An Evaluation of the Rapid Risk Factor Surveillance System (RRFSS):
A System to Collect Public Health Surveillance Data in Ontario

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RRFSS Evaluation Group

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List of Abbreviations

Agency	Ontario Health Protection and Promotion Agency
AMOH	Associate Medical Officer of Health
CCHS	Canadian Community Health Survey
ISR	Institute for Social Research, York University
LHIN	Local Health Integration Network
MHP	Ministry of Health Promotion
MHPSG	Mandatory Health Programs and Services Guidelines
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
PHRED	Public Health Research, Education and Development Program
RRFSS	Rapid Risk Factor Surveillance System
SPSS	Statistical Package for the Social Sciences

An Evaluation of the Rapid Risk Factor Surveillance System (RRFSS):

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EXECUTIVE SUMMARY

RRFSS has continued to evolve and expand since the 2001/02 evaluation. The Memorandum of Understanding which outlines the roles and responsibilities of each partner is supported by all participating health units and the Institute for Social Research (ISR). Processes and guidelines are described in the Manual of Operations (MOO). Options to increase a health unit's sample have been established and there is an ongoing commitment to ensure timely receipt of the datasets.

RRFSS activities are time-consuming, requiring on average, 0.6 FTE epidemiologist or data analyst in each participating health unit. RRFSS representatives report that the time they spend on RRFSS is inadequate to complete all work to their satisfaction. Health unit resources required to support RRFSS are also frequently inadequate.

RRFSS representatives spend about three and one half days per month, on average, on tasks related to data management and analysis. Centralized support, especially in the analysis of core modules, would reduce this workload. Dissemination activities are also time-consuming, requiring 3 days per month, but RRFSS representatives feel that the responsibility for these activities should remain at the local level.

Most data analysis is done in response to data requests, although other dissemination strategies such as reports and presentations to program staff would be more efficient and proactive. More support at the local level is needed to improve analysis and dissemination in the 60% of health units reporting that dissemination is inadequate.

Generally, most health units report high usage of RRFSS results at all staff levels and for all purposes. RRFSS results are being used for program planning and evaluation in almost all health units, but not to an optimal extent. Many program staff lack the skills to use the information that RRFSS provides. Further education of program staff is needed.

Chronic Disease Prevention, Child Health, Early Detection of Cancer and Injury Prevention, Including Substance Abuse Prevention are the programs for which RRFSS results are most often used. Results are rarely used for Infection Control and Sexually Transmitted Diseases, Including HIV/AIDS. The use of RRFSS results likely parallels the availability of modules. Whether modules need to be developed in the other program areas is a complicated question. Within the Sexual Health program, for example, surveillance data would be valuable, but the appropriateness of sexual health content in a telephone survey has been questioned.

Sharing of RRFSS data with local and provincial agencies and organizations occurs in two-thirds of RRFSS-participating health units. Advantages of sharing datasets include maximizing the use of RRFSS, promoting RRFSS, sharing in analysis and dissemination tasks and sharing the costs of RRFSS. Disadvantages include extra workload for the RRFSS representative, the risk that agencies will know or disclose sensitive information about a health unit and the risk that it will be used for profit. Formal approval processes, including data-sharing agreements, should be in place. In all cases, use of the data should be congruent with the mandate of public health.

The majority of RRFSS representatives and medical officers of health feel that external agencies should have access to RRFSS data for provincial level analyses. However, support is much lower, particularly among the RRFSS representatives, for external agencies' access to RRFSS data for local level analyses. User fees are not strongly supported for publicly funded organizations but in some cases may help to offset administrative costs of RRFSS. A streamlined process for data-sharing is needed as interest from external agencies is likely to increase with a provincial system.

Allowing external agencies to pay for questions on the RRFSS interview is not strongly supported and is not without risks. These include a loss of control over content, potential reductions in the quality of questions and a reduction in the number of questions which health units are permitted to ask. The benefits are financial.

RRFSS representatives and medical officers of health are not supportive of external agencies as partners in RRFSS. A loss of control over the survey and deviation from the original intent of the survey as a surveillance system were identified as potential risks. There was agreement that agencies should not have the same status as a participating health unit, but should be invited for their expertise and influence.

The quality of RRFSS data is generally good. Improvements would be achieved by taking more care to ensure that modules properly address data needs, testing questions for reliability and validity, correcting data quality issues as they arise and addressing sampling issues.

The efficiency of the RRFSS partnership can be increased by greater centralized support for many RRFSS tasks, including core module selection, data management and external presentations of RRFSS results. Tasks such as optional module selection, dissemination within the health unit and local presentation of results should remain local functions.

Module development and review are generally conducted in a satisfactory way, but are time-consuming processes. More staff resources and streamlined protocols are needed. Smaller working groups might help with the process. It is critical to include program staff as well as experts in questionnaire development.

Decision-making within the working groups--Steering, Regional and Analysis Groups--is felt to be effective about half of the time. It was suggested that decision-making processes could be streamlined by giving more autonomy to the Steering and Analysis Groups to make decisions on behalf of the partnership, but there are trade-offs in the democratic processes that have historically been part of the RRFSS philosophy. More administrative support for all three groups is needed.

The cost and resource requirements of RRFSS are significant barriers for non-participating health units. However, the majority of RRFSS representatives, medical officers of health and respondents from non-participating health units feel that it is important that all health units participate in RRFSS. Funding and support of centralized services and personnel, in addition to promotion of RRFSS, would support participation.

There is broad support for the Ministry of Health and Long-Term Care (MOHLTC) to help fund the survey contract costs.   A number of potential funding models for data collection were suggested; these ranged from 100% MOHLTC funding to cost sharing proposals. There are advantages and disadvantages for each. While 100% MOHLTC funding would provide stable funding, there could be loss of local flexibility and control over content. The majority of all respondent groups supported 100% MOHLTC funding of other RRFSS costs such as the RRFSS coordinator position and RRFSS website, and there was substantial support for MOHLTC funding of centralized data analysis and the RRFSS workshop.

MOHLTC funding of RRFSS would reduce cost as a barrier to participation, especially if support services in the health units and centrally were also funded. This would facilitate a province-wide RRFSS dataset that could be used for planning and evaluating provincial initiatives, as well as providing comparative data for regional or health unit level analyses. The utility of RRFSS would be greatly increased if it allowed the calculation of provincial estimates.

Loss of local control and flexibility are concerns expressed by all groups of respondents if the MOHLTC were to fund RRFSS. Suggestions to increase the stability of RRFSS included the provision of funds through health unit base budgets or through another agency such as the Ontario Health Protection and Promotion Agency (Agency). The two factors cited most often to increase buy-in from the MOHLTC are better validated modules and more centralized staff.

There was some variation in opinion as to the roles that other Ministries and agencies could play in RRFSS. The Ministry of Health Promotion (MHP) and the Agency were both mentioned as alternative agencies for provision of funding, support or infrastructure for RRFSS.   The Agency is seen as having a coordinating role for RRFSS, housing centralized staff, providing expert advice, conducting provincial analyses and ensuring knowledge transfer and exchange.

Universal participation in RRFSS is felt to confer significant benefits in terms of a province-wide representative sample. It enables comparisons on multiple levels--health units, Local Health Integration Networks (LHINs), regions and the province.

There was agreement from all key informants that provincial representation for RRFSS data is desirable. There are many potential users of provincial RRFSS data, particularly from the Ontario government. The uses for provincial data are consistent with the purpose of RRFSS: setting targets, monitoring trends, supporting planning and evaluation, and comparison purposes. The timeliness of the RRFSS data is a benefit.

Financial and human resource investment is needed to support RRFSS provincially. In expanding RRFSS provincially, there is a need to balance local and provincial interests to ensure that RRFSS maintains its value for local priority setting.

RECOMMENDATIONS

The strengths of RRFSS are its capacity to provide quality data to meet information needs for program planning and evaluation as set out by the Mandatory Health Programs and Services Guidelines (MHPSG), to provide these data in a timely manner and to meet these needs at the local level. RRFSS has demonstrated its flexibility to address emerging local health needs. The present challenges facing RRFSS include a heavy workload at the local level, the fact that not all health units participate, sub-optimal use of RRFSS results and the need for continuous quality improvement.

It is worth noting that this evaluation was conducted at a time of revitalizing and renewing public health in Ontario. Moreover, the roles of the MOHLTC, the new MHP, the Agency and other strategic partners, and their involvement with RRFSS, will likely evolve over time as the new agencies and their mandates are established.

The following recommendations are drawn from the results of the report, and structured to meet the four objectives of the evaluation. They are directed primarily to the RRFSS partnership, but will also be of interest to current and future users of RRFSS data. They are presented here in such a way as to improve RRFSS at the partnership, local and provincial levels, but not necessarily in order of importance. The recommendations are designed to increase the efficiency of the system, increase the use of local data, achieve universal participation, and facilitate the appropriate use of provincial data.

At the level of the partnership, it is recommended that:

1. More autonomy be given to the Steering and Analysis Groups to make decisions on behalf of the partnership. This will improve the efficiency of the partnership.

At the level of the health unit, it is recommended that:

2. Each health unit dedicate at least 0.6 FTE for RRFSS-related activities, to ensure that the health unit is able to fully participate in RRFSS and to ensure that results are used.
3. There be increased marketing of RRFSS to all staff within each health unit to acquaint them with the potential uses of RRFSS. Health unit staff should be encouraged to use RRFSS results, to participate in the development of new modules and to participate in module review.
4. The process of module development include methodological experts as well as program staff. This will ensure new modules are of high quality as well as useful to program staff.

At the provincial level, it is recommended that:

5. RRFSS be incorporated as a requirement in the next revision of Mandatory Health Programs and Services, ideally within Program Planning and Evaluation.
6. Provincial funding be provided for the collection of RRFSS data in all health units in the province of Ontario. This would ensure universal access to RRFSS and would provide a representative provincial dataset.
7. Provincial funding be provided for the 0.6 FTE position recommended in all Ontario health units for local RRFSS-related activities. This would ensure that all health units are able to fully participate in RRFSS and have the resources to use the results.
8. Provincial funding be provided for centralized staff (analyst, coordinator, webmaster) as a cost-effective measure to reduce duplication and improve the efficiency of the partnership.
9. Provincial funding be provided to maintain the RRFSS Website and hold the annual RRFSS Workshop. These central resources are necessary for the dissemination of results, increased efficiency (by such means as access to syntax and analysis files) and continuous quality improvement.
10. The RRFSS dataset be made available free of charge (except for administrative charges) to external, non-profit agencies for regional and provincial level analyses, but only for purposes that are consistent with the public health mandate.

An Evaluation of the Rapid Risk Factor Surveillance System (RRFSS):
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BACKGROUND

"Ontario's RRFSS is a flexible, timely and responsive surveillance system designed to meet local Public Health intelligence needs and address information, geographic and time related data gaps."
RRFSS Mission Statement, RRFSS Strategic Plan Report, 2004

Description of RRFSS

The Rapid Risk Factor Surveillance System (RRFSS) is an on-going telephone survey used to gather surveillance data, to monitor public opinion on key public health issues and to collect information on emerging issues of importance to public health. The purpose of RRFSS is to provide timely data, relevant to local public health needs. The results are used to support program planning and evaluation, to advocate for public policy development and to improve community awareness regarding the risks for chronic diseases, infectious disease and injuries.[1]

The survey uses computer assisted telephone interviewing (CATI) technology, with sampling based on random digit dialing (RDD). Interviews are conducted by the Institute for Social Research (ISR) at York University, on behalf of all RRFSS-participating health units.[2] Each month, a random sample of 100 adults aged 18 years and older is interviewed regarding risk behaviours and knowledge, attitudes and awareness about health-related topics of importance to public health.

The survey consists of 'core' and 'optional' modules. All participating health units ask core modules that are selected by RRFSS representatives from all participating health units. Each health unit selects additional optional modules, until the average interview length reaches 20 minutes. Any participating health unit can initiate or create new optional modules. A description of core and optional modules at the time of this evaluation is attached as Appendix A.

The survey cycle begins each January. In the typical cycle, 100 interviews are completed in each of the following 12 months, for a total of 1,200 interviews per year in each participating health unit. Health units receive the data in SPSS (Statistical Package for the Social Sciences) format from ISR approximately two months after each month of data collection.[3]

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[1] Rapid Risk Factor Surveillance System. "About RRFSS" http://www.rrfss.on.ca accessed Jan 31, 2006.

[2] Rapid Risk Factor Surveillance System. "Home" http://www.rrfss.on.ca accessed Jan 31, 2006.

[3] Elsbett-Koeppen, R. Personal Communication to Amira Ali, November 30, 2005.

To assist in coordinating all of the activities required by RRFSS, each participating health unit identifies a RRFSS representative, often the epidemiologist or data analyst involved in the analysis and reporting of RRFSS results. An additional position of provincial RRFSS coordinator has existed since June of 2003. The coordinator works with the RRFSS Steering Group to facilitate the planning, organization, coordination and maintenance of RRFSS. The coordinator represents and acts on behalf of all RRFSS partners and seeks new opportunities for the promotion of RRFSS.

RRFSS representatives meet locally in Regional Working Groups, of which there are four. (The north and the east form one working group, because there is only one northern Ontario health unit participating in RRFSS.) One RRFSS representative from each Regional Working Group, together with the provincial RRFSS coordinator and members of ISR, constitute the provincial Steering Group. There are other working groups, whose activities and membership vary. An Analysis Group sets out analysis guidelines, reviews data dictionaries and responds to analysis issues. A Website Group manages the RRFSS website. A Workshop Planning Group plans and implements the annual RRFSS Workshop. Other ad hoc committees are created as needed. The RRFSS Evaluation Group is one such ad hoc group; the task of this group was to work with the Public Health Research, Evaluation and Development Program (PHRED) to oversee the 2005 evaluation.

The Terms of Reference for all working groups as well as the roles and responsibilities of the RRFSS coordinator are contained in a Manual of Operations (MOO).

Brief History of RRFSS

RRFSS was initiated as a pilot project aimed at conducting a survey of health-related risk factors in Durham region from June to October, 1999. The intent of the survey was to fill a need for ongoing, timely risk factor surveillance data at the health unit level. Timely data at the health unit level were not readily available from the national survey then in place (National Population Health Survey 1996/97) or under development (Canadian Community Health Survey (CCHS) 2000/01). The pilot survey was modeled on the Behavioral Risk Factor Surveillance System carried out in the United States. The Laboratory Centre for Disease Control of Health Canada, the Ontario Ministry of Health and Long-Term Care (MOHLTC), Cancer Care Ontario and the Durham Region Health Department were partners in the pilot project.

The successful pilot project prompted the establishment of a RRFSS Working Group, consisting of representatives of Durham Region Health Department, Haliburton, Kawartha, Pine Ridge District Health Unit and the Simcoe County District Health Unit. The Working Group revised the questionnaire, developed data dictionaries and

encouraged other health units to participate. By the end of 2001, 12 health units were involved in RRFSS.

In 2001, funding for Perinatal and Child Health Survey Strategies was announced by the Minister Responsible for Children and the Minister of Health and Long-Term Care. All Ontario health units were eligible, and many used part of these funds to become involved in RRFSS. Consequently, the number of participating health units grew to 21 in 2002 and 24 in 2003. Participation has remained relatively stable since then, including 23 health units in 2004 and 22 in 2005.

Because of the increasing complexity of coordinating activities, the position of provincial RRFSS coordinator was created in 2003. Participating health units share the costs of the RRFSS coordinator.

Previous Evaluations of RRFSS

Pilot Project: 2000
An evaluation of the pilot project concluded that the pilot was successful (Stewart and Sales, 2000). It demonstrated that the RRFSS had flexible content, had an adequate response rate, resulted in a sample similar in language, age and education to other surveys, provided timely and useful data, and constituted a working model that could be expanded to other health regions. Funding was identified as an issue affecting expansion of RRFSS to other health units and sustainability.

2001/02 Evaluation
By the end of 2001, 12 health units were participating in RRFSS. An Evaluation Subgroup of the RRFSS Working Group, including a member from PHRED and with the assistance of an evaluation consultant, conducted an evaluation in 2001 and 2002 (Ontario RRFSS Working Group, 2002). An Evaluation Framework identified four key components: process issues, collaboration, usefulness and cost effectiveness.

In the area of *process,* there was general satisfaction with questionnaire development, content and implementation. Data quality was felt to be adequate, but data analysis was found to present challenges. Although results were being disseminated, receipt of data from ISR was slow and therefore timeliness was an issue. In the area of ***collaboration,*** there was general satisfaction with the working relationships among the partners and within the working groups. With respect to ***usefulness,*** research staff at participating health units were generally aware of RRFSS and had used RRFSS results, while most program staff had not yet used the results. Costs of staff to manage RRFSS were estimated, on average, at 0.7 FTE, with a range of 0.2 to 2.0. It was too early to assess cost savings and therefore ***effectiveness***.

The 2001/02 evaluation resulted in fourteen key issues relating to RRFSS effectiveness, improvement and sustainability (Ontario RRFSS Working Group, 2002):
1. need for adequate staff/resources for data analysis and making data useable
2. increasing the use of data in program planning and evaluation in health units

3. limited new question/module capacity under the current questionnaire
4. process for increasing the sample size for a health unit
5. need for a process for revising old modules and developing new modules
6. overwhelming amount of work on the local level for RRFSS representatives
7. need for stability and support for central work of the RRFSS partnership
8. unequal access to ISR, decision-making, workload and resources
9. upgrading the RRFSS website
10. sustaining funding for existing and new participants (smaller health units in particular) – including funding for survey and administration and analysis
11. provincial representation of data
12. sharing data among organizations
13. improved timeliness of data from ISR
14. ISR ability to handle an increase in health unit participation

The 2001/02 evaluation provided both the framework and baseline data for the current (2005/06) evaluation.

The 2005/06 Evaluation Group

This evaluation was conducted by the RRFSS Evaluation Group, consisting of representatives from each Regional Working Group, the RRFSS coordinator and members of PHRED. The Evaluation Group designed the framework, tools and methods of the evaluation, consulted on the reporting of results and dissemination strategies and reviewed the final report. The PHRED members collected, collated and reported the results. Terms of Reference for the Evaluation Group are attached as Appendix B.

OBJECTIVES

Objectives of the 2005/06 Evaluation

The objectives of the 2005/06 evaluation were articulated by the Evaluation Group in their initial meeting. The objectives were:

a. To review key issues and future directions outlined in the 2001/02 RRFSS evaluation and describe the progress that has been made,

b. To determine the utility of RRFSS, specifically with respect to the contribution of RRFSS to decision-making at the local level, understanding of emerging public health issues and monitoring of progress towards the Mandatory Health Programs and Services Guidelines (MHPSG) goals and objectives,

c. To highlight examples of "best practices" in the operation of RRFSS, and

d. To document what would be required to make RRFSS a provincial system and to describe how such a system could work.

METHODS

Development of the Evaluation Framework

The RRFSS Evaluation Group accepted the 14 key issues identified in the previous evaluation as the starting point for the 2005/06 evaluation. The group agreed that four of the previously identified issues were no longer problematic and that their resolution would be documented in the report of the 2005/06 evaluation. These were:

4. process for increasing the sample size for a health unit
8. unequal access to ISR, decision-making, workload and resources
13. improved timeliness of data from ISR
14. ISR ability to handle an increase in health unit participation

The remaining issues were grouped into three themes: *local resources*, *centralizations issues (provincial implications)* and *process considerations*. Within these areas, each of the ten remaining issues was refined by formulating evaluation questions and expectations of the project. The tools to be used to collect the data and sources of information for the required data were identified. This information was captured in the form of an Evaluation Framework, which guided all subsequent activities of the project (Appendix C).

It became clear from the Evaluation Framework that there would be three parts to this evaluation. The first is the documentation of the four issues which were resolved in the interval between the 2001/02 and 2005/06 evaluations. The second part is a survey of health unit personnel regarding the ten continuing issues and the last is a survey of key informants, for the most part external to the RRFSS partnership, on the same ten continuing issues.

Documentation of Resolved Issues

Information to document resolved issues was provided by ISR or the RRFSS coordinator, or taken from the RRFSS Manual of Operations.

Continuing Issues: Survey of the RRFSS Partnership and Health Unit Staff

Questionnaire Development

Questionnaires were developed by the RRFSS Evaluation Group. The Evaluation Framework guided the design of the questionnaires. Where possible, questions were taken from the 2001/02 evaluation (Stewart and Sales, 2002) in order to facilitate comparisons. Copies of the questionnaires are included as Appendix D.

Data Collection

Data were collected from all 36 Ontario health units, whether or not they were participating in RRFSS. In health units participating in RRFSS, information was obtained from RRFSS representatives, members of the RRFSS Analysis Group, medical officers of health (including associates), and program and research staff. Information was also solicited from medical officers of health (including associates) and epidemiologists or program evaluators in health units not currently participating in RRFSS. These data were collected by self-administered questionnaire.

A formal assessment of "best practices" in RRFSS was not within the scope of this evaluation. Instead, it was decided that "success stories" would be documented. Attendees at the annual provincial RRFSS Workshop, held on June 23, 2005, were asked to participate in a focus group to gather perceptions of success stories in implementing RRFSS in the health units.

Distribution of Questionnaires

RRFSS representatives were identified by the RRFSS coordinator and a list of medical officers of health was provided by the MOHLTC. Program and research staff in participating health units were identified by the RRFSS representatives. Epidemiologists and program evaluators from non-participating health units were identified from the membership list of the Association of Public Health Epidemiologists of Ontario and by telephoning the health units themselves.

Questionnaires were distributed electronically and could be returned electronically, by mail or by fax. All questionnaires were returned to the PHRED lead in the RRFSS Evaluation Group.

Tabulation of Data and Analysis

Quantitative data were entered into EXCEL spreadsheets or SPSS datafiles and analyzed using frequencies and cross-tabulations. Sums and averages were calculated where appropriate. Qualitative data were transcribed so that responses from the all members of the same groups to the same questions could be examined together. These were grouped by theme and summarized.

Responses from the focus group were also transcribed. Main success stories and challenges were identified and summarized.

Continuing Issues: Key Informant Interviews of Partners and External Agencies

Content of Key Informant Interviews

Interview questions for key informants were developed by the RRFSS Evaluation Group, again using the Evaluation Framework as a guide.

Data Collection

Telephone interviews were conducted with key informants by various PHRED members of the RRFSS Evaluation Group. In one case the questions were sent and responses were returned electronically.

Six staff members of the MOHLTC, including the chief medical officer of health, were selected as those most knowledgeable about RRFSS. Also interviewed were one senior member of ISR and the RRFSS coordinator. External partners were identified by the RRFSS coordinator as those whose requests for RRFSS data had been approved. These included two additional members of the Ministry of Health, as well as representatives of Cancer Care Ontario, the Ontario Tobacco Research Unit and the Centre for Addiction and Mental Health. The two MOHLTC representatives were interviewed, but the interviews with Cancer Care Ontario, the Ontario Tobacco Research Unit and the Centre for Addiction and Mental Health did not take place within the timeframe of this evaluation.

Tabulation of Data and Analysis

Responses from key informant interviews were recorded while the interview was in progress. These were grouped by theme and summarized.

Presentation of Results

In general, throughout this report, tables contain information from closed-ended questions on the questionnaires. Information from the focus group, open-ended questions and key informant interviews is presented in text.

The first section of results presents issues which have been resolved since the last evaluation. Information comes from documents such as the RRFSS Manual of Operations. The second section presents the results of questionnaire responses. Focus group comments are interspersed throughout the results to give examples of "success stories". The results of the key informant interviews are presented in the third section of results.

**RESULTS I : ISSUES IDENTIFIED IN THE 2001/02 EVALUATION,
BUT RESOLVED BEFORE 2005**

Increasing the sample size for a health unit

Sample size constraints were identified as a limitation of RRFSS in the 2001/02 evaluation. In 2004 the opportunity to increase the sample became available through different contract options with ISR. In addition, the special request process enables participating health units to further increase their overall sample size or to oversample specific subgroups of the population.

Access to ISR, decision-making, workload and resources

In the 2001/02 Evaluation, the majority of RRFSS representatives felt that all RRFSS health units had an equal voice in the decision-making process. However, health units with longer involvement in RRFSS were perceived to have greater influence in decision-making. In addition, RRFSS representatives felt that participating health units did not make equal contributions to the development of RRFSS.   This was attributed to multiple factors. Health units differed in staff complement and their ability to support involvement, or in the extent to which they chose to be involved. Health units participating in module development were perceived to have greater influence, as were health units with more experience and history in RRFSS. Although some saw these differences as a problem needing a solution, others expected these differences to recede as health units gained more experience and still others felt that there needs to be room for different levels of involvement.

In 2002, a Memorandum of Understanding was developed and continues to be signed by all RRFSS-participating health units, through which they agree to accept the roles and responsibilities of each partner, as outlined in the Manual of Operations. The Manual of Operations outlines the terms of reference for each working group and establishes systematic and standard processes for the operation of RRFSS, including decision-making and access to ISR resources.

The organizational structure of RRFSS was changed with the formation of Regional Working Groups. These smaller groups facilitate collaboration among smaller groups of RRFSS representatives and help to identify common issues which are then brought forward to the Steering Group.

Timeliness of data from ISR

In the 2001/02 evaluation, timeliness of data from ISR was identified as a problem. ISR has contracted to send a datafile to participating health units within eight weeks of completion of each month of data collection. Data were received on or before the due date for seven of the first 12 waves (2001), five of the second 12 waves (2002) and have been received within six weeks of the completion of data collection since the

beginning of 2003. Timeliness of data appeared to be most problematic while there was rapid growth in the number of participating health units, but is no longer an issue.[4]

ISR ability to handle increase in health unit participation

       ISR has reported the capacity to enroll all 36 health units in RRFSS, provided that 3-4 months advance notice is given.[4]

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[4] Elsbett-Koeppen, R. Personal Communication to Amira Ali, November 30, 2005.

RESULTS II: CONTINUING ISSUES
SURVEY OF THE RRFSS PARTNERSHIP AND HEALTH UNIT STAFF

Response Rate

Data were collected between September and December, 2005. Overall, information was obtained from 32 of the 36 health units in Ontario. The following table provides response rates for each of the groups to which questionnaires were sent.

Table 1: Response Rates

Group	Number of Questionnaires Distributed	Number (%) of Questionnaires Returned	Number (%) of Health Units Represented
RRFSS Representatives and RRFSS Analysis Group	25	23 (92.0)	20 (90.9)[1]
Medical Officers of Health	54	18 (33.3)	17 (48.6)[2]
Program and Evaluation Staff (Participating Health Units)	170	48 (28.2)	16 (72.7)[1]
Epidemiologists and Program Evaluators (Non-participating Health Units)	14	9 (64.3)	9 (64.3)[3]

[1] Denominator is 22, the number of participating health units.
[2] Denominator is 35, the number of health units – 1. One MOH was covering two health units at the time of the survey.
[3] Denominator is 14, the number of non-participating health units.

Among the 20 responding RRFSS representatives and three members of the Analysis Group (n=23), there were 17 epidemiologists, five data analysts and one program evaluation specialist.

Among the 48 responding program staff, there were 18 program managers, 15 program staff, nine planners or evaluators, three senior managers, two other staff and one unspecified.

Of the 17 health units represented by medical officers of health or associates, 11 participated in RRFSS and six did not.

Local Resource Requirements for RRFSS

RRFSS duties are formalized in the job descriptions of 14 (70%) of the 20 responding RRFSS representatives.

Health Unit Resources Currently Dedicated to RRFSS

In this survey RRFSS duties were categorized as provincial and regional, or local. Average time estimates for activities related to the administration of RRFSS provincially or regionally are recorded in Table 2, while estimates for local tasks are presented in Table 3. These results are summarized in Table 4. All three tables include estimates of the time spent by RRFSS representatives and their alternates, data analysts or epidemiologists, but exclude the time of program staff.

Table 2: Staff Time Spent* on Provincial and Regional RRFSS Tasks

RRFSS Task	Average Hours/Month
Group Meetings	
Steering Group meetings (n=5)	**5.0**
RRFSS Analysis Group meetings (n=8)	**4.3**
Special Request Review Group (n=5)	**0.9**
Website Working Group meetings (n=4)	**1.6**
Other ad-hoc working group meetings (n=12)	**1.8**
AVERAGE/GROUP	**2.9**
Other Provincial and Regional Tasks (n=20)	
Regional Working Group meetings	**4.0**
Core module selection	**0.7**
Module development	**3.0**
Module review	**2.3**
General administrative tasks	**8.3**
Analysis of regional data	**1.1**
TOTAL	**19.4**

*estimates of the time spent by RRFSS representatives and their alternates, data analysts or epidemiologists, but excluding program staff.

Staff spend 2.9 hours per month, on average, on each group of which they are a member; this includes all associated tasks, such as preparations for meetings. Other provincial and regional tasks require an additional 19.4 hours per month. More than one third of this time is spent on general administrative tasks.

On average, staff spend 54.4 hours per month on activities and tasks required for local administration of RRFSS. Data management and analysis are major tasks, as is dissemination. These two groups of tasks require, on average, six days per month.

Table 3: Staff Time Spent* on Local RRFSS Tasks

Local RRFSS Task	Average Hours/Month (n=20)	
Determining the Content of the RRFSS Questionnaire		
Annual selection of modules	**1.4**	
Changing the selection of modules	**0.9**	
Adjusting questionnaire length	**0.7**	
Developing modules for local use	**2.2**	
Total		**5.2**
Data Management and Analysis		
Data management	**2.8**	
Analysis of data	**12.4**	
Making results useable	**8.3**	
Total		**23.5**
Dissemination		
Interpretation of the results	**4.4**	
Dissemination of results within HU	**3.1**	
Report writing for the Health Unit	**6.5**	
Assisting program staff to use results	**3.9**	
Review of materials which use RRFSS results	**1.6**	
Presentation about RRFSS to health unit staff or local Board of Health	**1.2**	
Presentation about RRFSS or RRFSS results externally	**0.3**	
Total		**21.0**
Administrative Tasks		
Local RRFSS Advisory Committee	**1.3**	
Administrative tasks	**1.5**	
Attendance at RRFSS workshops	**1.3**	
Other	**0.6**	
Total		**4.7**
GRAND TOTAL	**54.4**	**54.4**

*estimates of the time spent by RRFSS representatives and their alternates, data analysts or epidemiologists, but excluding program staff.

Table 4: Total Staff Time Spent* on RRFSS Tasks

RRFSS Task	Average Hours/Month
Regional and Provincial Activities	**19.4**
Local Activities	**54.4**
TOTAL	**73.8**
Additional Group Work (per group)	**2.9**

*estimates of the time spent by RRFSS representatives and their alternates, data analysts or epidemiologists, but excluding program staff.

In total, staff average 73.8 hours or 10.5 days per month on RRFSS-related tasks and more if they sit on a committee in addition to their Regional Working Group. This is equivalent to a half-time position.

RRFSS representatives were asked to estimate the proportion of the time they dedicate to RRFSS that is spent on each of the following four activities: determining questionnaire content, data management and analysis, dissemination, and administrative tasks. Table 5 presents the results. Three-quarters of RRFSS representatives spend 10% to 19% of their RRFSS time determining the content of their questionnaires and four out of five spend 20% to 59% of their time managing or analyzing data. Almost 70% spend 10% to 39% of their RRFSS time on dissemination. Half of the sample spends 10% to 29% of their RRFSS time on administrative tasks, but one in four respondents spends at least half of their RRFSS time on these tasks.

Table 5: Percentage of RRFSS Time Spent Locally on Questionnaire Content, Data Analysis, Dissemination and Administrative Tasks

% of time	Determining Questionnaire Content n (%)	Data Management and Analysis n (%)	Dissemination n (%)	Administrative Tasks n (%)
<10%	3 (15.8)	1 (5.3)	4 (21.1)	1 (5.3)
10-19%	14 (73.7)	1 (5.3)	7 (36.8)	6 (31.6)
20-29%	1 (5.3)	3 (15.8)	3 (15.8)	4 (21.1)
30-39%	1 (5.3)	6 (31.6)	3 (15.8)	2 (10.5)
40-49%	--	2 (10.5)	1 (5.3)	1 (5.3)
50-59%	--	4 (21. 1)	--	4 (21.1)
60-69%	--	1 (5.3)	--	1 (5.3)
70-79%	--	1 (5.3)	--	--
80-89%	--	--	1 (5.3)	--
90-100%	--	--		--
TOTAL	19	19	19	19

In addition to the time spent by RRFSS representatives, medical officers of health reported spending up to five percent of their time on RRFSS.

Success Story: Determining Questionnaire Content

Module selection is done annually in most health units, but more frequent selection has also been successful. The most satisfactory processes involve all levels of staff (program staff, manager and directors) as well as the RRFSS representative. The RRFSS representative ensures that modules are linked to program plans and data needs, and evaluates alternate sources of data. Information about new modules is presented to staff and management as the modules become available.

Adequacy of Resources Dedicated to RRFSS

The amount of time respondents reported spending on RRFSS activities varied greatly. The majority (65%) reported spending less than 30% of their time on RRFSS. Table 6 presents the percentage of time which respondents feel is required by RRFSS-related activities, by the percentage of time that they actually spend on these. In this table, responses indicating that the RRFSS representatives are able to spend the time required by the activity would fall on the shaded diagonal, while those above the diagonal spend less time than they feel should be spent. Thirteen respondents (65%) feel that RRFSS-related duties require at least half of their time and 19 (96%) feel that they should spend more time than they do on RRFSS activities.

Table 6: Proportion of Time that RRFSS Representatives Feel Should be Spent on RRFSS By Proportion of Time Actually Spent on RRFSS

% Time Spent on RRFSS	Percentage of Time Required for RRFSS (n)									
	5-19%	20-29%	30-39%	40-49%	50-59%	60-69%	70-79%	80-89%	90-100%	TOTAL
5-19%		4			1					5
20-29%			2		4	1			1	8
30-39%				1			1		1	3
40-49%						1				1
50-59%									1	1
60-69%										--
70-79%									1	1
80-89%								1		1
90-100%										--
TOTAL	--	4	2	1	5	2	1	1	4	20

One in four respondents, or fewer, feel that their health unit has sufficient resources for administration and co-ordination, data analysis, making data useable and interpretation of results (Table 7). Forty percent feel they have adequate resources for the related costs of RRFSS (clerical, financial, legal and translation functions) and half assess the resources as adequate for dissemination.

Table 7: Adequacy of Health Unit Resources to Accomplish Key Components of RRFSS, as Reported by RRFSS Representatives

Component of RRFSS	Adequacy of Resources (n(%))			
	Yes	No	Don't Know	TOTAL
Administration and coordination	5 (25.0)	15 (75.0)	--	20
Related costs of RRFSS	8 (40.0)	9 (45.0)	3 (15.0)	20
Data analysis	3 (15.0)	17 (85.0)	--	20
Making results useable	4 (20.0)	16 (80.0)	--	20
Interpretation of results	4 (20.0)	16 (80.0)	--	20
Dissemination of results	10 (52.6)	9 (47.4)	--	19

Administration and Coordination

In the area of administration and coordination, RRFSS representatives feel unable to keep up with training of new staff on RRFSS, committee work, linking with community groups and facilitating student use of RRFSS results. Additional staff are needed; clerical help was mentioned specifically.

Related costs of RRFSS (Clerical, Financial, Legal, Translation)

RRFSS representatives reporting insufficient resources for the related costs of RRFSS (clerical, financial, legal, translation) indicated that they are in need of support for administrative and clerical duties, web design and translation.

Analysis of Data

RRFSS representatives reported that systematic, complex and proactive data analyses are not being done adequately and that much analysis is in response to data requests. Work on the data dictionary and syntax files is also less than adequate. In order to fulfill these duties, respondents feel they need additional staff time in the areas of data analysis, report writing, program evaluation, epidemiology, research and biostatistics. They feel a lack of information technology (IT) support and they need increased software, training and professional development. A system of central or regional analysis for core and common modules would be helpful, as would standard syntax files, an accurate data dictionary and faster computers.

Making Results Useable

RRFSS representatives identified limitations in the capacity of program staff to use RRFSS results in program planning and evaluation as a challenge to making results useable. More staff time dedicated to RRFSS are needed. Respondents proposed that results be formatted in such a way that they can be posted on a website. Access to fast printers and the ability to create ADOBE files were mentioned as material aids. Increased training in complex data analysis and graphic design skills are needed to help make the results useable.

Interpretation of Results

RRFSS representatives feel that results are not interpreted in a timely manner and in-depth interpretation may be lacking. The epidemiologist may not have sufficient time for interpreting results to program staff. More time and additional staff would help them to meet the needs of their health unit for this function. Another suggestion was to increase the level of knowledge of surveillance and evidence-based planning in health unit staff; this would help to reduce the demand among health unit staff for the interpretation of results. Furthermore, in-services are needed to teach staff how to use results. More knowledgeable directors and managers are needed to make it their responsibility to

encourage staff to use RRFSS. RRFSS representatives also mentioned specific hardware and software needs.

Dissemination of Results

Health units with insufficient resources for the dissemination of results are limited by a lack of time, funds or human resources. A vision presented by one representative was that of enabling health unit staff to do simple analyses of RRFSS data on their own using data posted on the intranet. This would release the epidemiologist from many data requests, freeing up time which could be used on other RRFSS-related tasks. Also, establishing priorities for surveillance and evidence-based decision-making within the health unit would ensure that dissemination of RRFSS results is seen as a priority.

Health units that are not able to disseminate RRFSS results feel that, in order to do so, they need more staff resources in the areas of epidemiology, program evaluation, communications, research support and website management, as well as intranet resources.

Activities Required by RRFSS at the Local Level

Analysis and Interpretation of RRFSS Results

RRFSS data are obtained from ISR in SPSS format. All participating health units run frequencies and cross-tabulations on RRFSS data and all but two create graphs (Table 8). Fewer health units do multivariate or time trend analyses. Almost all health units convert SPSS output to some kind of word processed document, tables or graphs. Most RRFSS representatives give a written explanation of RRFSS results and about two-thirds do this in light of other information such as program description or health unit sociodemographic data.

**Table 8: Methods Used to Analyze RRFSS Data, Make Data Useable
and Interpret Results, Reported by RRFSS Representatives**

Component of Analysis	n(%)
Data Analysis	
Frequencies and other univariate analyses	20 (100)
Crosstabs and other bivariate analyses	20 (100)
Graphs	18 (90.0)
GIS mapping	2 (10.0)
Multivariate analyses within years	3 (15.0)
Time trend analyses, pre/post comparisons	10 (50.0)
Making Data Useable	
Output copied and distributed	1 (5.0)
Output converted from analysis package to word processing package	16 (80.0)
Output converted to tables	18 (90.0)
Output converted to graphs, maps and other pictorial representations	15 (75.0)
Interpretation of Results	
Verbal explanation, of results only	8 (40.0)
Written explanation, of results only	13 (65.0)
Verbal explanation, in light of program description or demographic data	12 (60.0)
Written explanation, in light of program description of demographic data	13 (65.0)
Number of Respondents	20

RRFSS representatives find that having a staff person dedicated to data analysis works well to assist with the workload required by RRFSS. Teamwork is required for the process of receiving data, through data management, to analysis. A good monthly data management system, including deriving new variables for module indicators, was reported to be working well. Respondents feel that it is helpful to do annual or seasonal analyses of all (or almost all) RRFSS data.

One representative has developed an Excel template with formulae for calculating confidence intervals (CI) and coefficients of variation (CV), with different worksheets to analyze data by gender, age and income.[5] This program was mentioned several times as a great help. It requires only data from the SPSS output in order to calculate the needed estimates and was reported to be working well. Syntax files were reported to be very helpful. The promptness with which data are now received from ISR is working well.

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[5] RRFSS Workshop 2003 Presentation – Ruth Sanderson June 2003 (PPT)
http://www.rrfss.on.ca/workshops/June%202003%20workshop/Ruth%20Sanderson%20-RRFSS%20Presentation.ppt accessed August 1, 2006.

Success Story: Interpretation

> *To make the data more useable, general statements such as indicator definitions, sample size warnings, explanation of "don't know" or "refuse" responses, etc. are added to the results. This assists program staff and management with the interpretation of the results. A collegial environment also encourages program staff and management to seek out the epidemiologist if they need further help with the interpretation of results.*

Dissemination of RRFSS Results

RRFSS results are most likely to be disseminated as presentations or tables to managers and/or staff, or as written reports to health unit audiences (Table 9). Results are least likely to be disseminated as SPSS output or postings on an internal or external website. Dissemination is more likely to be on request than with any regular frequency although annual reporting is fairly common. The majority (14 (70%)) of RRFSS representatives reported an average of one to four requests from managers and staff per month, while four (20%) reported fewer than this and two (10%) reported more.

Table 9: Frequency of RRFSS Dissemination Strategies
Reported by RRFSS Representatives

Method of Dissemination	Frequency of Reporting (n (% of all 20 respondents))							
	Annually	Quarterly	Monthly	Weekly	On Request	Other	Total	Not Done
SPSS output	1 (5)		1 (5)		6 (30)		8 (40)	12 (60)
Tables	3 (15)	2 (10)	1 (5)		11 (55)	1 (5)	18 (90)	2 (10)
Written reports for internal audiences	4 (20)	3 (15)		1 (5)	8 (40)		16 (80)	4 (20)
Presentations to managers or staff	4 (20)	1 (5)			13 (65)		18 (90)	2 (10)
Presentations to Board of Health or Council	4 (20)				8 (40)	1 (5)	13 (65)	7 (35)
Written reports for external audiences	4 (20)	1 (5)			6 (30)	2 (10)	13 (65)	7 (35)
Postings on internal website	2 (10)	1 (5)	1 (5)	1 (5)	3 (15)	1 (5)	9 (45)	11 (55)
Postings on external website	6 (30)				1 (5)	3 (15)	10 (50)	10 (50)

RRFSS representatives from three health units reported translating reports into French; no other languages were reported.

One program and research staff member did not know how RRFSS results are distributed; the remaining respondents reported a range of one to eight dissemination strategies in their health units. Almost all reported that RRFSS results are disseminated in response to ad hoc requests from health unit staff. About half of respondents reported

that they are disseminated in the form of presentations to managers and staff, and about one third as reports to the Board of Health or Council, or in response to ad hoc requests from agencies or community members (Table 10). These findings are consistent with the reports of RRFSS representatives, who said that they distribute results most frequently on request and that presentations to managers and staff are among the most frequent methods of dissemination.

Table 10: Dissemination Strategies Reported by Program and Research Staff

Method of Dissemination	Frequency of Reporting (n(%))
Responses to ad hoc requests from health unit staff	44 (93.6)
Responses to ad hoc requests from agencies or community members	16 (34.0)
SPSS output	6 (12.8)
Tables	10 (21.3)
Internal written reports, at least quarterly	5 (10.6)
Internal annual written report	12 (25.5)
Written report to Board or Council	16 (34.0)
Written report to community	9 (19.1)
Media reports	11 (23.4)
Presentations to managers or staff	22 (46.8)
Presentations to Board of Health or Council	10 (21.3)
Presentations to agencies or community members	3 (6.4)
Postings on internal website	10 (21.3)
Postings on external website	11(23.4)
Other dissemination strategies	7 (14.9)
Number of Respondents	47

Of 47 program staff and research staff who specified how results are disseminated, 46 assessed the adequacy of these strategies. Eighteen (39%) feel that results are adequately disseminated in their health units, while 28 (61%) do not. Those who feel that RRFSS results are adequately disseminated reported an average of 4.6 strategies in their health units, while those who feel results are inadequately disseminated reported, on average, 3.8. In spite of this, both groups reported a range of one to eight strategies.

In open-ended comments, RRFSS representatives reported that the following dissemination strategies are working well in their health units:
- annual one page reports presenting new information in a structured format such as a table or graph, with interpretation, posted on the website
- annual publication of RRFSS results in an internal report, to which all staff can refer
- annual or seasonal analysis of almost all RRFSS data
- issue specific mini-reports available electronically to all staff.

The ability to post reports on the intranet or internet to give staff easy access to results was described as very effective. The results presented to staff are being used for other reports, news releases, newletters and in operational planning.

Strategies for disseminating results which were deemed most useful by RRFSS representatives, also described in open-ended comments, include the following:

- using a variety of products with consistent formats,
- distributing reports in a variety of ways: hard copy, electronically, postings on the intranet and internet, meetings, presentations, external reports, newletters to community health professionals and press releases,
- ensuring reports are user-friendly and distributing them widely (medical officer of health, managers, staff, library), and
- distributing both summary and topic-specific reports and also reports of new results.

Program and research staff in health units in which results are not adequately disseminated reported two main needs. One need is for information about RRFSS itself. Many program staff feel uniformed and do not know of useful information unless it is specifically pointed out. The second need is for regular, comprehensive reports of RRFSS results. Many respondents perceive that most results are released only in response to data requests. Open-ended comments identified the following other needs:

- tailored presentations to teams, outlining the results in areas relevant to them, with assistance in interpreting the results and determining their relevance,
- presentations or written summaries to managers,
- newsletters to teams,
- timely dissemination,
- frequent updates with interpretation; comparisons so that trends can be identified,
- reports on specific topics (e.g. influenza, West Nile Virus) quarterly or monthly, and
- website access to reports.

Success Story: Data Requests

A data request form is a useful way of receiving requests, but also provides a means of tracking requests, providing justification for RRFSS and evidence for setting priorities.

Success Story: Dissemination

An annual report containing frequencies of all variables from the modules selected by the health unit provides a useful reference document and reduces the number of ad hoc requests. Reports can also be made useful by encouraging staff to identify program planning needs and tailoring reports to meet these.

Use of RRFSS Results

Perceptions of RRFSS Representatives

All RRFSS representatives reported that RRFSS results are used for program planning, and 80% reported that the results are used for program evaluation and for

presentations (Table 11). Results are used least often for educational initiatives, advocacy or press releases, but even in these cases more than half of respondents noted that results had been used in these ways in their health units.

Table 11: Uses of RRFSS Results Reported by RRFSS Representatives

Uses of RRFSS Results	n (%)
Program planning	20 (100)
Program evaluation	16 (80.0)
Media campaign	15 (75.0)
Reporting program results to management	14 (70.0)
Reporting program results to Board of Health	14 (70.0)
Policy development	12 (60.0)
Advocacy work	11 (55.0)
Development of a communications product	12 (60.0)
Preparation of a press release	11 (55.0)
Presentation	18 (80.0)
Funding proposal	12 (60.0)
Informing a decision	15 (75.0)
Educational initiative	10 (50.0)
Number of Respondents	20

It was reported that all staff use RRFSS results with high frequency, and especially program managers (90%), program staff (90%) and epidemiologists (90%) (Table 12). The low rate of reported use by researchers (45%) is likely a reflection of the lack of such staff in many health units.

Table 12: Users of RRFSS Results Reported by RRFSS Representatives

Users of RRFSS Results	n (%)
Medical Officers of Health	14 (70.0)
Senior Managers or Directors	17 (85.0)
Program Managers	18 (90.0)
Planners, Evaluators	13 (65.0)
Program Staff	18 (90.0)
Epidemiologists	18 (90.0)
Researchers	9 (45.0)
Media Staff	13 (65.0)
Number of Respondents	20

According to the RRFSS representatives, RRFSS results are used most often for Chronic Disease Prevention (95%), Child Health (90%) and Injury Prevention (84%) (Table 13). They are used least often for the Environmental Health and Communicable Disease programs.

**Table 13: Programs and Standards for Which RRFSS Results are Used,
Reported by RRFSS Representatives**

Programs and Standards for which RRFSS Results are Used	n (%)
Equal Access	4 (21.1)
Health Hazard Investigation	5 (26.3)
Chronic Disease Prevention	18 (94.7)
Early Detection of Cancer	15 (78.9)
Injury Prevention, Including Substance Abuse Prevention	16 (84.2)
Sexual Health	5 (26.3)
Reproductive Health	14 (73.7)
Child Health	17 (89.5)
Control of Infectious Diseases	9 (47.4)
Food Safety	10 (52.6)
Infection Control	2 (10.5)
Rabies Control	6 (31.6)
Safe Water	7 (36.8)
Sexually Transmitted Diseases, Including HIV/AIDS	2 (10.5)
Tuberculosis (TB) Control	--
Vaccine Preventable Diseases	12 (63.2)
Number of Respondents	19

Numerous barriers to the use of RRFSS results were reported by RRFSS representatives. One such barrier is the lack of staff time, awareness or capacity to understand or to use the results. Also mentioned were delays in the reporting of results, limited dissemination, lack of input by program planning staff into RRFSS module selection, the interview length and competing priorities for survey content, the relevance of questions for particular health units, limited resources for RRFSS or uncertainty of funding from year to year. Representatives feel that these can be overcome by additional staff dedicated to RRFSS, more centralized analysis, wider promotion of RRFSS and dissemination of results, involvement of staff in module development, educating staff on the need for surveillance and on evidence-based decision-making, and orienting new staff to RRFSS. Shortening the core content or increasing the length of the interview is a means of ensuring that the content of the RRFSS interview is relevant to a health unit.

The strategies that representatives have developed to promote RRFSS results are a reflection of the reported barriers to their use. These include:
- presentations of results to Boards of Health and to staff at management, team and program levels
- regular updates and wide dissemination of results
- involving management and staff in the selection of modules, analysis of RRFSS results or development of new modules
- creation of RRFSS committees to engage staff in using RRFSS results for program and policy development as well as program planning and evaluation
- demonstrations to staff of how RRFSS results can be used in program planning and evaluation, and its capacity to provide local results as well as "before and after" results

- linking RRFSS results to the goals and objectives of program logic models, or to program targets or guidelines,
- using staff (e.g. PHRED) to promote the use of RRFSS to other health unit staff,
- fostering a learning environment and evidence-based decision-making, and
- promoting RRFSS to new staff during their orientation.

Perceptions of Program and Research Staff

Thirty-seven of 47 (79%) program and research staff reported using RRFSS results for program planning. Of 46 who indicated their position, 13 of 17 (76%) program managers, 11 of 15 (73%) program staff, eight of nine (89%) planners or evaluators, all three senior managers and one of two (50%) other staff used RRFSS results for program planning. Of the 36 users who commented on the performance of RRFSS results, five (14%) indicated that they perform very well, 21 (58%) said they perform moderately well and 10 (28%) feel they perform poorly.

Of the 10 respondents who do not use RRFSS results for program planning, six reported that questions they need are not on the questionnaire, two reported that the sample size is too small and four said that the results they need are not available to them. Among other reasons for not using the results were: not being involved in program planning, not understanding the results and needing individual level rather than aggregate results.

Program and research staff who think that RRFSS results perform poorly for program planning cited small sample sizes, exclusion of target subpopulations (e.g. those 15-18 years of age), lack of relevant data, data gaps (years when a module is not included) and poorly summarized results as reasons for poor performance. Sometimes there is a lack of staff to incorporate RRFSS results into program planning. Those who think that RRFSS results perform moderately well cited similar limitations. Small sample sizes, limited representation of needed subgroups, lack of relevant content, the fact that knowledge or needs for service are not included in the content, and lack of staff familiarity with RRFSS or knowledge about how to use the results were cited as limitations. Some staff feel that they must use multiple sources of data, instead of being able to rely solely on RRFSS.

Twenty-four of 46 program and research staff (52%) use RRFSS results for program evaluation. Among the 45 who specified their position, eight of 17 program managers, four of 14 program staff, seven of nine planners, all three senior managers and both staff in other positions used RRFSS results for program evaluation. Of 23 who rated the performance of RRFSS results for program evaluation, one (4%) rated them as performing very well, 14 (61%) as moderately well and eight (35%) as poorly.

Of the 21 program and research staff who do not use RRFSS results for program evaluation and indicated a reason for not doing so, 11 reported that the questions they need are not on the questionnaire, six reported that the sample size is too small and a

further six said that the results they need are not available to them. Four had never considered using RRFSS.

The reasons for poor performance of RRFSS results for purposes of program evaluation were similar to those reported for program planning. Lack of needed results, small samples of needed respondent groups, lengthy data collection periods which do not provide adequate samples for time-limited program activities and the lag in receiving needed information were reasons given for poor performance. Those who said that RRFSS results perform moderately well feel that they are limited by small samples of target subpopulations or a lack of relevant questions. On the other hand, RRFSS provides good results for community-wide interventions and results for the analysis of trends. Respondents also mentioned that RRFSS is only one source of data; a combination of sources or an evaluation tailored to the program may be more useful.

A large number of barriers to the use of RRFSS results for program planning and evaluation were identified by program and research staff. Barriers arise in the following areas: sampling issues, module selection, question or module development, resources for analysis, interpretation and dissemination, and limited skills among program staff who use the results. In most cases, respondents had suggestions about how these barriers could be overcome. Perceptions of barriers and suggestions to overcome them are presented in Table 14.

**Table 14: Perceptions of Program and Research Staff of Barriers
to the Use of RRFSS Results for Program Planning and Evaluation**

Barrier to Using RRFSS Results For Program Planning and Evaluation	Suggestions for Steps which Could be Taken to Overcome Barriers
Sampling Issues	
Small sample size	• pool with other health units • conduct more monthly interviews
Small sample size for subgroup analysis	• conduct more monthly interviews
Non-representativeness of the sample; not able to reach specific target populations	• develop a methodology to allow subgroup sampling • find a way to incorporate parental consent to allow for inclusion of respondents less than 18 years of age • consider different strategies for studies of specific subgroups
Module Selection	
Limited space for questions, modules	• rotate modules
Limited flexibility for module selection	• make it easier to add questions, but ensure that current results are used before more modules are added
Question or Module Development	
Module development is a long and time-consuming process	• fund 100% of RRFSS costs • provide more funds to health units for Planning and Evaluation Standard
Process for module development is complex	--
Modules cannot be developed in timely way	• provide more support to teams to develop and implement modules in a timely manner
Modules which appear relevant to a team may not meet current needs of the team	• provide program expertise to developers of modules

**Table 14: Perceptions of Program and Research Staff of Barriers
to the Use of RRFSS Results for Program Planning and Evaluation (Cont.)**

Barrier to Using RRFSS Results For Program Planning and Evaluation	Suggestions for Steps which Could be Taken to Overcome Barriers
Question or Module Development (Cont.)	
Modules for needed program areas are not always available (sexual and environmental health mentioned specifically)	• continue to develop new modules • extend tolerance for risky, sensitive or intimate questions • conduct a supplementary survey in these areas
Questions don't address information needs	• constitute an advisory group of program planners • solicit questions from program planners for review areas
Limited ability to be responsive to local needs (RRFSS is provincial in focus)	--
Too few questions to allow program planning and evaluation	• focus on one issue at a time and ask for more details • change focus annually
Lack of program input into questions, limited ability to change questions	• encourage more consultation between epidemiologist and program staff
Results not always availably when needed for program evaluation	• conduct more interviews per month
Lack of qualitative data	--
Poor quality survey questions	• solicit more input from program managers/specialists, epidemiologists, survey design specialists (process may need facilitator)
Audio and visual components of campaigns cannot be evaluated	• build capacity to include audio clips into RRFSS interview
Resources for Analysis, Interpretation and Dissemination	
More data than can be analyzed with available resources	• priorize requests through an advisory committee • offer a range of reports • increase capacity by adding an epidemiologist and data analysts
Lack of staff and time for analysis, interpretation and dissemination, timeliness of dissemination	• hire more staff including epidemiologist • provide more funds to health units for the Program Planning and Evaluation Standard • fund 100% of RRFSS costs • provide central support for data analysis
Poor dissemination	• make greater use of intranet, internet • produce monthly publications • hire more staff
Timely dissemination	• hire more staff
Data releases are not coordinated with planning needs	• coordinate the timing of modules in the RRFSS cycles with planning needs
Staff don't know where to find RRFSS results	• post results on the intranet, internet
Limited Skills among Staff	
Lack of buy-in on the part of management, limited skills among management to use RRFSS results	• provide tailored reports to teams • encourage management to educate themselves on results relevant to their programs
Lack of staff interest and awareness	• provide staff presentations • provide updates at team meetings • produce a communication plan
Staff are not using results	• produce more frequent reports • link evaluators to teams
Staff lack knowledge on how to use results for program planning and evaluation	• provide skill building workshops, presentations, self-directed learning opportunities, education
Program planning and evaluation activities are not valued	• provide more funds to health units for Planning and Evaluation Standard • increase public health accountability to Ministry
Evaluations tend to be very basic	--

Success Story: Communication

Including RRFSS in the orientation of new staff is helpful. It creates buy-in and demonstrates the role of RRFSS in program planning and evalution. Communication about RRFSS helps to prepare staff to assist with module selection.

Thirty-three of 46 program and research staff (72%) indicated that they used RRFSS results in other ways than program planning or evaluation (Table 15). The most frequent uses were reporting program results to the Board of Health, media campaigns and press releases.

Table 15: Uses of RRFSS Results Reported by Program and Research Staff

Uses of RRFSS Results	N (%)
Media campaign	14 (42.4)
Reporting program results to management	9 (27.3)
Reporting program results to Board of Health	15 (45.5)
Policy development	4 (12.1)
Advocacy work	8 (24.2)
Development of a communications product	12 (36.4)
Preparation of a press release	14 (42.4)
Presentation	12 (36.4)
Funding proposal	7 (21.2)
Informing a decision	11 (33.3)
Educational initiative	5 (15.2)
Other	4 (12.1)
Number of Respondents	33

Success Story: Using RRFSS Results

A public relations staff member who uses RRFSS results is an asset to the health unit. RRFSS results are popular in presentations to Council and can be even more successful when results are broken down by ward or community health centre. Using RRFSS results to support advocacy issues increases health unit buy-in.

Sharing of Health Unit RRFSS Datasets

Thirteen of 19 RRFSS representatives (68%) said that their health units had shared their RRFSS dataset with local community agencies and organizations, provincial agencies and organizations, branches within the MOHLTC or other health units.

Sharing Datasets with Other Health Units

RRFSS representatives reported sharing parts of datasets among at least ten health units. The purposes of sharing data were varied, and included cooperative data analysis, providing data for training in the use of analysis programs, and providing data for a number of analyses including artificial tanning, physical activity, Routine Universal Comprehensive Screening (RUCS), a SARS report and the "Not to Kids" campaign. Comparison data were provided for the analysis of results on the familiarity of the population with the services of their health unit and data were provided to assist in planning a food disclosure program. Sharing of datasets also enabled some regional analyses to be done.

Sharing Results and Data with Local Community Agencies and Organizations

Results were shared with the United Way Success by Six program to provide a number of indicators for the 0-6 year age group. Data were shared with university departments for students projects. Data were provided to a local District Health Council and to a local school board for planning. A PHRED program obtained health unit data for a research project on woman abuse.

Sharing Datasets with Provincial Agencies and Organizations

RRFSS data were shared with Cancer Care Ontario for several analyses, including Cancer Risk Factors in the Greater Toronto Area (GTA) in support of the GTA Cancer Plan and the Cancer 2020 Plan.

Sharing of Data with the Ministry of Health and Long-Term Care

The MOHLTC has requested RRFSS data for two studies to estimate influenza vaccine coverage.

Barriers to Sharing Health Unit-Specific Data

RRFSS representatives identified barriers to the sharing of health unit-specific datasets, including minimal capacity within local agencies to analyze and interpret RRFSS results, health unit guidelines limiting data-sharing, health unit sensitivities about being compared to other health units and the observation that external agencies do not always complete the work for which data are requested. Timeliness of the data has been an issue. Fulfilling requests for health unit-specific datasets is not always seen as helping the health unit do its job locally.

Respondents felt that these barriers could be overcome by 100% health unit participation in RRFSS, getting legal advice on when and how sharing should take place, simplifying the decision-making process by giving the epidemiologist or RRFSS representative the authority to make decisions about the sharing of datasets, signing

formal agreements and using a centralized ethics review process for requests. Other means of overcoming barriers included ensuring that the end user has the capacity to correctly interpret the results and encouraging the end user to complete the projects for which data are requested, to receive approval from the health unit before releasing the report (particularly if sensitive issues are being addressed) and to report back to the local agencies in a timely manner.

General Considerations Concerning the Sharing of Data

The responses of RRFSS representatives and medical officers of health to general considerations concerning the sharing of data are reported in Table 16. The number of respondents to each question is variable and is provided in the appropriate cell. Each dimension is further described in its own section following the table.

Table 16: Sharing of RRFSS Data

Dimension of Data-sharing	RRFSS Representatives	MOH in Participating Health Units
	(number responding positively/total respondents (%))	
External agencies should have access to RRFSS data to do analyses at the provincial level	16/19 (84.2)	11/12 (91.7)
External agencies should have access to RRFSS data to do analyses at the health unit level	10/19 (52.6)[1]	8/11 (72.7)
External agencies should have to pay for access to RRFSS datasets	8/19 (42.1)	5/11 (45.5)
External agencies should be allowed to pay for questions to be added to the RRFSS questionnaire	10/18 (55.6)	6/11 (54.5)
External agencies should have a place at the table as a RRFSS partner	6/16 (37.5)	2/11 (18.2)

[1] One respondent specified "in some cases"

Access of External Agencies to RRFSS Datasets for Provincial Analyses

In general, 84% of RRFSS representatives feel that external agencies should have access to RRFSS data to do analyses at the provincial level. Respondents who responded positively feel that this is a good use of taxpayers' money and would promote interest in and the use of RRFSS. There would be wider dissemination of RRFSS results.

There were some caveats. Several respondents pointed out that a complete and representative provincial dataset is not yet available and RRFSS should not be used for provincial analyses until all health units participate. It was also pointed out that RRFSS data without health unit identifiers is archived two years after collection and is available on request.

Other comments were that the data should not be provided free of charge to profit-making companies or corporations, agencies requesting data should provide a proposal with a sound rationale and demonstrate that they have the expertise to analyse the data and interpret the results, and that the partnership should agree prior to sharing

data. A formal data-sharing agreement should be in place. There is a cost associated with the collection of data, and sustainability should be considered. Perhaps provincial agencies could be granted access and use of RRFSS data in exchange for funding. Guidelines are needed to ensure that partners are notified of results before they are made public.

Medical officers of health who thought external agencies should have access to RRFSS datasets to do analyses at the provincial level (92% of respondents) expressed the opinion that it is a responsibility of health units to provide data and information to community partners and that this would be useful for health planning. Local Health Integration Networks (LHINs), universities and health care agencies were mentioned as potentially having an interest in the data. This group also had some caveats. They thought that sharing should take place only with permission and acknowledgement of the local health units, only for projects widely relevant to public health programs and in accordance with privacy legislation. Standardization (or weighting) of the data would be required to achieve results representative of the province. Agencies using RRFSS data could become partners or could provide a contribution for access to the data. It was also suggested that aggregate data instead of raw data could be provided. The contrary opinion was expressed by one medical officers of health, who felt that RRFSS data should not be shared for analysis at the provincial level because it is a local information tool.

Access of External Agencies to RRFSS Datasets for Analyses at the Health Unit Level

Fifty-six percent of RRFSS representatives think that external agencies should have access to RRFSS datasets in order to do analyses at the health unit level. In some cases the analyses done by agencies could be used by health units, freeing health unit resources for other analyses. Analysis done by external agencies stimulates interest in RRFSS and allows wider dissemination of results. Permission to use the data and a data-sharing agreement were regarded as important by many respondents. The data-sharing agreement should include provision for the results to be shared with and approved by the health unit prior to release. The request should provide some benefit to the health unit, since health unit resources are required to make the system work. The RRFSS External Data Request process should be followed.

Respondents who do not support sharing data with agencies for analyses at the local level (44%) think that these analyses should be done by the health unit. The health unit should retain control over its own data. External agencies are unlikely to be aware of all the data issues required to correctly analyze, interpret and disseminate the results.

Once again, medical officers of health supporting the sharing of data to do analyses at the level of the health unit (73%) expressed the opinion that because the RRFSS survey is supported with public funds, the data should be made available for projects related to public health. RRFSS data are useful for local planning and evaluation. Agencies could be requested or required to contribute to the cost. Again,

permission and privacy considerations are important. There was wider concern with confidentiality when analyses are performed at the health unit level. A mechanism for the review of proposals from those wishing health unit RRFSS data is required. Again, perhaps it is results, rather that data, which should be shared.

The contrary opinion, that data should not be shared for analyses at the health unit level, was held by 27% of medical officers of health and was supported by the position that the goal of RRFSS is to inform local health unit programming and decision-making. Also, the opinion was expressed that health units or potential respondents may not be as willing to participate if they know that data are being shared for these analyses.

Payment for Access to the RRFSS Dataset

Forty-two percent of RRFSS representatives feel that external agencies should pay for access to RRFSS datasets. Representatives who think that external agencies should pay for the use of the dataset feel that this would assist health units in recovering part of the costs of the survey and therefore help in the sustainability of RRFSS.

Those who feel that there should be no cost to external agencies (58%) pointed out that health units are publicly funded agencies and that charges might be a deterrent when the partnership should be encouraging use of the data. If datasets are made available through ISR's archives, they should be without cost. Payment may be difficult to arrange.

Some respondents were not sure that agencies should pay for access, or feel there should be conditions attached to payment. The view was expressed that the MOHLTC, Cancer Care Ontario or other agencies that provide the health unit with results should not have to pay, and that agencies other than these should not have access to the data. Opinions were expressed that administrative costs should be recovered, or that agencies on tight budgets should not have to pay for the use of data, but that costs should be recovered for time-consuming requests and requests from profit-making agencies.

Like RRFSS representatives, 54% of medical officers of health feel that agencies should pay a fee to help offset administrative costs and ensure compliance with Ontario's privacy laws. This is similar to fees charged for data from CIHI or Statistics Canada.

Forty-six percent of medical officers of health feel that publicly funded agencies should not have to pay for the use of RRFSS data since it is supported by public funds. The data should be used. Contributions could be requested, however, and private companies should be required to pay.

Payment for Adding a Set of Questions to the RRFSS Interview

Fifty-six percent of RRFSS representatives feel that external agencies should be allowed to put a set of questions on the RRFSS interview in return for payment.

Proponents of an arrangement through which an external agency pays for additional questions suggested that this might enable a health unit to particpate in RRFSS. The money from such an arrangement should help to defer the costs of RRFSS to the health unit and perhaps eventually some of the costs of centralized services.

RRFSS representatives opposed to this arrangement (44%) said that it is outside the parameters of the current RRFSS terms of reference. Health unit staff and ISR are the only members identified. It was also pointed out that American experience with the Behavioral Risk Factor Surveillance System showed that this practice adversely affects the quality of the interview, that agencies ask for questions of little public health importance and control over the quality of the questions is reduced.

If it were permitted to add questions in return for payment, respondents felt that only questions which are consistent with the purpose of RRFSS and mandates of public health should be allowed, and that the health units should be allowed to increase the length of the interview so that content of importance to them would not be lost. In all cases modules selected by the health unit should have priority. A more workable arrangement might be for external agencies to submit a proposal for a new module instead of paying for the addition of questions.

Medical officers of health who are willing to allow external agencies to pay for content on the RRFSS survey (54%) specified that there should be restrictions. Permission would be necessary from the participating health units and/or RRFSS Steering Group, content should be limited to mandated public health programs or needs assessments and the reliability and validity of questions should be monitored. Consideration should be given to the length of the interview. There should be Ministry and local access to results.

Medical officers of health who feel that content should be determined solely by the health unit (46%) cited the negative experience of the Brief Risk Factor Ssurveillance System and subsequent loss of control over the content and quality of the survey when external agencies contributed questions. The interview could become too lengthy and data quality and response rates could be adversely affected.

External Agencies as Partners at the RRFSS Table

Thirty-eight percent of RRFSS representatives feel that external agencies could take a place at the table as a RRFSS partner, with input into content, methodology, and so forth.

Among those who do not feel that external agencies should sit as a partner at the RRFSS table (63%), several think that this would change the basic concept of RRFSS. They suggested that perhaps changes in the current structure could allow them to provide input, expertise and influence or to act as advocates. However, they feel that agencies should not have the same "say" as a RRFSS partner in decision-making.

As with other questions, the challenges of incorporating the interests of other groups into the RRFSS collective were enumerated. These included the difficulties of maintaining a focus on Mandatory Health Programs and Services, maintaining the quality of the interview, keeping the length within the agreed 20 minutes, negotiating payment and defining decision-making processes.

There was a feeling that external partners might become RRFSS partners if they are paying to add questions to RRFSS or if they have been approached by RRFSS to provide expertise. Among respondents who feel that it is possible for external agencies to become RRFSS partners, there was an observation that such agencies must be aligned with and committed to the philosophy of RRFSS, demonstrate the relevance of their questions to public health and be prepared to commit the resources needed to participate in the module development process. Again, it was stated that the needs of health units should be given priority.

Eighteen percent of medical officers of health feel that external agencies should have a place at the RRFSS table. There was some feeling that external agencies could become a RRFSS partner if they are paying for content or for a regional or provincial sample, or if they are specifically invited. Like the RRFSS representatives, medical officers of health were more likely to suggest that they be invited to make a specific contribution, such as that of consultant or advisor, than to become a full partner. There need to be checks and balances in place. Those opposed to allowing external agencies as partners (82%) see RRFSS as a public health assessment tool and feel that control should remain with the health units. It is difficult to determine what bodies are represented by external agencies and to whom they are accountable, and to define their contribution to decision-making.

Data Quality

None of the RRFSS representatives or Analysis Group members rated the quality of RRFSS data as poor (Table 17). The majority rated it of high, but not very high, quality. Similarly, the majority of program and research staff rated the quality as high, although two rated it a poor.

Table 17: Quality of RRFSS Data

Rating of Quality	Respondent Group (n(%))	
	RRFSS Representatives and Analysis Group	Program and Research Staff
1 (very poor quality)	--	1 (2.4)
2	--	1 (2.4)
3	7 (30.4)	7 (17.1)
4	14 (60.9)	30 (73.2)
5 (very high quality)	2 (8.7)	2 (4.9)
TOTAL	23	41

RRFSS representatives who rated the quality of RRFSS data as less than "4" did so for reasons related to sampling and content. Sampling issues included concern that the sample is not representative of the health unit population because of a low response rate and under-representation of some socio-demographic groups, and the observation that proper estimations of variance and weighting schemes or age standardization need to be considered when deriving estimates. Pooling of present health unit results does not allow accurate provincial estimates to be calculated. Issues related to the content include superficial treatment of module content, module-specific data quality issues (skip patterns, flow of questions, lack of consistency in response categories between modules) and data that have not been tested for reliability or validity. The quality of data can be improved by ensuring that modules address issues in a way that produces useful data, validation studies, applying appropriate survey weights when calculating estimates or confidence intervals, following up on data quality problems as soon as they are identified and improving the response rate and therefore the representativeness of results (i.e. by having funds to invest in the advance letter).

Program and research staff who questioned the quality of RRFSS data feel that there are inherent limitations in a telephone survey; for example, questions are too general because of time restrictions. Some modules contain questions of less than optimal quality. More input from program managers and specialists, epidemiologists, researchers, evaluators and survey design specialists was suggested. The pilot is important to ensure good questions. The inclusion of qualitative data would be an asset.

Factors Affecting the Efficiency of the RRFSS Partnership

Centralization of Personnel, Services and Processes

Extent to which Personnel, Services and Processes are Currently Centralized

Currently (in 2006) there is one centralized position funded by the RRFSS partnership, that of RRFSS coordinator. Syntax and analysis programs are available for some of the analyses which are performed in most health units. These were located on the ISR Server at the time of the survey and are available to all. Table 18 shows the

frequency with which RRFSS representatives use common syntax files. The majority of
representatives use common syntax for fewer than half of the analyses they conduct.

Table 18: Frequency with Which Respondents Use Common Syntax

Frequency of Use	n(%)
Not at all	3 (15.0)
< 50% of the time	11 (55.0)
> 50% of the time, but not always	4 (20.0)
100% of the time	2 (10.0)
TOTAL	20

Success Stories: Analysis

*Common syntax files, shared among epidemiologists, are a
great help. There is a strong commitment among the
epidemiologists for the ongoing development of a central
syntax library to ensure timely access for all epidemiologists
to high quality syntax files.*

Optimal Centralization of Personnel, Services and Processes

Table 19 presents the extent to which RRFSS representatives feel that various
RRFSS tasks should be centralized. More than half of respondents feel that determining
optional modules, dissemination within the health unit, report writing for the health unit,
assisting program staff to use results and presentation of RRFSS results within the health
unit should be solely local responsibilities. There was considerable support for sharing
the responsibilities of determining core modules, module development, data management,
data analysis, making data useable, interpretation of results and external presentations of
results.

Table 19: Extent to Which RRFSS Representatives Feel that
RRFSS Tasks Should be Local or Centralized

RRFSS Task	Mainly a Local Responsibility			50/50	Mainly a Provincial Responsibility			Total
	100% Local	75% - 90% Local	55% - 70% Local	50% Local/50% Provincial	55% - 70% Provincial	75%-90% Provincial	100% Provincial	
Determining core modules	2 (10.5)	3 (15.8)	3 (15.8)	6 (31.6)	--	3 (15.8)	2 (10.5)	19
Determining optional modules	11 (57.9)	6 (31.6)	1 (5.3)	1 (5.3)	--	--	--	19
Module development*	1 (5.3)	6 (31.6)	1 (5.3)	7 (36.8)	2 (10.5)	1 (5.3)	1 (5.3)	19
Data management	2 (11.1)	2 (11.1)	1 (5.6)	7 (38.9)	2 (11.1)	2 (11.1)	2 (11.1)	18
Data analysis	1 (5.3)	3 (15.8)	2 (10.5)	10 (52.6)	1 (5.3)	3 (15.8)	--	19
Making data useable	1 (5.3)	5 (26.3)	3 (15.8)	7 (36.8)	1 (5.3)	2 (10.5)	--	19
Interpretation of results	1 (5.3)	6 (31.6)	3 (15.8)	9 (47.4)	--	--	--	19
Dissemination within the health unit	12 (63.2)	7 (36.8)	--	--	--	--	--	19
Report writing for the health unit	15 (78.9)	4 (21.1)	--	--	--	--	--	19
Assisting program staff to use results	14 (73.7)	4 (21.1)	--	1 (5.3)	--	--	--	19
Review of materials using RRFSS results	7 (38.9)	3 (16.7)	--	4 (22.2)	1 (5.6)	3 (16.7)	--	18
Presentation of RRFSS results within the health unit	17 (89.5)	2 (10.5)	--	--	--	--	--	19
Presentation of RRFSS results externally	2 (10.5)	3 (15.8)	--	9 (47.4)	1 (5.3)	4 (21.0)	--	19

*one respondent specified that local modules should be entirely local and core modules should be entirely centralized

Working Groups: Module Development and Review

Some tasks have always been undertaken by the partnership collectively; module development and review are two such tasks. The RRFSS Evaluation 2001/02 recommended that a formal process for module development and review be established and documented. This occurred with the development of the Manual of Operations in 2002. The current Module Development and Review process is outlined in the Manual of Operations, defining the roles and responsibilities of the members of the Module Development Group. A key component of the process is engaging health unit program staff in the process and ensuring representation across health units.

Table 20 presents the level of satisfaction with the current processes by which new modules are developed and existing modules are reviewed.

Table 20: Level of Satisfaction with Module Development and Review

Level of Satisfaction	Module Development	Module Review
Very Satisfied	4 (19.0)	6 (28.6)
Somewhat Satisfied	17 (81.0)	11 (52.4)
Somewhat Dissatisfied	--	4 (19.0)
Very Dissatisfied	--	--
Total Involved	21	21
Not Involved	2	2
TOTAL	21	21

All representatives involved in module development are very or somewhat satisfied with the process (19% and 81% respectively). There is somewhat less satisfaction with the module review process, with four representatives (19%) expressing some dissatisfaction. Of those dissatisfied with module review, two feel that more central support is needed.

RRFSS representatives reported lack of time as a barrier to initiating the development of new modules. For some, initiating new modules is of low priority because there have been no requests from program staff, because the current optional modules are sufficient to meet their needs or because their health units have only recently become involved in RRFSS. Lack of time was also cited as a major reason for not participating in the development of modules initiated by other health units.

In order to participate in module development, these health units would need more staff with the time and willingness to take this responsibility on. Health promotion staff, program staff, epidemiologists and data analysts were mentioned specifically. Also needed are: space on the survey to pilot test new modules, formalized "secondment" opportunities with front-line staff to help with module development, better interface technology for group projects and project management, money to cover teleconference expenses and administrative time to organize meetings.

Representatives feel that the process of module development could be improved by revising and streamlining the decision-making process. The extent to which the partnership needs to be involved in the development of a health unit-specific module to address a local program was questioned. Efficiency might be improved by limiting the size of the group, giving more authority for the end product to the group that initiates the module and ensuring that everyone in the group understands the basic principles of questionnaire design by such means as communicating or reiterating guidelines and keeping the focus on the nature of the RRFSS survey.   Representatives also feel that the process would be improved if content experts and academic researchers were present to ensure that questions are based on scientific evidence, and experts in questionnaire design were more involved. They also reported a need for support staff to assist with documentation and communication requirements. There needs to be a clear understanding that module development is a shared responsibility between the RRFSS representative and the program staff who bring content expertise. More attention to reliability and

validity is important. All health units should adhere to the process as outlined in the Manual of Operations.

Program and research staff reported that lack of time or interest prevents them from initiating the development of modules. Some staff are not aware that this is possible. Lack of time or interest prevents program and research staff from participating in the development of RRFSS modules as well, although they are asked about content.

The process of module development is reported to be long and cumbersome by program and research staff, with no guarantee that the modules will be added to the survey or that health units will be able to use the new module because of restrictions on the length of the survey. The process needs to be shorter and more efficient. Suggestions for improvements included increased interaction between the epidemiologist and program staff to decide what information is needed, clear articulation of the "question" and a clear process or protocol. The process needs sufficient staff with more involvement from program staff, lots of feedback and both content and methodological expertise. Leadership is important and involvement of staff with previous experience in module development is helpful. Input from multiple health units and meetings by teleconference are reported to be useful.

Success Story: Module Development

Involving program staff in module development ensures that the module is linked to their program planning and evaluation needs. This builds capacity among program staff and support for the module development process.

RRFSS representatives reported that the process of module review is very time-consuming and largely invisible to their health units. Many representatives would like additional staff, either locally or centrally, to do the majority of this task, with working group members reviewing recommendations and making the decisions about proposed changes. As it is, representatives reported that reviews are sometimes not completed; the group should be responsible for completing the tasks which stem from the review. As with module development, respondents expressed the need for experts in survey design to be involved and for content to be evidence-based. Representatives should be asked to review only modules with which they are familiar. The process would be more efficient if the groups reviewing the modules were smaller. There is a need for staff and techniques to better "validate" the modules.

Program and research staff at participating health units feel that the process of module review could be improved by providing guidelines and protocols for an effective and efficient review process. Key staff should be involved in identifying issues. An annual planning cycle was suggested. Time constraints were reported, again, in this area.

Decision-Making Process within the Partnership

Satisfaction with the Decision-Making Processes

The Steering Group

Decision-making processes were rated by the RRFSS representatives and members of the Analysis Group (n=22). The decision-making processes of the RRFSS Steering Group were rated as *effective most of the time* by 11 (50%) and *effective some of the time* by eight (36%). Three respondents (14%) didn't know how effective these processes are.

Suggestions to increase the effectiveness of decision-making within the Steering Group centred on giving the group the authority to make decisions and streamlining the decision-making process. Records of decisions should be recorded and stored centrally, and be accessible to all RRFSS representatives. This group also needs more centralized and coordinated administrative support.

The Regional Working Groups

The decision-making processes of the RRFSS Regional Working Groups were rated as *effective most of the time* by 13 RRFSS representatives (59%), *effective some of the time* by six (27%) and *ineffective* by one (5%). Two respondents (9%) could not comment on the effectiveness of their group. Several respondents feel that these groups do not make decisions, but act as channels of communication between the Steering Group and the RRFSS membership. The process of communication is felt to be ineffective and to take too much time. More support for this group is seen as necessary, including paid time for leading the group, ensuring that minutes are kept, and linking with representatives. A central means of communication between meetings (such as a board) would be useful.

Success Story: Regional Working Groups

The creation of the regional working groups is a RRFSS success story. These groups help representatives to feel more connected.

The Analysis Group

The decision-making processes of the RRFSS Analysis Group were rated as *effective most of the time* by 11 RRFSS representatives (50%) and *effective some of the time* by seven (32%). Four (18%) did not know. Suggestions to increase the effectiveness of decision-making within the Analysis Group included increased autonomy and authority to make decisions, and access to experts in such areas as biostatistics and survey methodology. Respondents again identified a need for support, especially to assist with the data dictionaries and syntax files. One respondent also identified a need to accept the responsibility to complete and review data dictionaries on time and to develop syntax files.

The Special Request Review Commitee

The decision-making processes of the RRFSS Special Request Review Committee were rated as *effective most of the time* by eight RRFSS representatives (36%) and *effective some of the time* by five (23%). Nine respondents (41%) did not know. One respondents said that the Committee does not make decisions, but makes recommendations which are decided on by the RRFSS representatives. Suggestions to increase the effectiveness of the Special Request Review Committee include a need for administrative support and access to experts to help assess the methodological rigour of requests. It has been suggested that the Special Request Review Committee be dissolved and that special requests be reviewed as part of the Steering Group meetings.

The Website Group

The decision-making processes of the RRFSS Website Group were rated as *effective most of the time* by four representatives (18%) and *effective some of the time* by six (27%). Twelve respondents (54%) could not assess the effectiveness of the group. It was suggested that the group needs leadership, expertise and support. More meetings, increased visibility and increased efficiencies are seen as necessary for the group. Respondents feel that this group needs a budget and staff, including a paid secretariat.

Overall Decision-Making

Decision-making with the RRFSS partnership, overall, would be improved with more central support for RRFSS administration, including a RRFSS Director, data analyst, archivist and clerical support in addition to the RRFSS coordinator. In addition, if each health unit had a paid staff person responsible for RRFSS, the RRFSS representative might have more time to effectively participate in decisions. There are currently too many demands on local representatives.

More authority needs to be given to the Steering Group to make decisions, with perhaps one round of consultations with the Regional Working Groups. Although the current process is democratic, it is inefficient and time-consuming. An annual meeting of RRFSS representatives to resolve issues and make decisions might be helpful.

Factors Affecting Participation in RRFSS

Current and Expected Participation in RRFSS

In the 22 health units participating in RRFSS at the time of this evaluation, RRFSS representatives reported that 15 (75%) plan to continue in RRFSS; the others did not know whether their health units will continue. Of the 12 responding medical officers of health from 11 participating health units, all plan to continue in RRFSS.

Responding medical officers of health in six non-participating health units indicated that three (50%) had previously participated in RRFSS. Two are considering participation in the next two years.

Barriers to Participation in RRFSS

In participating health units, five RRFSS representatives (25%) did not know whether their participation will continue. Cost is a barrier for four health units, insufficient staff for two and other issues for two. Of the six medical officers of health from non-participating health units, cost was cited as a barrier for six and insufficient staff for three. Other barriers were that RRFSS takes too much staff time, it takes too long to get RRFSS results, that the standard contractual arrangement with ISR for a 20 minute interview is too restrictive and that greater flexibility can be achieved by arranging for a survey outside the RRFSS partnership.

Importance of Universal Participation in RRFSS

The majority of all respondent groups feel that it is important that all health units participate in RRFSS (Table 21).

Table 21: Importance of Universal Participation in RRFSS

Respondent Group	Importance of Universal Participation in RRFSS			
	Yes	No	Don't Know	TOTAL
Participating Health Units				
RRFSS Representatives	18 (90.0)	2 (10.0)	--	20
Medical Officers of Health	11 (91.7)	1 (8.3)	--	12
Non-Participating Health Units				
Medical Officers of Health	5 (83.3)	--	1 (16.7)	6
Epidemiologists or Program Evaluators	8 (88.9)	1 (11.1)		9

RRFSS representatives who feel that it is important for all health units to participate in RRFSS (90%) do so because the kind of surveillance data available through RRFSS is valuable for every health unit. Universal participation also allows accurate provincial estimates of indicators to be made available for comparison to local data. A provincial dataset aids in the evaluation of provincial programs and helps to identify emerging issues. Estimates would also be available for regions or for peer groups of health units.

Universal participation in RRFSS would allow the work of the RRFSS partnership to be distributed among more people, reducing the burden on each health unit.

RRFSS representatives who do not see universal participation as important (10%) feel that the most important function is to provide health unit-specific results to address local needs. If universal participation is not achieved, more autonomy in module selection should rest with each local health unit to enable to them to do this. It was also felt that not all health units have sufficient resources to analyze RRFSS data, and interpret and disseminate results, in which case they do not benefit from participation.

Medical officers of health of participating health units who feel that it is important for all health units to participate in RRFSS (92%) believe that provincial estimates of risk factor knowledge, attitudes and behaviour are needed. The absence of some health units means current estimates are inaccurate. A provincial dataset would allow comparisons between areas. Provincial data supports the evaluation of provincial public health initiatives and would be a source of data to monitor progress towards the MHPSG objectives. It provides a basis for comparisons between areas and between areas and the province, as well as data for policy development, advocacy, program planning and program evaluation. Universal participation would provide important data to every health unit for local planning.

The medical officer of health who does not feel that universal participation is important cautioned that participating health units must have the capacity to use the data; otherwise resources are wasted.

Medical officers of health from non-participating health units have similar opinions; 83% agree that universal participation is important. Universal participation would allow the calculation of provincial estimates. The value of provincial data for comparisons and evaluation purposes was mentioned. The medical officer of health who could not say whether universal participation in RRFSS is important expressed the opinion that RRFSS is too time-consuming, but would support a less bureaucratic risk factor surveillance system.

Epidemiologists and program evaluators of non-participating health units who support universal participation (89%) pointed to the advantages of a provincial dataset to provide provincial estimates and allow comparisons between heath units and the province or health units and their peer groups. Universal participation gives every health unit the data they need to describe their population, assess programming needs, evaluate current programs and monitor changes over time. Local data are needed for planning, reporting and accountability. A provincial sample would be large enough to enable various subgroup analyses not possible at the county level. The respondent who indicated that universal participation in not important does not see it as necessary, but recognizes the importance of universal participation if provincial or peer group comparisons are to be done.

Strategies to Strengthen Participation in RRFSS

Opinions of Staff in Participating Health Units: RRFSS Representatives, MOH and AMOH

RRFSS representatives feel that promotion of RRFSS and RRFSS products, and increased funding would help to strengthen participation. Education and promotion about RRFSS was mentioned as a means to strengthen participation, especially through the Council of Medical Officers of Health. Showcasing the data and products using RRFSS results and demonstrating how these can be used to support the work of the health unit would increase buy-in.   Tying results specifically to Mandatory Programs and using

them to monitor progress would help to promote RRFSS. Knowledge exchange workers were mentioned as a group who could do this. Continuing to foster an evidence-based learning environment would also help.

RRFSS representatives also think that funding of the RRFSS survey and support of centralized services and personnel for RRFSS would help to strengthen participation.

Medical officers of health and associates of participating health units suggested that funding RRFSS in all health units, making it mandatory (through the MHPSG) and expecting the results to be used for local program planning, evaluation and monitoring would be required to strengthen participation in RRFSS. Results should be tied into a revised Mandatory Program Indicator Questionnaire and key performance indicators should be measured through RRFSS. Other suggestions centred on raising the profile of RRFSS. These included promoting a culture of evidence-based planning, monitoring and evaluation in health units, updating and improving the website, providing public access to all results through the website, disseminating the findings through publications and presentations, and demonstrating the impact of RRFSS results on programming.

It was also suggested that participation might be increased through improvements to RRFSS itself. On-going review of existing modules, increased resources for analysis and module development, staff training and professional development and a faster module development process were considered improvements which would encourage more health units to join.

A provincial sample would result if all health units were able to participate and this would, in turn, raise the profile of RRFSS among other public health stakeholders (e.g. Cancer Care Ontario).

Opinions of Staff in Non-Participating Health Units: MOH and AMOH, Epidemiologists and Program Evaluators

It is particularly revealing to look at the comments of medical officers of health in of non-participating health units, since the needs of these agencies must be addressed to increase buy-in. Once again, the lack of funding is identified as barrier. Centralized analysis of (for example) provincial and regional indicators would encourage participation. A larger sample size would also encourage participation because shorter timeframes would be required to achieve a reportable sample. Oversampling of populations of particular interest, such as parents and youth, was also mentioned. Respondents also suggested that content development must be linked to needs identified by program directors and medical officers of health.

Epidemiologists and program evaluators identified funding as a factor which would encourage participation. They suggested that not only funding of the survey, but also funding of RRFSS positions within the health units for analysis, interpretation and dissemination, are needed. Provincial coordination of these staff is also needed. Other suggestions included increased cost efficiency, greater flexibility in content with more

ownership by the health unit, more timely release of data to the health unit, less overlap with the CCHS, centralized analysis of provincial and regional indicators, regional meetings to demonstrate the uses of RRFSS results and regular updates on current activities and plans within RRFSS.

Funding Models

Funding of Contract Costs with ISR

Opinions on how the survey contract costs should be covered are presented in Table 22. In participating health units, RRFSS representatives are equally divided on whether the contract costs of RRFSS with ISR should be covered 100% by the MOHLTC (35%), should be supported in health unit budgets along with Mandatory Health Programs and Services (29%) or whether the MOHLTC should cover the costs of core modules while the health units covers the costs of optional modules (35%). Medical officers of health are split between costs being covered 100% by MOHLTC and the costs of core modules covered by the MOHLTC and optional modules by health units. Respondents from non-participating health units favour 100% funding by the MOHLTC.

**Table 22: Proposed Funding of RRFSS Contract Costs
with the Institute for Social Research**

Funding Ratio	Respondent Group (n(%))			
	RRFSS Representatives	MOH Participating HU	MOH Non-Participating HU	Epidemiologists Non-Participating HU
100% MOHLTC	6 (35.3)	5 (45.5)	4 (66.7)	6 (66.7)
Same Ratio as MHPSG	5 (29.4)	1 (9.1)	2 (33.3)	2 (22.2)
100% MOHLTC for Core/ 100% Local for Optional	6 (35.3)	5 (45.5)	--	1 (11.1)
TOTAL	17	11	6	9

Funding of Centralized, Regional and Local RRFSS-Related Activities

All 20 RRFSS representatives feel that the MOHLTC should contribute to other RRFSS costs as well as the contract costs with ISR. Eleven of 12 medical officers of health from participating health units as well as five of six medical officers of health and eight of nine epidemiologists and program evaluators from non-participating health units feel that the MOHLTC should make a contribution to other RRFSS costs.

Centralized Services

Opinions on funding ratios for the RRFSS coordinator, website, annual workshop and centralized analysis are presented in Table 23. The majority of respondents in all groups feel that the MOHLTC should cover the costs of the RRFSS coordinator, website and, with the exception of medical officers of health from participating health units, the annual workshop. Opinions vary on the costs associated with centralized analysis of

RRFSS results. Overall, slightly fewer than half (47%) of respondents feel that the MOHLTC should pay for this cost entirely.

Table 23: Centralized Services Required for RRFSS
and Proposed Funding Ratios

Centralized Personnel or Service	Respondent Group (n(%))			
	RRFSS Representatives	MOH Participating HU	MOH Non-Participating HU	Epidemiologists Non-Participating HU
	(n = 20)	(n = 12)	(n = 6)	(n = 9)
RRFSS Coordinator				
50% local/50% MOHLTC	2 (10.0)	--	--	--
Same ratio as MHPSG	3 (15.0)	1 (8.3)	--	1 (11.1)
100% MOHLTC	15 (75.0)	10 (83.3)	5 (83.3)	7 (77.8)
MOHLTC should not fund	--	1 (8.3)	1 (16.7)	1 (11.1)
TOTAL	20	12	6	9
RRFSS Website				
50% local/50% MOHLTC	2 (10.0)	--	--	--
Same ratio as MHPSG	2 (10.0)	--	--	--
100% MOHLTC	16 (80.0)	10 (83.3)	5 (83.3)	8 (88.9)
MOHLTC should not fund	--	2 (16.7)	1 (16.7)	1 (11.1)
TOTAL	20	12	6	9
Annual RRFSS Workshop				
75% local/25% MOHLTC	1 (5.0)	--	--	--
50% local/50% MOHLTC	--	1 (8.3)	--	--
Same ratio as MHPSG	3 (15.0)	10 (83.3)	--	--
100% MOHLTC	16 (80.0)	--	5 (83.3)	7 (77.8)
MOHLTC should not fund	--	1 (8.3)	1 (16.7)	2 (22.2)
TOTAL	20	12	6	9
RRFSS Analysis				
100% local	2 (10.5)	--	--	--
50% local/50% MOHLTC	3 (15.8)	--	--	--
25% local/75% MOHLTC	1 (5.3)	--	--	--
Same ratio as MHPSG	5 (26.3)	3 (25.0)	1 (16.7)	2 (22.2)
100% MOHLTC	7 (36.8)	7 (58.3)	4 (66.7)	4 (44.4)
100% MOHLTC for core/ 100% local for optional		--	--	1 (11.1)
100% MOHLTC for provincial analyses/ 100% local for health unit analyses	1 (5.3)	--	--	--
MOHLTC should not fund		2 (16.7)	1 (16.7)	2 (22.2)
TOTAL	19	12	6	9

Other centralized personnel and services suggested by respondents are given in Table 24.

Table 24: Other Centralized Services Required for RRFSS and Proposed Funding Ratios (Responses to Open-Ended Question)

Centralized Personnel or Service	Respondent Group (n(%))			
	RRFSS Representatives	MOH Participating HU	MOH Non-Participating HU	Epidemiologists Non-Participating HU
RRFSS training				
50% Local/50% MOHLTC	1			
100% MOHLTC	1			
Data analyst for provincial analysis				
100% MOHLTC	2	1	1[1]	
Webmaster				
100% MOHLTC	1			
Module Development				
Same Ratio as MHPSG		1		
100% MOHLTC		1		
Research and Validation Studies				
100% MOHLTC		1		
HR for Local Program Evaluation				
Same Ratio as MHPSG				1
Number of Respondents	20	12	6	9

[1] provincial analysis not specified

Medical officers of health in participating health units assign highest priority to the cost of the survey for every health unit and centralized support (coordinator, website, information technology and analysis). There is support for the development of reliable and valid modules and methodological work to increase sample representativeness. Regional and local support for RRFSS personnel were mentioned less often as a priority.

Medical officers of health in non-participating health units expressed the opinion that RRFSS should be funded in full by the MOHLTC; this includes module development as well as the contract costs to ISR. Other priorities include data analysis, the RRFSS coordinator and training for local users.

Epidemiologists and program evaluators at non participating health units also identify the survey costs as a priority. This group was more likely to identify health unit support—personnel, training and analysis software—as a priority. Also mentioned were the RRFSS coordinator, regional analyses, regional support and expenses incurred during module development.

In identifying items which they think should be funded by the MOHLTC, RRFSS representatives assign high priority to the cost of the survey contract with ISR, centralized coordination of RRFSS (RRFSS director or coordinator), and centralized support for data management, provincial analysis and dissemination, including the website.

Of 12 RRFSS representatives who specified where centralized services should be located, five suggested Toronto or the MOHLTC in Toronto, three suggested the Agency, one suggested the Agency or PHRED and one suggested the location at the time of the

evaluation (Halton Region Health Department). One respondent said the location should be determined by the location of appropriate staff and the services could be located in several offices. A last respondent was of the opinion that centralized services should not be located in a health unit.

Medical officers of health were more likely to suggest the Agency as a location for centralized RRFSS personnel and services (five of nine respondents), while other suggestions included either the Agency or a volunteer health unit and either the Agency or the MOHLTC once their roles have been clarified. Other respondents feel that links with the MHP and the Ministry of Children and Youth Services are needed, or that location is unimportant.

Three medical officers of health from non-participating health units suggested locations for centralized personnel and services. These included the Agency and the MOHLTC.

Of seven epidemiologists or program evaluators from non-participating health units, three feel that centralized services should be located with the MOHLTC and one with the Agency. Other responses indicated that location should be other than Toronto, or should be determined by access to health units and other RRFSS services.

Regional Services

Opinions on regional personnel and services which should be supported by the MOHLTC are presented in Table 25. There is support for regional RRFSS directors or coordinators, regional epidemiologists or data analysts and support for dissemination. In most cases it was suggested that these be completely supported by the MOHLTC.

**Table 25: Regional Services Required for RRFSS and Proposed Funding Ratios
(Responses to Open-Ended Question)**

Regional Personnel or Service	Respondent Group (n(%))			
	RRFSS Representatives	MOH Participating HU	MOH Non-Participating HU	Epidemiologists Non-Participating HU
RRFSS Director				
100% MOHLTC	1			
RRFSS Coordinator				
Same Ratio as MHPSG	1			
100% MOHLTC	1	1		
RRFSS Representative				
Same Ratio as MHPSG	1			
Epidemiologist				
Same Ratio as MHPSG				1
100% MOHLTC	2	3		
Data Analyst				
Same Ratio as MHPSG	2			1
100% MOHLTC	1			3
Webmaster				
100% MOHLTC	1			
Admin Support/Research Assistant				
100% MOHLTC	1	1		
Analysis and Report Writing				
100% MOHLTC	1			
Communications				
100% MOHLTC		1		
Number of respondents	20	12	6	9

RRFSS representatives suggested the following locations for regional services: a central location such as Toronto, the PHREDs, the Agency, each region of the province (in the PHREDs if these are given a regional mandate) and the LHINs.

Medical officers of health from participating health units suggested the LHINs, the PHREDs or volunteer health units as suitable locations for regional personnel and services. Regional offices of the Agency were also suggested. PHREDs were suggested by a medical officer of health from a non-participating health unit.

Epidemiologists and program evaluators from non-participating health units suggested host health units or PHREDs as appropriate locations for regional services. This group mentioned that it is important that all health units in the region have access to these services, including northern health units, and that this should influence the choice of location.

Local Services

Personnel and services which respondents feel should be supported at the local level are presented in Table 26. These include epidemiologists, research or data analysts, support staff and staff to support dissemination of RRFSS results. Health unit contributions to these staff were proposed for two thirds of the suggested personnel and

services. Respondents from all groups feel that these services should be located in the health units.

Table 26: Local Services Required for RRFSS and Proposed Funding Ratios
(Responses to Open-Ended Question)

Local Personnel or Service	Respondent Group (n(%))			
	RRFSS Representatives	MOH Participating HU	MOH Non-Participating HU	Epidemiologists Non-Participating HU
Epidemiologist				
50% Local/50% MOHLTC	1			
Same Ratio as MHPSG	2	2	1	2
100% MOHLTC				4
Unspecified	1			
Data/Research Analyst				
100% Local	1			
50% Local/50% MOHLTC	3			
Same Ratio as MHPSG		6		3
100% MOHLTC	2			
Epidemiologist or Data Analyst				
50% Local/50% MOHLTC	1			
Same Ratio as MHPSG				1
RRFSS Representative				
Same as MHPSG	1			
100% MOHLTC		1		
Performance Measurement Officer				
100% MOHLTC		1		
Support Staff				
100% MOHLTC		1		
Data Clerk				
100% MOHLTC			1	
Report Writer				
100% MOHLTC			1	
Data Analysis/Dissemination				
Same Ratio as MHPSG	1			
Number of Respondents	20	12	6	9

RRFSS representatives feel that the MOHLTC would be more likely to support RRFSS if there were more standardized data analysis and more centralized staff. Epidemiologists and program evaluators feel that better coordination with CCHS would increase buy-in (Table 27).

Table 27: Factors that Would Increase MOHLTC Buy-in to RRFSS

Factors	Respondent Group	
	Participating HU: RRFSS Representatives	Non-participating HU: Epidemiologists & Program Evaluators
More standardized data analysis	13 (68.4)	4 (44.4)
More centralized staff	13 (68.4)	4 (44.4)
Better validated modules	8 (42.1)	3 (33.3)
Improved co-ordination with CCHS	7 (36.8)	5 (55.6)
Use of time trend analysis	6 (31.6)	4 (44.4)
Use of more sophisticated analysis	4 (21.1)	1 (11.1)
Larger sample size	2 (10.5)	1 (11.1)
More modules	2 (10.5)	3 (33.3)
Change in sampling design	--	2 (22.2)
Other	7 (36.8)	4 (44.4)
Number of Respondents	19	9

Advantages of MOHLTC Funding of RRFSS

Opinions of Staff in Participating Health Units: RRFSS Representatives, MOH and AMOH

Many advantages of MOHLTC funding of RRFSS were expressed by RRFSS representatives. The most commonly expressed advantage is that MOHLTC funding reduces cost as a barrier. All health units would benefit from having local data for surveillance and program planning and evaluation. Health units that do not currently participate in RRFSS would be able to join in, and participating health units would be able to put the money they currently invest in RRFSS into programs and other priorities. In some health units the cost of RRFSS is paid by programs with more funding, which then claim a larger share of optional questions; such program disparities would be reduced. MOHLTC funding demonstrates a commitment to evidence-based decision-making and provides the tools needed to do this.

Across the province there would be a uniform tool that could be used to evaluate programs and campaigns and meet funding requirements. A complete provincial dataset would be available; this would heighten awareness and utility of RRFSS. MOHLTC funding would provide a reason to select core modules of interest to the MOHLTC and these could be used to monitor key provincial initiatives. Provincial evaluations could be better coordinated and central administration would be improved. A provincial dataset would allow improved provincial comparisons.

In addition, provincial funding would provide a surveillance system which is equally important as reportable disease systems. This would hopefully bring in additional expertise to help and improve the system overall, and also provide more centralized support and services.

Medical officers of health and associates of participating health units see universal participation and increased stability as advantages of MOHLTC funding of RRFSS. A provincial dataset of core indicators would be available to evaluate provincial initiatives and to facilitate coordination of programming and evaluation activities across Ontario health units. The utility of RRFSS results would be greatly increased by having provincial data. All health units would benefit by having RRFSS results, especially if local flexibility is assured. MOHLTC funding would also allow for the centralization of many tasks which are currently done in all participating health units, resulting in increased efficiency. MOHLTC funding would also increase the opportunities for this ministry to contribute to module development, data analysis and knowledge exchange; in addition it would enable the Ministry to mandate RRFSS as a means to provide performance indicators.

It was mentioned that there would be no advantages to the MOHLTC to fund RRFSS if the Ministry is at "arm's length" and does not contribute to content and analysis.

Opinions of Staff in Non-Participating Health Units: MOH and AMOH, Epidemiologists and Program Evaluators

Medical officers of health in non-participating health units feel that MOHLTC funding would allow more health units to participate in RRFSS, especially if an epidemiologist or data analyst in each health unit were also funded 100%. Coordination of RRFSS activities centrally, such as module development, would decrease the burden to individual health units. Providing data to all health units would improve local planning and increase their ability to respond to community issues. RRFSS would become more comprehensive. Provincial and regional indicators would be available.

Epidemiologists and program evaluators in non-participating health units said that MOHLTC funding would reduce the impact of cost as a barrier to participation and ensure equitable access to local data. They also identified a provincial dataset as a benefit of MOHLTC funding. This group suggested that provincial funding might result in some centralized services such as analysis of core modules, which would benefit smaller health units with limited resources. MOHLTC support is seen as not necessarily improving the surveillance system; the RRFSS Working Group is "doing a good job".

Disadvantages of MOHLTC Funding of RRFSS

Opinions of Staff in Participating Health Units: RRFSS Representatives, MOH and AMOH

The greatest disadvantage of MOHLTC funding perceived by RRFSS representatives is a loss of health unit control, autonomy and decision-making powers. RRFSS is working well for participating health units because they retain control. There is a concern that the Ministry will dictate the content of RRFSS and that health units will have little say in module selection. Local decision-making and flexibility might be lost in

a desire to standardize the content provincially. Standardization of the content would reduce the usefulness of RRFSS to address local needs.

MOHLTC funding of RRFSS might make it more vulnerable, due to changing political priorities.

One respondent felt that the MOHLTC has difficulties supporting a complex system such as RRFSS and that it would therefore be important to involve MOHLTC staff dedicated to this task. It was also noted that there would have to be agreement on such issues as ownership of data and data-sharing, and that some degree of local autonomy would have to be guaranteed.

Workload issues were also mentioned. One potential scenario would require PHRED epidemiologists to produce regional analyses. This is seen as increasing an already overwhelming workload.

Loss of local control is seen as a disadvantage of MOHLTC funding by medical officers of health and associates in participating health units. The MOHLTC could ask or demand modules addressing provincial priorities or political issues. These might replace modules of local interest (core or optional), or at least reduce the flexibility of the health unit. The ministry could potentially censor some local content, analysis or dissemination. This would undermine the usefulness of RRFSS at the local level, particularly for surveillance, local planning, program evaluation and risk communication. Through the current process of Public Health Renewal, it is possible that programs will be transferred to other ministries. If the MOHLTC were the sole funder, content relevant to programs housed in other ministries might be lost. There is a need to ensure integration across the ministries.

Reduced stability and insecure funding were also identified as risks; RRFSS would be subject to budget cuts and political whims. This would be avoided if RRFSS were to become part of the core business of the Agency. MOHLTC funding could reduce the RRFSS sample size, since ministry priorities might be satisfied with a smaller total sample size, and consequently local analyses would suffer.

Opinions of Staff in Non-Participating Health Units: MOH and AMOH, Epidemiologists and Program Evaluators

Medical officers of health of non-participating health units mentioned similar disadvantages to those of their conterparts in participating health units: lack of local control over content, a risk that the content would not address local needs and funding insecurity. Local input over the content of RRFSS was identified as important so that local, current issues and priorities continue to be addressed in a timely way.

Similar to the other groups, epidemiologists and program evaluators of non-participating health units identified loss of local control and flexibility as a risk of MOHLTC funding. The ministry would have control over the length and content of

RRFSS, without adequate reflection of the needs of health units for local data to aid in program planning and evaluation. Financial insecurity was identified by this group also. MOHLTC funding would reduce local control and impose bureaucratic restrictions and requirements, generally unhelpful but unavoidable because the ministry is ultimately under political control. This concern was echoed by others throughout the evaluation—that funding arrangments must allow the current RRFSS groups to continue to run RRFSS if efficiency of the system is to be preserved. Bringing RRFSS under the funding envelope for Mandatory Programs would allow this.

It was cautioned that funding of the survey alone would increase workload in the health units, but centralized analysis or report-writing might reduce this burden.

Other responses were that MOHLTC funding would carry no disadvantages and that the equal access assured by funding is worth the price of lack of control.

Implications of Provincial Expansion

Provincial Estimates of Health Indicators

The majority of respondents are in favour of being able to derive provincial estimates of health indicators from RRFSS results (Table 28).

Table 28: Opinions on Whether RRFSS Should Provide Provincial Estimates of Health Indicators

Respondent Group	Opinions on Whether RRFSS Should Provide Provincial Estimates of Health Indicators		
	Yes	No	Total
Participating Health Units			
RRFSS Representatives	18 (94.7)	1 (5.3)	19
Medical Officers of Health	10 (83.3)	2 (16.7)	12
Non-Participating Health Units			
Medical Officers of Health	5 (83.3)	1 (16.7)	6
Epidemiologists or Program Evaluators	6 (66.7)	3 (33.3)	9

RRFSS representatives feel that a provincial sample is valuable because it allows comparisons between individual health units and the province, region, peer group, or LHIN area. A provincial sample provides tools for the evaluation of provincial programs and campaigns, and provides results for setting provincial targets and goals. The results can be used to monitor Mandatory Health Programs and Services. A provincial sample is useful for external agencies and might allow estimates to be available more quickly. MOHLTC buy-in would be increased if a provincial sample were available, although throughout this survey it was also suggested that Ministry buy-in would be required in order to achieve a provincial sample.

Reasons for not deriving provincial estimates from RRFSS results included the comments that this was a purpose of the CCHS and need not be duplicated by RRFSS, that not all health units participate in RRFSS, that the RRFSS sample is non-representative and includes only people with telephones, and that RRFSS is a local tool and the goal of provincial estimates may reduce the flexibility of health units to incorporate content of local interest.

One respondent reminded the investigators that provincial estimates would require appropriate weighting of data unless proportional sampling were used.

Of 18 RRFSS representatives and 10 medical officers of health who feel that provincial estimates should be derived from RRFSS results, 11 (39%) feel that the sampling strategy to derive these estimates could be kept as is, and four (14%) think sampling should remain as it is but that there should be oversampling in Toronto. Two (7%) support sampling in proportion to population and a further six (21%) support proportional sampling with a minimum sample of 100 per health unit per month. Two (7%) suggested other methods (separate provincial sample for provincial estimates and the use of CCHS methodology), two (7%) think the question needs more consideration. One (4%) did not suggest a strategy.

Medical officers of health from non-participating health units feel that a provincial sample is important for comparison purposes and to provide data for benchmarking. A provincial samples permits detailed analysis. A provincial system with improved sampling techniques would provide rapid information on important issues and faster reporting.

Epidemiologists and program evaluators from non-participating health units feel that a provincial sample is important for allowing comparisons across health units and between health units and the province, and enabling provincial, regional and local issues and trends to be identified. A provincial sample would allow subgroup analyses which cannot be done at the local level. A provincial sample must be an aggregate of all health unit samples. RRFSS should be used to provide estimates of health indicators not covered by CCHS.

Potential Roles for the Ministry of Health and Long-Term Care in RRFSS

Opinions of Staff in Participating Health Units: RRFSS Representatives, MOH and AMOH

Funding is the role most frequently mentioned by RRFSS representatives for the MOHLTC. Funding of the survey itself was mentioned, particularly to allow participation of all health units. Funding of centralized staff, including the RRFSS coordinator, staff to perform analysis and RRFSS staff within the health units was also mentioned. Support of centralized functions, such as administrative support, coordination of core content (with other MOHLTC data collection tools and campaigns),

module development, analysis of core modules and provincial and regional data analysis (particularly to evaluate provincial initiatives), were mentioned by almost all respondents. Respondents also mentioned the need for MOHLTC support for the following: developing overarching policies and procedures, the RRFSS website, a RRFSS listserve, the annual meeting, research into data quality, centralized training of RRFSS representatives and analysts, office space for centralized personnel and leadership in encouraging RRFSS to lead chronic disease surveillance in Ontario and in Canada.

Some respondents suggested that the role between RRFSS and the MOHLTC should be that of a partnership. Although the MOHLTC might be involved in the development of core modules, optional module development and selection should remain in the hands of individual health units. An alternative to full funding of RRFSS in all health units is the purchase of additional sample in non-participating units so that a representative provincial sample is available.

The majority of medical officers of health and associates feel that the MOHLTC should provide the necessary funds for health unit participation in RRFSS. In addition to data collection, respondents specified that the costs of the coordinator, local data analysis, module validation and an increase in the size of the sample should be included in the funding. Respondents feel that the MOHLTC should support module development and/or data analysis, including special studies, comparative reports, provincial analyses, regional comparisons, local needs assessments and results for provincial planning and evaluation. The MOHLTC should be involved in knowledge transfer. Respondents see a coordinating role for the MOHLTC and full partnership was also mentioned.

Opinions of Staff in Non-Participating Health Units: MOH and AMOH, Epidemiologists and Program Evaluators

Medical officers of health from non-participating health units feel that the MOHLTC should provide funds to allow participation in RRFSS. It was also proposed that the MOHLTC should be a full participant and should be allowed to add questions of interest to them.

The majority of epidemiologists and program evaluators from non-participating health units believe that the MOHLTC should be involved in funding RRFSS. It was suggested that the funding for RRFSS could flow from the MOHLTC (or other agency) to the health units as part of their base budgets. Other roles identified by this group include those of coordination, training, priority-setting, setting policies and procedures to ensure access to timely data, providing resources for data analysis, producing reports, providing a network for dissemination to the health units and evaluation. The tension between funding and control of RRFSS was recognized. It was suggested that the MOHLTC could fund the Agency to run RRFSS.

Potential Roles for Ministries Other than the Ministry of Health and Long-Term Care in RRFSS

Opinions of Staff in Participating Health Units: RRFSS Representatives, MOH and AMOH

When discussing the roles of the MOHLTC, many respondents, including RRFSS representatives, medical officers of health and associates, epidemiologists and program evaluators, mentioned that the MHP or the Agency might be more appropriate agencies to provide funds, support or infrastructure for RRFSS.

The Ontario Health Protection and Promotion Agency

RRFSS representatives feel that the Agency should have a coordinating role in RRFSS. They believe that centralized personnel—a RRFSS director, the RRFSS coordinator, data analysts, an archivist and clerical staff—could be housed in the Agency and the website could be supported from here. It was also suggested that the Agency could provide expert advice, ensure knowledge transfer and exchange, provide training for RRFSS and support regional RRFSS staff. The Agency could also do provincial analyses and write provincial reports, provide input and advice for emerging public health issues, identify data gaps and assist in module development, especially in areas of interest to the MOHLTC. The Agency was identified as a user of RRFSS results on chronic disease and injury prevention.

Medical officers of health and associates in participating health units see the Agency as taking a coordinating and supporting role in RRFSS, including the website. Respondents feel that the Agency could participate in sampling and module development, do centralized data analysis of RRFSS core content as well as complex analyses, engage in knowledge transfer and exchange, and create reports for the health units as well as provincial health status reports. The Agency is seen as able to assure increasing development and appropriate use of RRFSS, to establish core modules with consultation from the field and from multiple ministries, to scan national and international developments that could impact desired modules, to provide technical support to epidemiologists, health units and ministries and to provide professional development and training of local health unit staff responsible for interpreting and using RRFSS results. A research role was also suggested, including validation studies and acting as a partner at scientific meetings. Funding was mentioned less frequently as a role for the Agency than as a role for the MOHLTC.

The Ministry of Health Promotion

RRFSS representatives feel that the MHP should be advisory to RRFSS, and could assist in the identification, selection and development of modules. The MHP could also help to coordinate content with other ministry data collection tools or campaigns. The MHP is also seen as a user of RRFSS results, particularly in the areas of smoking,

physical activity and healthy weights, and for purposes of monitoring provincial initiatives and making decisions.

The MHP is also seen as an alternate funder of RRFSS. Again the funding role is seen as extending to housing and support for centralized staff, administration and suppport for analysis as well as for the survey itself.

Medical officers of health and associates in participating health units see a funding role for the MHP, particularly for modules covering risk factors for chronic disease such as body mass index (BMI), tobacco and physical activity. The MHP is also seen as providing content expertise for module development. Respondents also feel that the MHP might use chronic disease results, particularly for program planning. As a user of the results, the MHP could or should be involved in funding, module development, proposing questions to be asked, data synthesis and analysis, and knowledge transfer and exchange. Perhaps this ministry could be a RRFSS partner instead of the MOHLTC if provincial sampling were to be a goal for RRFSS.

Ministry of Children and Youth Services

From RRFSS representatives, there was a suggestion that the Ministry of Children and Youth Services could link with RRFSS to use results and help to build on this system or encourage the development of a similar system to provide a child and youth surveillance system (e.g. Parent Survey).

Medical officers of health of participating health units also identified roles for the Ministry of Children and Youth Services. This ministry could be involved in funding, module development, proposing questions to be asked, data synthesis and analysis, and knowledge transfer and exchange. Also, RRFSS can provide information for the Early Childhood Development Initiatives.

Ministries (Generalized) Other than the MOHLTC

Several RRFSS representatives commented generally on "other Ministries", meaning ministries other than the MOHLTC. They suggested that other ministries could provide funding, help to coordinate content, house centralized staff, and provide advice and expertise. Other ministries are also seen as users of RRFSS results.

Medical officers of health and associates of participating health units identified the Ministry of Education and School Boards as users of RRFSS information. Ministries such as Education, Labour and Municipal Affairs might request information or even specific modules, but their requests should be secondary to the needs of the MHP or the MOHLTC.

Opinions of Staff in Non-Participating Health Units: MOH and AMOH, Epidemiologists and Program Evaluators

The Ontario Health Protection and Promotion Agency

Medical officers of health from non-participating health units suggested that the Agency could assume some overall responsibilities for RRFSS, including funding and coordination. The Agency could also be a consultant for question development and assist in selecting content indicators relevant to their program mandate.

Some epidemiologists and program evaluators from non-participating health units see the Agency as a funder or potential host agency. Some feel that, instead of ISR, the Agency should take a lead role in the design and methodological considerations of RRFSS, obtain input on content from the field and liaise with the CCHS, carry out the survey and distribute the raw data files. Other respondents feel that the Agency should participate in planning and training, consult on question development, carry out provincial analysis of selected data and provide funding for special projects.

The Ministry of Health Promotion

Medical officers of health from non-participating health units see the MHP as fulfilling similar roles as the Agency: coordination, funding and module development in content areas relevant to their ministry. In addition, it was suggested that the MHP is a potential host agency.

Epidemiologists and program evaluators from non-participating health units feel that this ministry should be involved in funding RRFSS, training, planning and coordinating, priority-setting and establishing policy, determining content and providing resources for analysis, dissemination and evaluation. The MHP might define modules relevant to provincial health indicators (with local and ministry input), consult on question development and carry out analysis of selected data. It was also suggested that this ministry might fund the Agency to coordinate RRFSS or fund only core modules.

Public Health Research, Education and Development Program

It was suggested by respondents from a non-participating health unit that PHRED could perform regional data analysis.

RESULTS III: CONTINUING ISSUES
KEY INFORMANT INTERVIEWS

Provincial Representation of Data

There is general agreement that provincial presentation of data is a desired RRFSS product. Particularly useful is a provincial dataset which can be drilled down to the local level. Provincial estimates are useful for MOHLTC needs. Health units benefit from comparisons with other health units and the province. The current system is disadvantaged because not all health units participate and also because questions are not necessarily useful at a provincial level. Ideally the strengths of RRFSS will complement the weakness of other data sources. A balance between local and provincial needs is necessary. The need for health unit autonomy is respected.

Strengths and Limitations or Challenges of a Provincial System

The strengths of a provincial system include a representative provincial dataset and the ability to derive provincial estimates, the addition of questions to address government priorities, high quality data, economies of scales and potential cost savings.

A provincial system includes the challenges of collaboration between the province and all health units as equal partners, avoiding a "take-over" by the province. A provincial system is likely to operate more slowly than the current RRFSS system. Sharing of data may also be a challenge. Presumably, the aim of the MOHLTC is to have provincial data, while the health units will wish their own datasets. Sharing beyond this will require agreements.

Partners Who Want or Need Provincial Data

A wide variety of partners were reported to want or need provincial data. All levels of government, including the premier, cabinet, treasury board, assistant deputy ministers and program personnel are potential users of the data. The MOHLTC, MHP, Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Education and Ministry of the Environment were mentioned specifically. These partners are changing and new sectors would be interested. LHINs would be interested, but it is not known whether boundaries will align.

Outside government, many agencies were reported to be potentially interested: Ontario Public Health Association, Cancer Care Ontario, AIDS Bureau, Hepatitis C Secretariat, Ontario Medical Association, Association of Local Public Health Agencies, Ontario Public Health Association and Institute for Clinical Evaluative Sciences (ICES). Academics, researchers and provincial ministries outside of Ontario might be interested. The private sector may also wish data, but it may be advisable not to provide data to this sector.

Information in both infectious and chronic disease areas are of interest. The quality of data will likely influence requests. Data-sharing agreements would need to be developed.

Uses for Provincial Data

MOHLTC representatives reported a wide variety of uses for provincial data. Provincial data are useful to establish baselines, to set targets and monitor whether they have been achieved, to provide information for planning and evaluating programs as well as adapting methods of delivery. RRFSS data can be used to assess and monitor risk behaviours, determinants of health and health status and to provide analyses of current or emerging issues. They can be used to evaluate provincial initiatives and programs (especially with respect to attitudes and behaviours). They are useful for communication in many forms--communications on mandate, in response to questions from stakeholders and in the political arena. They can assist with setting program priorities and can be used for funding decisions.

Within the public health system, they can be used for surveillance and for comparisons with other provinces or countries. RRFSS may provide potential performance indicators, including some relevant to compliance with MHPSG.

Alternate Sources of Provincial Data and their Performance in Comparison to RRFSS

The CCHS was mentioned most often as an alternate source of data. It has advantages of being national in scope, large and of high quality, conducted by Statistics Canada which is a trusted source. It is possible to purchase an increased sample in Ontario to provide sufficient data to aid in decisions. Comparisons can be done with other provinces and from year to year. The CCHS is a longer survey than RRFSS, allowing more content. The CCHS takes place every two years and questions can become outdated, whereas RRFSS is continuous. RRFSS has the advantage of providing data more quickly, closer to events which are being monitored or to events for which the data are to be used. Flexibility is an advantage of RRFSS. Content can be tailored to health unit needs and emerging issues can be rapidly integrated into the survey. ISR is willing to aggregate data for different geographic regions of interest to the MOHLTC. The MOHLTC would find RRFSS more useful if they could have some input into the content.

RRFSS is limited by the problems inherent in a telephone survey, notably fatigue on the part of the general public. Health-related surveys may be misconstrued as political surveys. It also cannot capture behaviours of children and youth because of the age restriction. Respondents pointed out that RRFSS and CCHS should complement each other. It was also pointed out that there was an advantage to using each other's questions because of the pretesting that takes place in these surveys.

There may be changes in CCHS which will confer some of the advantages now enjoyed by RRFSS. It may allow health units to select questions and may permit the calculation of provincial estimates every six months rather than every two years.

Other surveys such as those of the Centre for Addiction and Mental Health and the Ontario Tobacco Research Unit, and the Canadian Tobacco Use Monitoring Survey were mentioned as useful, especially if the MOHLTC has some input into content. This is sometimes not possible, especially with respect to questions about Ontario legislation. Public opinion surveys are large in scope and are conducted more quickly than RRFSS, but are more expensive.

Payment for Access to Provincial Data

There is some agreement that the public should not pay twice for RRFSS data, and therefore data should be shared freely with other health units and publicly funded agencies such as Cancer Care Ontario. If, however, the request requires additional work, it might be permissible to charge for this. The opposite opinion, that partners or agencies should pay for their access to data, was also expressed. It was also pointed out that partners who pay may have expectations that they can influence the content of the survey.

If the request comes from a private source, the question of charging for data should be carefully considered. Sensible guidelines need to be established. It may be that the staff and record-keeping that this would require would not make it worthwhile.

It is important to develop a process to handle external requests. Health units must decide how much autonomy they are willing to give up. Some loss of autonomy may be balanced by additional data or analysis.

Extent of MOHLTC Investment in RRFSS

This is currently under discussion. There is support in the MOHLTC to contribute to RRFSS. However, RRFSS is most valuable to the MOHLTC if all health units participate.

The question of MOHLTC support was clearer before the MHP split from this ministry. What is left in the MOHLTC may not have as much use for RRFSS results. They do have access to other existing data sources (hospital discharge data, integrated public health information system (iPHIS) data, etc.) and the monitoring data they need may not be available in RRFSS.

Financial and Human Resources that MOHLTC Might be Willing to Invest in RRFSS to Enable it to Extend to a Provincial System

Respondents raised several possibilities for providing all health units with the resources they need to participate in RRFSS. Options include paying for RRFSS directly or funding it as a mandatory, cost-shared program. Another option would be for the MOHLTC to pay for the survey and provincial analysis, while health units analyze their own data, although it was not considered outside the realm of possibility that the MOHLTC would support analysts at the health unit level as well.

Potential Provincial Models, their Advantages and Disadvantages

It is important that health units participate in any decision which is to be made about a provincial model. The model has to meet the needs of health units as well as the province and should build on the strengths of current RRFSS structures and process. The current model, extended to all health units, was proposed; this would require provincial funding. In order to work, it was suggested that funding should not only cover the costs of the survey, but also human resources at the local level.

A consistent provincial database would be an asset, although not easy to achieve while health units retain autonomy in choosing optional modules. The most promising model would enhance the system by providing provincial data.

The three models proposed were:
- full (100%) MOHLTC funding,
- cost-shared funding, including providing RRFSS funds in health unit base budgets, and
- a model in which the MOHLTC covers core modules while the health units pay for optional modules with cost-shared funds.

Full MOHLTC funding would provide RRFSS to all health units and result in a provincial dataset. RRFSS would enjoy more stability and be better coordinated. Although health units currently participating in RRFSS are likely to continue, non-participating health units are looking to the MOHLTC for a stable source of funding. It is possible that economies of scale would enable a better contract to be negotiated with ISR, especially if all heath units ask the same questions. Provincial funding gives the MOHLTC the potential to collect data relevant and responsive to provincial priorities. Other advantages include single site contract negotiation, greater resources and the potential to support centralized resources such as those required to conduct and analyze the survey.

Disadvantages include the loss of local autonomy, flexibility and control. Full MOHLTC funding would likely require sign-off and a need for some scrutiny. It would reduce the ability of health units to focus on local issues. It would be a challenge to coordinate the selection of modules [with different priorities at the two levels]. Under MOHLTC funding, it may be assumed that the MOHLTC owns the data. It then becomes a challenge to get the data to the health units. A streamlined process to get provincial comparators to the health units would be needed. Health units should be able to move forward with analysis without waiting for provincial comparators. A risk of the provincial model is that small health units may have a small sample size and insufficient data to make programming decisions.

Advantages of a cost-shared funding model are that the health units retain local autonomy and flexibility. However, the costs remain the same regardless of the size and budget of the health unit. This means that some health units are unable to participate and

the provincial dataset is not representative. Health units have ownership of their data and may or may not be willing to share.

Under a model in which core modules are funded completely by the MOHLTC, while optional modules are paid for by the heath unit, the MOHLTC achieves a provincial dataset of core variables, while health units maintain the flexibility to choose optional module of relevance to their needs.

An additional model suggested in the key informant interviews was the creation of a legal entity called "RRFSS". The provincial government should give money to that legal entity to support personnel as well as data collection. MOHLTC support should cover not only the contract costs for data collection, but also personnel for central support and someone in every health unit to carry out RRFSS-related duties.

It was acknowledged that the Capacity Review may result in changes to the configuration of health units and therefore it is possible the present funding may give province-wide coverage if the number of health units are reduced.

Funding Model Preferred by the MOHLTC

The MOHLTC would like provincial-wide, consistent data to address ministry priorities. The MOHLTC has needs for information for strategic directions which could be provided by RRFSS. A provincial RRFSS system could also provide the data needed for a performance measurement system, an example of which might be to measure short term outcomes related to Mandatory Health Programs and Services.

The need for local control is appreciated and respected. The final model will be determined in consultation with the health units and will be informed by the RRFSS evaluation.

Decision-Making Processes

RRFSS decision-making processes are described in the Manual of Operations. Issues are discussed and decided in the Regional Groups. If consensus cannot be reached in the regional groups, all RRFSS representatives are asked to vote. Last year the partnership realized that there was a need to increase the power of the Steering Group with respect to requests. Authority to decide upon special requests, emergency requests and requests to join RRFSS was given to the Steering Group in 2005.

The decision-making process of RRFSS, which ensures that all health units have a voice, was reported to work very well. It is slow and ponderous, but this is not necessarily a problem because of the benefits of a high rate of participation. The current structure does not allow decisions to be made in an emergency situation.

MOHLTC funds should be used to pay for some of the time of the chair of the Steering Group. This position is time-consuming, and it is not possible to be the chair as

a "volunteer" while doing the duties of a regular position. In a time-sensitive or emergency situation, the collective should invest more power in the Steering Group and its chair so that decisions can be made more quickly. The current process is too cumbersome if there is a public health emergency.

The position of RRFSS coordinator is helpful, but more support is needed. The RRFSS team needs a data person centrally, to do analysis for the collective, provide datasets for external requests, review all existing modules when new modules are proposed and review data at the request of program staff.

Data-Sharing Processes

There are two kinds of external data requests. Each health unit is asked to sign a data-sharing agreement which allows their anonymized data to be posted to the website. Most health units sign this agreement. In addition, individual agencies or organizations may request data, and these usually request the content of optional modules or may request data more quickly than the website postings allow. Each applicable health unit is asked to agree to the release of its data and ISR produces the final dataset. The process is described in the Manual of Operations and seems to work well now. If there were to be a significant increase in the number of requests, as might be expected if a provincial dataset becomes available, the number may exceed the capacity to fill them.

Key informants suggested that there *will* be increasing interest from external agencies and organizations with the creation of a provincial sample. At that time RRFSS will be judged as an important source of data because the timelines to receive data are much shorter than the CCHS. Programs will be available to map from postal codes to LHINs or health units to increase the usefulness of the dataset.

The challenge of data-sharing is to decide who is the custodian of the data. Currently, because each health unit pays for its contract with ISR, some health units feel that they "own" their data. The opposite view was also expressed: that data collected by publicly funded health units should be shared with publicly funded agencies freely and widely, within six months of collection. This view says that health unit "ownership" of data is contrary to the concept of public health. A question raised was whether ownership can be divested to a consortium if the data are centrally handled.

The data-sharing process is linked to funding. If RRFSS is funded by the MOHLTC, there is no problem with sharing, [since the province will have access to the data]. If a cost-shared model is adopted, decision-making is more problematic. Major negotiation is required; every health unit has to give approval for the province to use the data. If the database is housed centrally, the mechanism has to satisfy the stakeholders. There should be a core group to act as manager of the database; this must maintain connectivity with the field.

Key informants reported that present data-sharing agreements are cumbersome, slow and inappropriate. Another point of view expressed was that the present data-sharing process takes time because of the necessity of obtaining permission from all

health units, but it is not unreasonably long. Again it was suggested that a smaller group could approve data requests on behalf of the partnership.

Access to ISR

Access is not a problem. Although all health units have equal access to ISR, it was reported that some do not use ISR as much as others. ISR responds to requests and those health units requesting help do receive it.

It was also reported that there is some confusion among new health units about the role of ISR. The orientation process should educate health units about what they can get from ISR and from various groups (Steering Group, Analysis Group, Coordinator, etc.).

Other Comments about RRFSS

A number of other comments were made during the conduct of key informant interviews:

- If RRFSS were well resourced and centrally run, the result would be a better product, but its value for local priority setting would be lost.

- [I am] affirming interest in building a model that meets the needs of the health units and province, recognizing that it will take a lot of work and commitment by all parties.

- [RRFSS is a] useful tool; its strength is that it covers a wide range of topics; timeliness and relevance are also strengths. Would like to support it.

- The RRFSS decision-making body should include a provincial representative from the national committee of the CCHS in the information loop to ensure the two surveys complement each other.

- Current size of RRFSS (about 100/month) is convenient and gives reasonable precision, but there are varied confidence intervals because the populations of the health units vary; perhaps proportional sampling would be better.

- This type of survey is better with centralized support to try to reduce duplication. A central coordinator is good, but may not be enough in the way of centralized support. RRFSS is not inexpensive.

- RRFSS is very useful at the local level. Major considerations are scope, size and cost.

DISCUSSION

The RRFSS partnership is dedicated to providing a surveillance system which contributes to the provision of effective programs and services within the Ontario public health system. This is the third evaluation of RRFSS in the six years since its inception, showing the commitment of the partnership to continuous improvement and quality assurance. The first evaluation demonstrated, in one health unit, the potential of RRFSS to provide a flexible and responsive surveillance system which could be expanded to others across the province. The second evaluation examined the performance of RRFSS early in its development, and noted general satisfaction with the processes but identified 14 areas in which improvements were needed. The third evaluation built on the second. It addressed the 14 issues previously identified and formulated additional objectives related to improving and expanding the system.

The findings of this evaluation are discussed in light of its objectives, including the 14 issues brought forward from the previous evaluation.

Objective 1: Key issues from the 2001/02 evaluation

The first objective of the 2005/06 evaluation was to review key issues and future directions outlined in the 2001/02 RRFSS evaluation and describe the progress that has been made. Key issues were listed at the end of the **Background** section, page 3 of this document. These issues are referred to by number (in brackets) in the following discussion.

Among the fourteen key issues identified in the 2002 evaluation, four were considered resolved in 2005/06:

- **Limitations to the sample size for each participating health unit (4)** has been resolved through greater flexibility to increase the total sample and to oversample specific subgroups.
- **Access to ISR, decision-making, workload and resources (8)** is deemed to be equal across health units. Similar to the results of the 2001/02 evaluation, in the 2005/06 evaluation there was a perception that health units with greater resources and more experience with RRFSS were able to become more involved in decision-making. This is not a problem of access.
- **Timeliness of data from ISR (13)** has ceased to be an issue. For the past three years health units have received data within six weeks of the completion of data collection.
- **ISR is able to handle participation of all health units in RRFSS (14).**

The remaining 10 issues were addressed in the 2005/06 evaluation and results are summarized and discussed below:

The need for adequate [local] staff/resources for data analysis and making data useable (1) and the overwhelming amount of work on the local level for RRFSS representatives (6)

The results of this evaluation showed that, on average, RRFSS requires 74 hours per month, excluding participation on RRFSS working groups, each of which requires, on average, an additional 2.9 hours. When adjusted for vacation time, this is approximately equal to .6 FTE if a representative is involved in two working groups, close to the estimate of .68 FTE in the 2001/02 evaluation. Two-thirds of RRFSS representatives spend less than 30% of their time on RRFSS-related activities. Consequently, 19 of 20 RRFSS representatives felt that the time they can devote to RRFSS is less than the time required to perform these activities adequately.

The activity requiring the most time is data management and analysis (23.5 hours). Centralized support in the areas of data management and data analysis, especially of core modules, would assist RRFSS representatives in dealing with the workload. Dissemination activities are also time-consuming, requiring 21.0 hours per month, but RRFSS representatives feel that the responsibility for these activities should remain at the local level. The position of RRFSS coordinator has helped significantly with the administrative duties and is deemed to be a successful model, reducing the administrative workload of the RRFSS representative.

Lack of appropriate local staff to work on RRFSS is a significant barrier to participation.

The need for stability and support for central work of the RRFSS partnership (7)

The cost of RRFSS for data collection and local staff poses a barrier to universal participation. The advantages of MOHLTC funding mentioned most frequently by all respondent groups are that it would provide stability and ensure that all health units could participate.

Creating the position of RRFSS coordinator as well as sharing syntax files have been helpful in alleviating some of the pressures on local RRFSS representatives. The majority of all respondent groups feel that the MOHLTC should fund 100% of the costs of the RRFSS coordinator and the RRFSS website. Centralization of some data management and analysis tasks would assist further. There is support for MOHLTC funding of centralized data management and analysis, and more limited support at the regional or local levels.

The provincial tasks of RRFSS, done through the working groups, are extensive and time-consuming. These include administration, module development, module review, creation of data dictionaries and syntax files, and dealing with data requests. It was suggested that there should be MOHLTC resources to assist the Working Groups with the work of the partnership.

Funding for existing and new participants, smaller health units in particular (10)

MOHLTC funding for RRFSS would enable all health units to participate, regardless of size or budget. Half of all respondents (49%) are of the opinion that the MOHLTC should cover all of the survey costs, while an additional 28% feel that they should cover the costs of the core modules. The remaining 23% believe that the contract should be funded in the same ratio as other mandatory programs. There is also support for making RRFSS part of Mandatory Health Programs and Services.

Several respondents pointed out that it would not be sufficient to cover only the survey costs, since RRFSS also has requirements locally for data analysis and the dissemination of results. Although it would be efficient to do as much as possible of this centrally, many of the smaller health units do not have the expertise to do the local work. There is support for covering the costs of a local epidemiologist, or of regional epidemiologists who could provide this service to the smaller health units.

Provincial representation of data (11)

The majority of all respondent groups feel that RRFSS should be expanded to all health units to allow provincial estimates of health indicators to be calculated. The benefits of a provincial dataset include comparisons at every level from individual health units to the province, as well as providing indicators for provincial initiatives. A provincial sample was felt to be a motivator for MOHLTC support.

Those who do not support using RRFSS results to calculate provincial estimates said that these were provided by the CCHS, cited limitations of the RRFSS survey, or supported retention of RRFSS as a local tool.

Increasing the use of data in program planning and evaluation in health units (2)

In the 2001/02 evaluation, 82% of RRFSS representatives reported that their health units used RRFSS results for program planning and 55% for program evaluation. They expected usage to increase to 100% for both program planning and evaluation. In 2005/06, 100% of RRFSS representatives reported that RRFSS results are used for program planning, and 80% for program evaluation. Both uses of RRFSS results increased over the four year period.

Although the use of RRFSS results for program planning and evaluation is high in participating health units, use is lower than this among individual program staff members, 79% of whom use RRFSS results for program planning, and 51% for program evaluation. Barriers include lack of appropriate data and small samples, especially for certain subgroups. It was also noted that program staff may lack the skills to interpret and use RRFSS results, or may not be aware of results which might be useful to them. Dissemination of results with interpretation is therefore regarded as an important task for RRFSS representatives. Although the use of RRFSS data for program planning and

evaluation has grown over the past four years, respondents feel that optimal use had not yet been reached.

Limited new question/module capacity under the current questionnaire (3) and the need for a process for revising old modules and developing new modules (5)

At the time of the previous evaluation, there was no process to develop new modules or to revise old ones. In 2003, processes for module development and review were established, approved by all RRFSS representatives and incorporated into the Manual of Operations. One in five RRFSS representatives is very satisfied with the process of module development, while the remainder are somewhat satisfied. The process is reported to be very time-consuming because of the necessity of putting together an appropriate advisory group, but the limitations appear to be those imposed by local capacity.

There is less satisfaction with the process of module review. Roughly one third are very satisfied with the process and half are somewhat satisfied, but one in five is somewhat dissatisfied. Historically, each of the modules was reviewed annually. The number of modules to be reviewed is now limited to five annually for each of the regional groups. Even though this makes the workload more manageable, some respondents feel that further improvements need to be made to increase the efficiency of the review process.

Upgrading the RRFSS website (9)

Maintenance of the RRFSS Website remains an ongoing issue at the time of the 2005/06 evaluation. The location of the website and staff time to maintain it are dependent on the goodwill of a health unit. The site has no official home.

The majority of all respondent groups feel that the website should be supported by the MOHLTC.

Sharing data among organizations (12)

Two-thirds of participating health units had shared their datasets with local or provincial agencies and organizations, with the MOHLTC or other health units. There is a high level of support for data-sharing for analyses at the provincial level and less at the level of the health unit. Slightly fewer than half of respondents believe that such agencies or organizations should have to pay for RRFSS data. Barriers to sharing include considerations of capacity and health unit sensitivities.

Current requests for RRFSS data are relatively few and the process required to release data has been described as lengthy. Even so, between 2004 and 2006 the average time from receipt of the request to the release of the data was two months[6], with a range of one to four months. This does not seem unrealistic, given that each health unit must

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[6] Russell, L. Personal Communication to Kathleen O'Connor, April 12, 2006.

consider and respond to each request. It is anticipated that, should the MOHLTC support RRFSS such that all health units are able to participate, more requests for data would be received. Many respondents feel that the question of data ownership might become less clear and that agreements for data-sharing should be put in place earlier rather than later. Many respondents were not aware of the references to data-sharing contained in the Manual of Operations.

Although some health units appear to feel that they "own" their data, some respondents pointed out that this attitude is contrary to the spirit of health surveillance and that such data should be shared freely with health-related organizations for which it is relevant. Some respondents pointed out that since the data are collected with public funds, they should be made freely available. However, nearly all respondents said that RRFSS data should not be given freely to profit-making enterprises.

Objective 2: The utility of RRFSS, specifically its contribution to local decision-making, understanding of emerging public health issues and monitoring of progress towards the MHPSG goals and objectives

RRFSS results are used for program planning in all health units, and for program evaluation, media campaigns, presentations and informing decisions in at least three out of four health units. There was an increase in use for all programs and standards since the 2001/02 evaluation, generally in line with projections made by RRFSS representatives in 2001/02. The 2005/06 evaluation shows that RRFSS results are being used for all programs and standards except tuberculosis control. Results are used most often (by at least 75% of health units) in the areas of chronic disease prevention, child health, injury prevention and early detection of cancer. In the earlier evaluation, use of RRFSS was concentrated in the area of chronic disease prevention.

A frequently-cited benefit of RRFSS in comparison to other sources of surveillance data was its ability to be flexible and to respond to emerging public health issues. These might be widespread, such as SARS, or local, such as opinions to limit smoking in public places. Modules can be developed and initiated more quickly with RRFSS than with other provincial surveys.

Objective 3: Examples of success stories in the operation of RRFSS

Examples of success stories were solicited at the Annual RRFSS Meeting and are interspersed with the content from questionnaires. These include ideas for module selection (eg. involve program staff as much as possible), analysis (eg. sharing of syntax files, data request form) and dissemination (eg. an annual report of all variables). Such ideas are shared frequently among RRFSS members.

Objective 4: What would be required to make RRFSS a provincial system and how such a system could work

Eighty-nine percent of respondents feel that all health units should participate in RRFSS and 85% of respondents feel that RRFSS should provide provincial estimates of health indicators. However, expanding RRFSS to a provincial system would require an investment in resources, both funding and personnel, within each health unit and centrally. RRFSS representatives feel that the time they spend to manage RRFSS within their health units is inadequate and far below the requirements of the position.

RRFSS representatives support some degree of shared responsibility between local and provincial levels for data analysis and administrative tasks. A provincial system for RRFSS would need enhanced personnel at the local level for data analysis and administrative tasks such as the selection of optional module content. In addition, centralized personnel are needed to support data analysis and reporting at the provincial level.

RRFSS representatives clearly believe that dissemination of RRFSS results within the health unit should remain a local responsibility. Because dissemination is considered to be inadequate in 60% of health units, a provincial system for RRFSS would need to consider additional local personnel to support and enhance dissemination. Extensive dissemination and promotion of RRFSS results is consistent with the vision and mission of RRFSS, and are areas which should be targeted for improvement.

In 2003, participating health units made funding commitments to support a RRFSS coordinator position. There has been a positive response to this position, as evidenced by continuing support. Even with the addition of this position, centralized and regional RRFSS tasks require, on average, 19 hours/month in each participating health unit, in addition to 10 hours/month for determining the content of the questionnaire and other local administrative tasks. Further efficiencies in the system can be realized by extending centralized support to a data analyst, administrative support, the RRFSS website and an annual meeting. It is clear that a provincial system for RRFSS will require greater central support for the administrative tasks of RRFSS.

Various funding models were suggested to enable RRFSS to be expanded provincially, with most recommending MOHLTC funding to collect the data, administer RRFSS and perform some centralized functions such as data analysis. There is strong support for the RRFSS coordinator position and the RRFSS Website to be funded 100% by the MOHLTC.

The strategic direction of RRFSS clearly supports the expansion of RRFSS to a provincial system. It was acknowledged that provincial and local goals may differ and that provincial funds might erode the autonomy of the health units. It may be that a cost-sharing arrangement, such as incorporating RRFSS into MHPSG, would best satisfy the needs of both partners. It would be very important to address these issues before entering

into a financial agreement to ensure that system remains flexible, timely and responsive to local public health intelligence needs.

REFERENCES

1. Stewart PJ, Sales P. Evaluation of the Rapid Risk Factor Surveillance System: Final Report. Community Health Consulting, May, 2000.

2. Ontario RRFSS Working Group 2001. An evaluation of the Rapid Risk Factor Surveillance System. RRFSS Working Group, October, 2002.