ensure their compliance with relevant laws or regulations and relevant contractual agreements. Other screening questions may be added as appropriate, e.g., alignment with funding or planning objectives.

1. Does the project violate any relevant laws or regulations?
   If no, PASS. Go to question 2.
   If yes, FAIL.

2. Does the project violate any relevant contractual arrangements? (e.g., MoHLTC-LHIN MOU, MLAA, HSAA)
   If no, PASS.
   If yes re. MLAA, FAIL.
   If yes re. HSAA, is it negotiable? If yes, PASS. If no, FAIL.



All project proposals that PASS move forward to Step 2.

STEP 2. Evaluation
Project proposals are evaluated and rated against the decision criteria based on available evidence and rationale provided with the proposal submission.

		Guidelines for rating				Scoring		
DOMAIN	**CRITERION**	**0 points**	**1 point**	**3 points**	**5 points**	**Rating[1]**	**Weight[2]**	**Overall score[3]**
Strategic Fit	Alignment with IHSP and/or ASP	Not aligned with any IHSP/ASP priorities or goals	Minimal impact on advancing IHSP priorities or goals	Strong impact on *one* IHSP priority or goal, and/or some impact on one or more IHSP priorities or goals	Strong impact on advancing *more than one* IHSP priority or goal			0.00
	Alignment with provider system role	Not aligned with provider system role and/or project is better aligned with another provider's health system role.	Some alignment with provider mandate and/or there are significant capacity constraints.	Strong alignment with provider mandate, but there are some capacity constraints	Strong alignment with provider mandate and capacity			
Population Health	Health status (clinical outcomes & QOL) [4]	No improve-ment in health status	Minimal improvement in health status	Moderate improvement in health status	High degree of improvement in health status			
	Prevalence[5]	very low (rate/100,00	low (rate/100,000 =	moderate (rate/100,000 =	high (rate/100,000			

		Guidelines for rating				Scoring		
DOMAIN	**CRITERION**	**0 points**	**1 point**	**3 points**	**5 points**	**Rating[1]**	**Weight[2]**	**Overall score[3]**
		0 = < 1)	1-10)	10 -1000)	= 1,000-10,000)			
	Health promotion & disease prevention[6]	No improve-ment (e.g., no change in service utilization)	Minimal improvement (e.g., 1-10% reduction in service utilization)	Moderate improvement (e.g., 11-20% reduction in service utilization)	High degree of improvement (e.g., 20+% reduction in utilization)			
System Values	Client-focus[7]	No difference compared with current services	Minimal improvement compared with current services	Moderate improvement compared with current services	High level of improvement compared with current services			
	Partnerships	Lack of appropriate partnerships	Limited appropriate partnerships	Moderate appropriate partnerships	High level of appropriate partnerships			
	Community Engagement	Complete lack of community engagement	Limited community engagement	Moderate community engagement	High level of community engagement			
	Innovation[8]	Not innovative	Small gains in innovation	Moderate gains in innovation	Large gains in innovation			
	Equity[9]	No impact on equity	Small impact on equity	Moderate impact on equity	Large impact on equity			
	Efficiency (operational) [10]	0-10% greater efficiency	10-20% greater efficiency	20-30% greater efficiency	30+% greater efficiency			

		Guidelines for rating				Scoring		
DOMAIN	**CRITERION**	**0 points**	**1 point**	**3 points**	**5 points**	**Rating[1]**	**Weight[2]**	**Overall score[3]**
System Performance	Access	No impact on improving access.	Marginal impact on improving access or advancing MLAA performance objectives.	Moderate impact on improving access, and/or advancing MLAA performance objectives for some target populations.	Significant impact on improving access, and/or advancing MLAA performance objectives for target population across the health system.			
	Quality[11]	No impact on improving quality.	Marginal impact on improving quality or advancing MLAA performance objectives.	Moderate impact on improving quality, and/or advancing MLAA performance objectives for some client populations.	Significant impact on improving quality, and/or advancing MLAA performance objectives across the health system.			
	Sustainability	Not sustainable or adverse impact on health system capacity over time.	Project requires significant resource investment in order to be viable and sustainable.	Project requires start-up funds, but will be viable and sustainable following initial investment.	Project is viable and sustainable within available resources and/or project creates new			

		Guidelines for rating				Scoring		
DOMAIN	**CRITERION**	**0 points**	**1 point**	**3 points**	**5 points**	**Rating[1]**	**Weight[2]**	**Overall score[3]**
					resource capacity in the local health system.			
	Integration[12]	No appreciable improve-ments in continuity of care or provision of care in appropriate settings.	Project has limited impact on continuity of care or provision of care in appropriate settings.	Project improves continuity of care and advances MLAA performance objectives for some client populations.	Project improves continuity of care and advances MLAA performance objectives across the local health system.			
							100.00	

Proposals EITHER move forward to optional Step 3 (cost-benefit analysis)

OR top ranked proposals move forward to the Step 4 (system readiness screen.)

STEP 3. Cost-benefit analysis (optional)

To calculate a cost-benefit ratio, the overall benefit score for each proposal can be divided by the total project operating cost and adjusting for scale by dividing the operating cost by the total number of patients/clients served by that proposal. Top ranked proposals (lowest cost-benefit ratio to highest) would then move forward to Step 4 (system readiness screen).

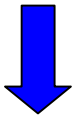
STEP 4. System Readiness Screen (N.B. Other screens can be added as appropriate.)

LHIN capacity: Does the LHIN have the needed material, financial, and health human resources to support this project at this time? If the project is sufficiently important, are there ways to leverage system resources to make the project viable now or in the future?

Interdependency: Does this project depend on the completion of other projects? Are other high-priority projects depending on the completion of this project? Is this project aligned with other projects that would need also to be funded in order for them to be viable?

Risk: Is the level of risk involved acceptable? Have mitigation strategies been identified to address this risk and are they practical? What are the risks of not funding or endorsing this project at this time?

Health system impact: Does this project raise any considerations of health system impact that were not addressed in the evaluation process? What impact would funding this project have on other fundable projects in terms of material, financial, and health human resources?



Proposals satisfying the system readiness screen are eligible for funding as per the rank order identified through the process.

Notes:

1. Only responses of 0,1,3,5 can be entered into this column.
2. This is the average weight that is obtained from the individuals that were polled. The sum of all the values in this column should equal 100 (slight variation may arise due to rounding).
3. Overall score is the sum of the rating on each criterion (0 to 5) multiplied by the weight of that criterion, scaled to a maximum score of 100.
4. Improvement can be defined as comparison of proposed intervention with current/existing practice measured against any one of the following parameters: mortality; quality of life (physical, mental or social wellbeing); life circumstance; client satisfaction/perception of well-delivered service; or improved standard of care.
5. Number of individuals in the population with the condition at a given time.
6. Likelihood that program/service as proposed will reduce downstream service utilization or measurably increase longer term health outcomes.
7. Client focus measured against the following: consistency with health needs of population and/or extent to which patients/ clients get a say in type/delivery of care.

8. Innovation determined, for example, in terms of application of leading practices, knowledge generation and transfer, and novelty in addressing health or health system problems.
9. Impact on the health status and/ or access of disadvantaged or vulnerable sub-populations.
10. Impact on utilization of clinical, staff, or other resource capacity.
11. Quality considers: client/patient safety, overall client/patient experience, HHR well-being, and MLAA performance objectives regarding quality.
12. Integration considers: continuity of care, care provision in appropriate settings, and MLAA performance objectives.
13. Each of the components listed below can be viewed as hurdles: the more hurdles cleared, the more likely the proposal is 'ready to go'.

d) Business Case Template

A generic business case template is provided here. Note that it is designed to capture information (i.e., evidence, rationale) specifically related to the funding/planning objectives and decision criteria. It could be augmented further with guidelines about the use of evidence.

Business Case Template

Sponsor:

Portfolio Lead / Originator:

Portfolio:

Date:

INITIATIVE TITLE:

1. SUMMARY:

Provide a brief, clear description of the proposed initiative. State whether this is an integration, investment or disinvestment proposal, and if the latter, whether it is a proposal for service reduction or operational efficiency.

2. DETAILED DESCRIPTION: What is being proposed?

Describe the proposed initiative, including details about the following:

- Proposed health service change - What intervention is being proposed?
- Target population – How many clients served, what impact on those clients?
- Service impact – What impact will this intervention have on current service levels and what new service levels are expected for this target population?
- Location of services – Where will the service be provided and by whom?
- System partners – Who is partnering on this initiative and what is each partner's role?
- Key planning assumptions – What assumptions (e.g., demographic, HHR capacity) were made in developing this proposal?

3. RATIONALE: Why should we do it?

Provide a rationale for implementing this initiative. In your rationale, please address the following considerations and provide supporting evidence wherever possible:

- Alignment with the LHIN's IHSP priorities and goals.
- Alignment with each provider's system role, including mandate and capacity (i.e., why should these providers do this?).
- Contribution to improving population health (i.e., health status, prevalence, health promotion and/or disease prevention).
- Contribution to fulfilling key local and health system values (i.e., client-focus, partnerships, community engagement, innovation, equity, operational efficiency).
- Contribution to improving LHIN health system performance (i.e., access, quality, sustainability, and integration).

4. IMPACT: What results or outcomes are expected?

Describe the expected results or outcomes of implementing this initiative. Provide details with supporting evidence wherever possible about:

- Expected outcomes (positive and negative).
- How outcomes will be tracked and measured.
- Impact on key stakeholders (e.g., HHR, other clients/patients, other providers).
- Impact on other health services in the local health system.
- Impact of not proceeding with this initiative? (Investment proposals only)

5. RISKS: What risks does this initiative pose and how would these be mitigated?

Please identify any anticipated risks and proposed strategies for mitigating these risks. A variety of risks may apply including legal, operational, financial, reputational, or political risks.

6. LHIN CAPACITY: Do we have the capacity to do this?

Describe the capacity requirements to support this initiative. Identify any gaps and possible strategies to bridge these gaps. Consider:

- Capital requirements (e.g., equipment, space, systems development).
- Health Human Resource requirements.
- Technological requirements (e.g., information systems, personnel).
- Administrative services requirements (e.g., decision support, financial analysis, human resource, project management).
- Direct care support costs (e.g., housekeeping, plant operations, patient transportation, security).

7. IMPLEMENTATION PLAN: How would we do this?

Provide details about the following:

- Timeline, including lead time required from decision to implementation and anticipated start date (month/year).
- Action Plan, including phasing/sequencing of activities.
- Key Milestones.
- Communications Plan.
- Human Resources Plan.
- Change Management Plan.
- Evaluation Plan (including key success factors and performance indicators).

8. FINANCIAL SUMMARY: (to be developed with your budget manager/analyst)

Provide details about the following as relevant to your proposal*:*

- Funding assumptions.
- Capital Costs – start up and recurring.
- Operating Costs – start up and recurring.
- Cost impacts for affiliated services (labs, pharmacy, medical imaging).
- Cost Impacts for administration & overheads (food services, information management).
- Revenues (net of allowance for doubtful accounts).
- Write-down of assets.

3. Work plan and timeline

The eight-stage priority setting framework can be operationalized further into four multi-step phases, outlined below. On the next page, these actions steps are mapped out with suggested accountabilities and timeline.

Preparation and Training	1. Determine the aim and scope of the priority setting exercise and clarify decision-making roles/responsibilities. 2. Identify a local project manager or lead. 3. Establish priority setting committee. 4. Identify key decision inputs and key stakeholders. 5. Compile a map of existing activity and expenditure. 6. Provide formal training for decision-makers and stakeholders.
Process Development	1. Develop decision criteria linked to the priority setting aim, LHIN values, and other relevant considerations in consultation with stakeholders. 2. Develop criteria-based decision support tools to collect relevant data/information (i.e., business case template) and to facilitate evaluation and ranking of proposals (i.e., scoring tool). 3. Develop formal communication plan to support the process. 4. Develop decision review mechanism. 5. Develop evaluation strategy.
Process Implementation	1. Communicate call for proposals, including priority setting aim and scope, criteria, and process to stakeholders. 2. Provide support to HSPs as needed in preparation of proposals. 3. Evaluate and rank proposals using decision support tools and available data/information. 4. Develop draft recommendations based on the ranked list of options. 5. Solicit stakeholder feedback on draft decisions using a formal decision review process. 6. Communicate final decisions with a clear rationale linked back to the priority setting goal and criteria.

Evaluation	1. Evaluate the priority setting process to identify good practices and opportunities for improvement. 2. Revise process for next planning cycle.

The following table outlines the four phases of the priority setting process, key action items, accountabilities, and a possible timeline for a medium scale priority setting initiative determined by the number of expected project proposals and involved stakeholders.

Phase	Action Step	Accountability	Timeline *
Preparation and training	➢ Determine aim and scope of priority setting process in relation to strategic goals and context.	LHIN CEO and Senior Directors (may include Board input)	Month 1
	➢ Identify project leader and form a priority setting committee, including clarification of roles and responsibilities.	LHIN CEO and Senior Directors	Month 1
	➢ Conduct environmental scan of decision inputs and stakeholders (external/internal), and identify any possible barriers and facilitators to priority setting process.	LHIN staff	Month 1
	➢ Compile map of existing activity and expenditure, linking to output data where available.	LHIN staff	Month 1
	➢ Provide training in economic and ethical principles and process to inform priority setting.	LHIN staff, priority setting committee, and HSPs	Month 1
	➢ Issue initial communication to stakeholders about the priority setting process using existing communication mechanisms.	LHIN CEO and Senior Directors	Month 1
Process development	➢ Develop draft decision making criteria (and weights), gather feedback from stakeholders, and revise in light of feedback.	Priority setting committee with stakeholder input	Month 1-2
	➢ Finalize criteria definitions and weight criteria.	Priority setting committee	Month 1-2
	➢ Revise proposal scoring tool and business case template to local context, as required.	Priority setting committee and LHIN staff	Month 1-2
	➢ Develop formal communication plan.	LHIN Senior Directors & staff	Month 2
	➢ Develop decision review mechanism.	LHIN Senior	Month 2

Phase	Action Step	Accountability	Timeline *
		Directors & staff	
	➢ Develop evaluation strategy.	LHIN Senior Directors & staff	Month 2
Process implement-tation	➢ Communicate call for proposals to stakeholders (including details about aim/scope, criteria, and process) and invite submission of 'idea sheets' from HSPs about possible projects.	LHIN CEO and Senior Directors	Month 2
	➢ Prepare 'idea sheets' with attention to aim/scope and criteria.	HSPs	Month 2
	➢ Review idea sheets using compliance screen and evaluation criteria, invite full business cases for top-ranked projects, and provide general feedback on unsuccessful submissions.	Priority setting committee	Month 3
	➢ Prepare business case proposals.	HSPs	Month 3-4
	➢ Support HSPs as needed in preparation of business case proposals, including training sessions, guidelines for use of evidence, etc.	Priority setting committee & LHIN staff	Month 4
	➢ Evaluate business cases using proposal scoring tool and make draft recommendations.	Priority setting committee with CEO & Senior Director input	Month 4-5
	➢ Solicit feedback on draft decisions and revise if necessary.	LHIN staff and HSPs	Month 5
	➢ Finalize and communicate decisions with explicit rationales.	CEO and Senior Directors	Month 5
Evaluation	➢ Engage stakeholders in identifying good practices and opportunities to improve.	LHIN staff	Month 6
	➢ Develop plan to implement improvements in next cycle.	LHIN staff	Month 6

*Depending on the aim and scope, the process may be streamlined and certain steps may be omitted.

4. Evaluation Checklist

This checklist provides a starting point to assist you in monitoring and evaluating your priority setting process using the principles of accountability for reasonableness as a guide (see Appendix B).

RELEVANCE: Decisions should be based on reasons (i.e., evidence, principles, values, arguments) that fair-minded people can agree are relevant under the circumstances.	
▪ Were appropriate criteria used to set priorities? (Do stakeholders agree that the criteria were appropriate?)	
▪ Were available data and information sufficient to make evidence-guided decisions? (What critical gaps in data/information need to be filled for future priority setting?)	
▪ Was a rationale for each decision clearly identified based on aim and scope of the priority setting process, the decision criteria, and available data/information?	
PUBLICITY: Decisions processes should be transparent and decision rationales should be publicly accessible.	
▪ Were the context, aim and scope, criteria, processes, and possible outcomes of the priority setting process communicated clearly from the outset and throughout to both LHIN staff and external stakeholders?	
▪ Was the decision and its rationale communicated clearly to stakeholders?	
▪ Was the communication plan effective in reaching affected stakeholders, including HSPs, patient/client populations, and the community? (How do you know? What do we need to improve for future processes?)	
REVISION: There should be opportunities to revisit and revise decisions in light of further evidence or arguments, and there should be a mechanism for resolving disputes.	
▪ If stakeholders had concerns about the decision process or the outcomes, did we provide an effective mechanism to capture and respond to these concerns in a timely fashion? (How do you know? What do we need to improve for future processes?)	
▪ Were there opportunities to revisit and revise decisions on the basis of new evidence or argument, and a validation process to engage stakeholders around draft decisions?	
▪ Did any decisions change as a result of these revision processes?	
EMPOWERMENT: There should be efforts to optimize effective opportunities for participation in priority setting and to minimize power differences in the decision-making context.	

▪ Were any stakeholder views allowed to dominate the decision-making process? (What was the effect? How well did we manage this?)	
▪ Were there any stakeholders that we realize in retrospect that we ought to have engaged, but did not? (What are we doing now to engage them?)	
▪ Given differential internal capacity across HSPs, were their mechanisms in place to support those with less capacity and ensure a more level playing field, especially in the development of project proposals?	
▪ Were we attentive to the impact of our decisions on vulnerable client or patient populations? (How are we monitoring this?)	
ENFORCEMENT: There should be a leadership commitment to ensure that the first four conditions are met.	
▪ Were we disciplined in our commitment to apply the priority setting framework consistently and if we needed to depart from it, were we able to articulate good reasons for this to our stakeholders?	
▪ Was a formal evaluation strategy implemented to monitor progress and to identify good practices and opportunities for improvement?	
▪ Is there a mechanism in place to learn from this experience to improve future iterations?	

Appendix D: List of Reference Material

Included here is a list of cited and recommended literature:

Ashton T, Cumming J, Devlin N. Priority-setting in New Zealand: translating principles into practice. *Journal of Health Services Research and Policy* 2000; 5(3):170-5.

Bohmer P, Pain C, Watt A, Abernethy P, Sceats J. Maximising health gain within available resources in the New Zealand public health system. *Health Policy* 2001; 55(1):37-50.

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Ham C, Coulter A. Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices. *Journal of Health Services Research and Policy* 2001; 6(3):163-169.

Mitton C, Donaldson C. *The Priority Setting Toolkit: A Guide to the Use of Economics in Health Care Decision Making*. London: BMJ Books, 2004.

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Peacock S, Ruta D, Mitton C, Donaldson C, Bate A, Murtagh M. Using economics for pragmatic and ethical priority setting: two checklists for doctors and managers. *British Medical Journal* 2006; 332:482-485.

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