

2004/05 Annual Health Authority Performance Agreement Report



Health Authorities Division
British Columbia Ministry of Health

2004/05 Annual Health Authority Performance Agreement Report

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Executive Summary

The Ministry of Health and British Columbia's (BC) health authorities are working together to ensure BC's health system provides high quality patient care, strives for improved health and wellness for British Columbians and provides a sustainable, affordable health care system for the future.

With the establishment of six health authorities in 2001, BC created a strong foundation to improve the management and delivery of provincial health care services. Health authorities now have three-year performance agreements, which outline expectations for the delivery of patient services, health outcomes and health care spending, while providing flexibility and autonomy to meet regional needs. BC was the first province in Canada to implement this process, and is leading the country in health care system and resource accountability.

The *2004/05 Health Authority Performance Agreement Report* is part of the Ministry of Health's ongoing commitment to transparency and accountability. The report shows the progress health authorities have made in meeting their annual performance targets and how they are evolving and strengthening the accountability process while meeting the needs of their populations.

The report outlines the 2004/05 Performance Agreement deliverables for the health authorities, which reflected the government's directions for change as expressed in the Ministry of Health's 2004/05 Service Plan.

For 2004/05, all health authorities met their performance targets in a number of areas including:

- May Not Require Hospitalization rate - a 15.4% reduction in the provincial rate for hospital visits by people who may appropriately be treated in an ambulatory setting rather than the hospital.
- Cancer Treatment - ensuring 90% of patients receive radiotherapy within 4 weeks of being ready to receive treatment.
- Aboriginal Health - improving Aboriginal infant mortality and life expectancy rates.
- Immunization - Influenza vaccination of 90% of residents of care facilities.
- Budget Allocation - a 7% reduction in expenditures for administrative and support services.

However, there were some areas in which individual health authorities were not successful in achieving their targets:

- Alternate Level of Care (ALC) days – IHA, VIHA and NHA have large rural and/or isolated populations and experienced ALC rates that vary from densely populated regions.
- Home and Community Care – VCHA did not meet the target due to high utilization rates in both residential care and home support services.

- Mental Health - Under reporting of data and a need to develop additional capacity in the community resulted in some health authorities missing targets in this area.
- Core Public Health – All the health authorities missed the target of immunizations for two-year-olds. Concerns over data quality and reporting practices make it difficult to assess the reasons the targets were not reached.

It is recognized there is still work to be done and challenges to be met for BC's health care system. By working collaboratively, the Ministry of Health and health authorities will continue to monitor, evaluate and share best practices to build a more cohesive, effective, patient-centred health care system to meet the needs of British Columbians, now and in the future.

1. Introduction

For several years, health jurisdictions across the country have been working to balance the increased demand for health care services, and the need to contain public health care spending.

In response to British Columbia's (BC) health care demands, six health authorities were formed in 2001 to create a strong foundation for making fundamental improvements to the management and delivery of hospital and community-based health services. In addition to this, BC became one of the first provinces in Canada to initiate formal Performance Agreements, a key accountability mechanism between the Ministry of Health¹ and the health authorities. Performance Agreements define specific performance targets and deliverables for the management and delivery of health care services. It provides a framework in which BC's health care system can be monitored and evaluated with the intent to report back to the public. The accountability principles, development, and monitoring of the Performance Agreements will be addressed in more detail in section three of this report.

Recognizing that Performance Agreements would evolve with time and experience, the Province constructed them as three-year rolling documents - to be updated annually - to provide the stability needed to undertake multi-year system reforms. The resulting framework combined consistent direction with enough flexibility to adapt to changing needs and experience.

Performance targets and deliverables within the 2004/05 Performance Agreements are aligned with the goals, objectives and relevant priority strategies set out in the *Ministry of Health Services 2004/05 Service Plan*. The goals, objectives and priority strategies that relate to the performance of the health authorities will be discussed in section four of this report.

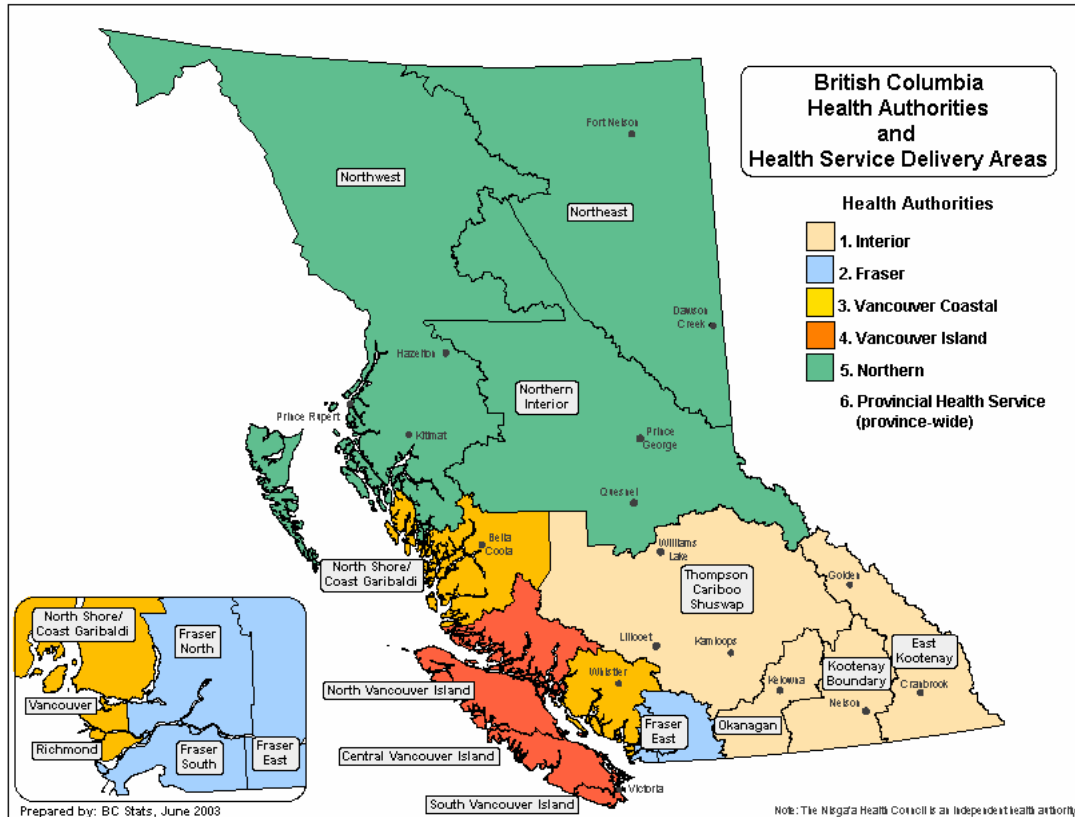
The *Ministry of Health Services 2004/05 Annual Service Plan Report* speaks to the progress made in implementing Service Plan strategies at a provincial level. The Annual Health Authority Performance Report provides more detail on specific health authority-related progress and strategies. While health authorities have responsibility for, and influence over, a vast array of health services within their geographical area, this report focuses on those strategies directly reflected in the 2004/05 Performance Agreements. While recognizing the unique circumstances and challenges of each health authority, this report describes the progress made in achieving the common goals and strategic objectives established for BC's publicly funded health care services.

¹ The Ministry of Health was formerly known as the Ministry of Health Services. The name was changed in May 2005.

2. Profiles of British Columbia's Six Health Authorities

British Columbia has six health authorities that, in conjunction with the Ministry of Health, manage and deliver most publicly funded health services in the province. Responsibility for local health services, such as home and hospital care, rests with five regional health authorities. The sixth health authority, the Provincial Health Services Authority, is responsible for providing province-wide specialized services, and for supporting the regional health authorities with their service delivery.

Figure 1: Map of BC Health Authorities



Interior Health Authority (IHA)

Web Address: <http://www.interiorhealth.ca>

2004 Population²: 703,994

- 2004/05 budget of \$1.138 billion.
- Serves a large geographic area, ranging from densely to scarcely populated areas.
- Region stretches from Williams Lake to the U.S. border and from Anahim Lake in the Chilcotin to the Alberta border.
- Key Challenges: The delivery of effective health care services in a region of varying population density.

² Population statistics for all Health Authorities obtained from PEOPLE 30. BC STATS. (2004). Ministry of Labour and Citizens' Services.

Fraser Health Authority (FHA)

Web Address: <http://www.fraserhealth.ca>

2004 Population: 1,440,827

- 2004/05 budget of \$1.641 billion.
- Small geographic area with a high population density.
- Borders from Delta to Burnaby to Boston Bar and southward to the U.S. border.
- Significant population growth over the past 10 years, currently represents about 34% of BC's population.
- Key Challenges: Large population with projected growth, and an aging population has increased demand for health care services.

Vancouver Coastal Health Authority (VCHA)

Web Address: <http://www.vch.ca>

2004 Population: 1,036,970

- 2004/05 budget of \$1.950 billion.
- Small geographic area with a high population density.
- Serves residents in Vancouver, Richmond, the North Shore and coastal communities including: Squamish and Whistler along the Sea-to-Sky Highway; Gibsons and Sechelt on the Sunshine Coast; and Powell River.
- Through denominational agreements, serves the residents of Bella Bella and Bella Coola and partners with Providence Health Care in Vancouver.
- Key Challenges: Significant population growth and an aging population resulting in an increased demand for health care services.

Vancouver Island Health Authority (VIHA)

Web Address: <http://www.viha.ca>

2004 Population: 710,580

- 2004/05 budget of \$1.219 billion.
- Serves Vancouver Island, the Gulf and Discovery Islands and mainland residents located adjacent to the Mount Waddington and Campbell River areas.
- Almost half of Vancouver Island's population lives in and around the provincial capital of Victoria, at the southern end of Vancouver Island.
- Key Challenges: Providing services to a region with a varying population density and implementing concurrent changes in a large complex system.

Northern Health Authority (NHA)

Web Address: <http://www.northernhealth.ca>

2004 Population: 304,012

- 2004/05 budget of \$427 million.
- Covers almost two-thirds of BC, and is bordered by the Northwest and Yukon Territories to the North, the BC interior to the South, Alberta to the East, and Alaska and the Pacific Ocean to the West.
- Key Challenges: Providing quality services across a large, sparsely populated region with significant recruitment and retention issues.

Provincial Health Services Authority (PHSA)

Web Address: <http://www.phsa.ca>

- 2004/05 budget of \$1.160 billion.
- Key role is ensuring effective and high quality delivery of selected province-wide health care programs and services, either by directly providing them or through partnerships with regional health authorities.
- Agencies under the jurisdiction of the PHSA include: the BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Provincial Renal Agency, BC Transplant Society, BC Women's Hospital & Health Centre, Forensic Psychiatric Services Commission, PHSA Cardiac Services, and Riverview Hospital.
- Key Challenges: Delivering a wide variety of health care services at a provincial level.

3. Performance Agreements: Accountability Principles, Development & Monitoring

Accountability Principles

Health authorities provide a continuum of health services addressing the complexity and diversity of the clients in their regions. Health authorities are accountable to the public, the people they serve, and the Provincial Government through the Ministry of Health. Health authorities are required to take appropriate steps to ensure health services are high quality, universally accessible, and provided within a balanced budget. The Ministry of Health's role - as steward of the health system - is to provide leadership and support to health authorities. This includes monitoring their performance and providing them with information to improve their services.

The health authority performance agreements are a key component of the accountability framework (see Figure 2 below). These components include:

- Ministry of Health instructions for Redesign Plans³.
- Health authority Redesign Plans.
- Ministry of Health assessment of Redesign Plans.
- Monitoring of health authority actions and Performance Agreement.
- Regular Ministry of Health monitoring reports.
- Annual report of health authority performance.
- Annual site visit with health authorities.
- Ministry of Health Service Plan.

The Performance Agreement

The key accountability mechanism used by the Ministry of Health is the Performance Agreement. It is a rolling three-year agreement which is updated on an annual basis. The Performance Agreement defines deliverables for key performance requirements that health authorities must meet in specific service areas. These service areas include:

- Population and public health.
- Acute care (particularly emergency and surgical services).
- Home and community care.
- Mental health and addictions.

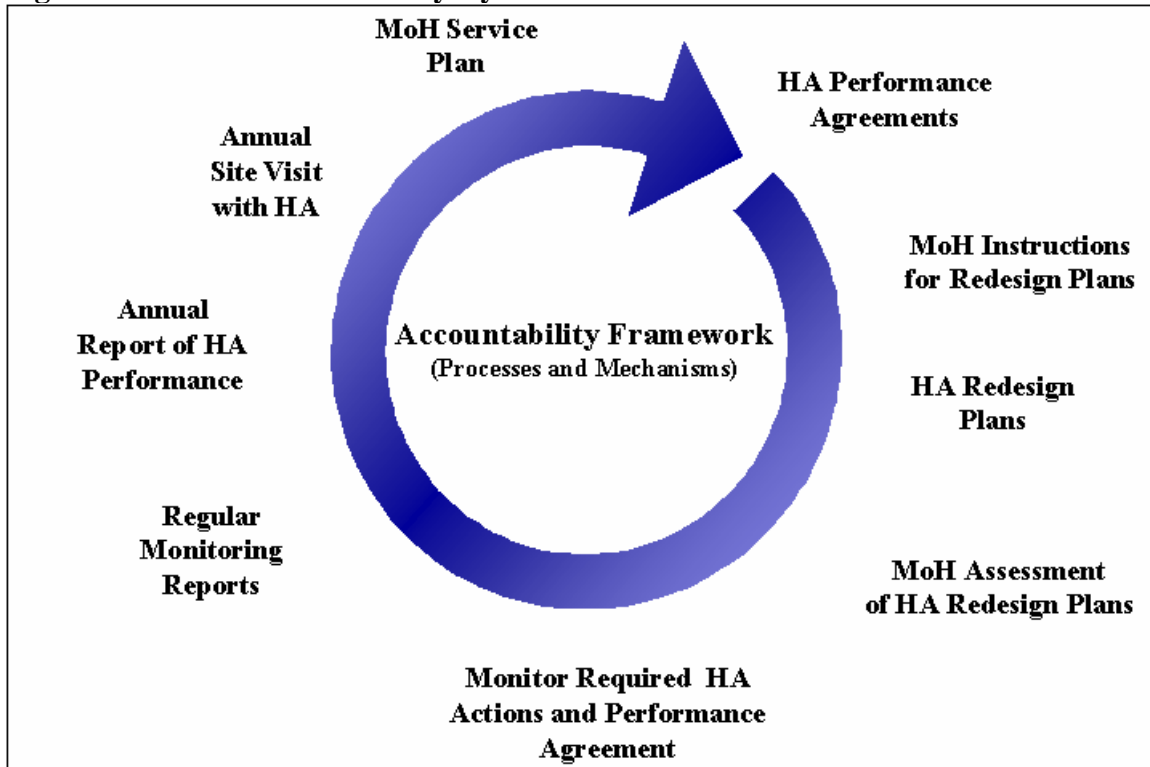
Provincial priority system improvement projects (priority projects) are underway across the health system to improve: accessibility, quality, appropriateness, effectiveness and efficiency of health service delivery. Performance measures form the key performance requirements and focus on areas that could be enhanced.

³BC health authorities are required to prepare plans that outline budget management and health care planning strategies that will help the province achieve its strategic priorities and goals. For further information on redesign plans: <http://www.healthservices.gov.bc.ca/socsec/serviceplan.html>.

These performance requirements align with the goals and objectives of the Ministry of Health Service Plan as well as provincial and national priorities for health care reform.

Figure 2 shows where performance agreements appear in the cycle.

Figure 2: Annual Accountability Cycle



Performance Agreement Development Process

The development of the Performance Agreements begins almost a year before they are finalized. Throughout the process, health authorities are consulted in a variety of forums about the specific deliverables for priority projects and performance measures. These performance requirements are revisited every year to ensure they are measuring key elements of performance and are consistent with the Ministry of Health’s Service Plan, and other goals and objectives for reform. The Ministry of Health makes adjustments to annual targets based on health authority achievement and Ministry of Health priorities.

In addition to health authority feedback, changes may be made because of special reviews or audits, such as the review on the Performance Agreements by the BC Office of the Auditor General (2003)⁴. As well, the Ministry of Health makes changes to the agreements based on the experience and ideas of other public sector jurisdictions both within Canada and internationally.

⁴This review can be found on the Office of the Auditor General (OAG) website. <http://www.oag.bc.ca/AuditorGeneral.htm>

National priorities can also affect performance requirements. In September 2004, the First Ministers of the Provinces and Territories committed to reducing wait times in priority areas such as cancer treatment, cardiac, diagnostic procedures, joint replacements, and sight restoration. Specific benchmarks within these key areas were announced in December 2005⁵ and these priorities will be incorporated into future Performance Agreements.

Performance Monitoring

Several times a year, the Ministry of Health provides data analyses to health authorities to help them monitor their progress towards meeting the performance requirements. Regular discussions regarding performance monitoring take place between the Ministry of Health and health authorities to consider and address emerging issues and challenges. Performance monitoring is essential for the Ministry of Health to fulfill its role as steward of the health system and to support effective health service delivery by the health authorities.

At the end of each year, the Ministry of Health receives and reviews the health authorities' performance measurement data. The Ministry of Health meets with each health authority to discuss their success in meeting the deliverables and targets in the Performance Agreement, and to develop a plan to address any outstanding deliverables. The Ministry of Health then monitors these plans as part of its overall accountability framework.

⁵Futher information on the specific benchmarks announced can be found on the Health Canada website at http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2006-wait-attente/2006-wait-attente-1_e.html

4. 2004/05 Health Authority Performance

For consistency, this report will use the same numbering for priority strategies as the *Ministry of Health Services' 2004/05 Service Plan*. This report only discusses priority strategies and subsequent performance measures that are under the direct influence of health authorities. For information regarding progress on Ministry of Health priority strategies please refer to the *Ministry of Health Services' 2004/05 Annual Service Plan Report*⁶.

For clarification purposes in this report, performance measures relate only to regional health authority performance, unless otherwise stated. Priority projects relate only to the performance of PHSA, as priority projects usually fall under their leadership, unless otherwise stated. In addition, measures and priority projects that deal specifically with agencies that fall under the jurisdiction of PHSA, such as the BC Cancer Agency, can be understood as evaluating the performance of PHSA.

a) Hospital-based Performance Measures

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 1 – Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care

Priority Strategy 1 – Hospital Admissions Prevention through Increased Community Care Options: Prevent unnecessary hospitalizations by providing patients with better access to family physicians, specialists, and other providers and services in the community

British Columbians are concerned about the level of congestion in many of the province's emergency departments. Enhancing primary care is a key strategy to reducing hospital admissions and to achieving this strategy. Primary care is a patient's first and most frequent point of contact with the health system and supports individuals and families to make the best decisions for their health. Patients access primary care when they visit their doctor, a medical clinic, or the public health unit in their community.

Performance Measure: Rates of admission for conditions that could be managed outside hospital (conditions classified as "may not require hospitalization").

When patients are to be admitted to hospital they are classified into case groups based on their diagnosis, procedures performed and age. One of these case groups is 'May Not Require Hospitalization' or MNRH, which refers to cases that may be more appropriately managed in a community-based setting.

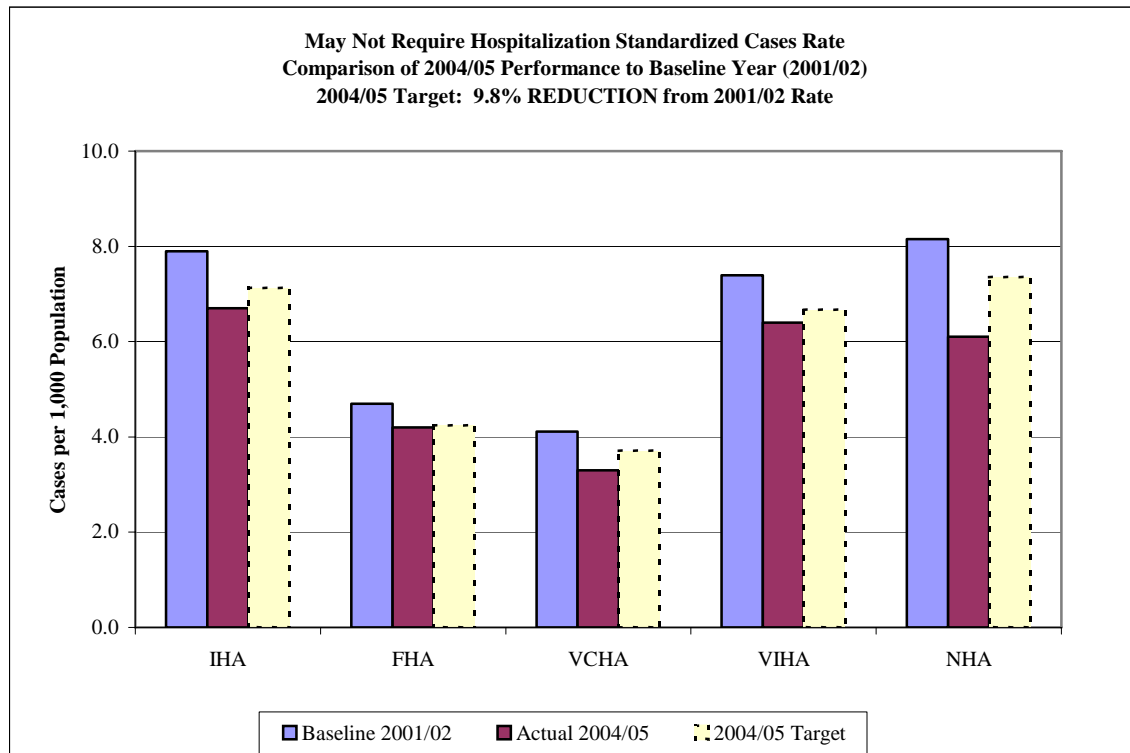
⁶ <http://www.bcbudget.gov.bc.ca/annualreports/hs/hs.pdf>

A low MNRH rate indicates a more efficient use of hospital beds. However, it is important to note that some cases within the broad MNRH category require hospitalization because of their specific clinical circumstances; or, the unavailability of a community resource, as may be the case in remote or rural communities.

All health authorities successfully reduced MNRH rates to below the target defined for 2004/05, which was a 5% decrease over the previous fiscal year. The overall provincial rate dropped from 5.9 cases/1,000 population in 2001/02 to 5.0 cases/1,000 population in 2004/05, which was a 15.4% reduction overall.

In terms of the reduction achieved, there was variation across health authorities as shown in Chart 1. VCHA had the lowest MNRH rate of all health authorities, 3.3 cases per 1,000 population. Rates were higher in IHA, VIHA and NHA. Since 2001/02, the rate of decrease for MNRH has slowed, which may indicate we are approaching a provincial threshold level.

Chart 1: May Not Require Hospitalization Rate (2001/02 and 2004/05)



Source: Discharge Abstract Database (DAD), November 28, 2005, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health.

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 1 – Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care

Priority Strategy 2 – Post-Acute (hospital care) Alternatives: Provide appropriate community health support to enable timely discharge of patients from hospital once the need for acute medical care has ended

Health authorities have been actively working to ensure patients do not remain in hospital longer than necessary. The Alternate Level of Care (ALC) days are those a patient spends in hospital after the acute-care phase of treatment has ended. ALC patients may be waiting for placement in a long-term care facility or in the community; or waiting for alternate care to become available (e.g., home-based or rehabilitation services).

Performance Measure: Percentage of days spent by patients in hospitals after the need for hospital care ended, measured by ALC days as a percentage of total hospital inpatient days.

One of the performance measures in the health authorities 2004/05 Performance Agreements was a 14.3% decrease in ALC days from 2001/02. The purpose of this measure is to determine whether patients receive timely access to the most appropriate care setting. If many patients occupying acute care beds could be more appropriately cared for in alternative settings, there could be issues with access to alternate types of care or other difficulties with discharge planning. Reducing ALC days in hospitals has the dual benefit of providing patients with care in a setting that best meets their needs and freeing up acute care beds for patients who truly need that intensity of service.

Chart 2 shows that the health authorities had varying degrees of success in reaching their 2004/05 target of a 14.3% decrease in ALC rates. FHA and VCHA have continued to decrease their ALC rates since 2001/02 and have surpassed the 2004/05 target. Both FHA and VCHA have implemented several strategies to address ALC rates: they have opened discharge lounges, transitional care units and other types of sub acute units, and have increased certain mental health and addictions services.

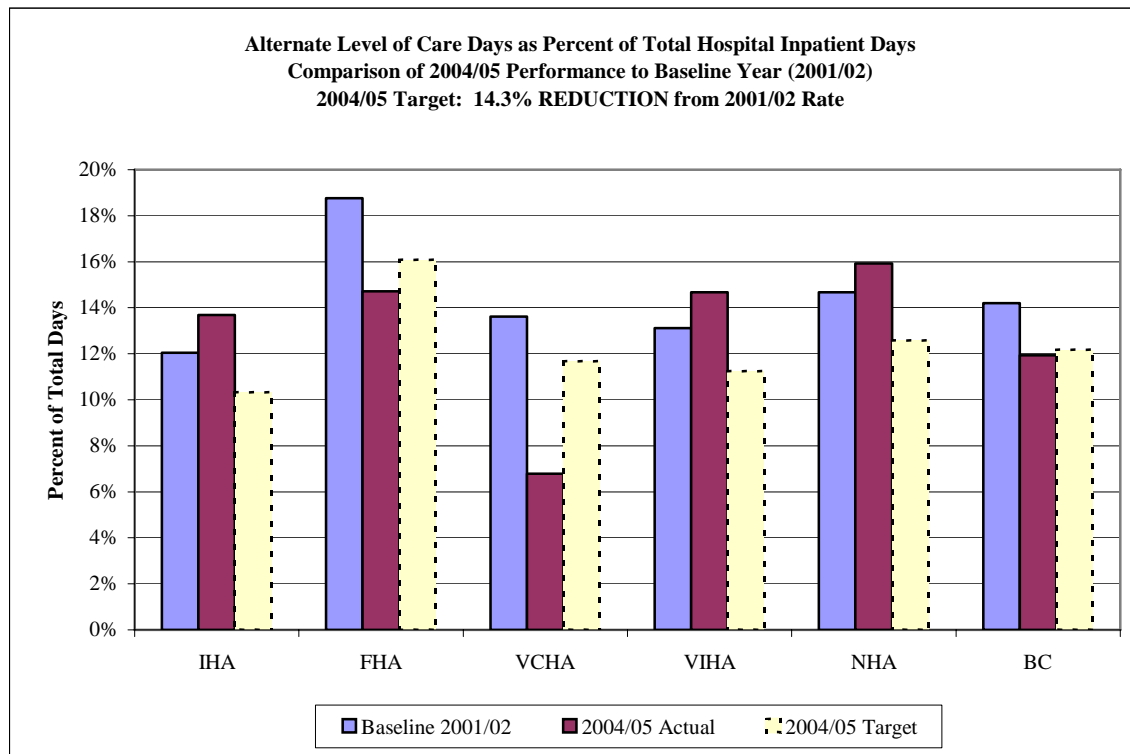
IHA, VIHA, and NHA were not successful in reaching the 2004/05 target decrease in ALC rates. The Ministry of Health recognizes the fact that, for health authorities with large rural and/or isolated populations, ALC rates may vary from more densely populated regions. These health authorities have also implemented a number of strategies to address this issue.

On April 1, 2004, IHA initiated a region-wide project to standardize the definition of ALC. This change led to an increase in the number of ALC clients reported. As a result of this change in reporting, it is difficult to assess whether or not there has been an actual increase in ALC. IHA continues to be involved in intensive analysis of ALC and other aspects of acute care utilization.

To reach their target in the future, NHA has extended their adult day care centres and enhanced home support hours and rehabilitation programs in their region. As well, NHA opened a Geriatric Treatment and Assessment Unit in February 2005 to support seniors and decrease their need for emergency department and acute inpatient services. VIHA has also implemented a number of strategies aimed at reducing ALC days, including increasing the capacity of sub acute care and community services.

The Ministry of Health will continue to monitor the health authorities' performance in reducing ALC days by including performance measures in the 2005/06 Performance Agreements.

Chart 2: Alternate Level of Care Days (2001/02 and 2004/05)



Source: Discharge Abstract Database (DAD), January 6, 2006 Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

b) Cancer Treatment Wait Times

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 1 – Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care

Priority Strategy 3 – Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services

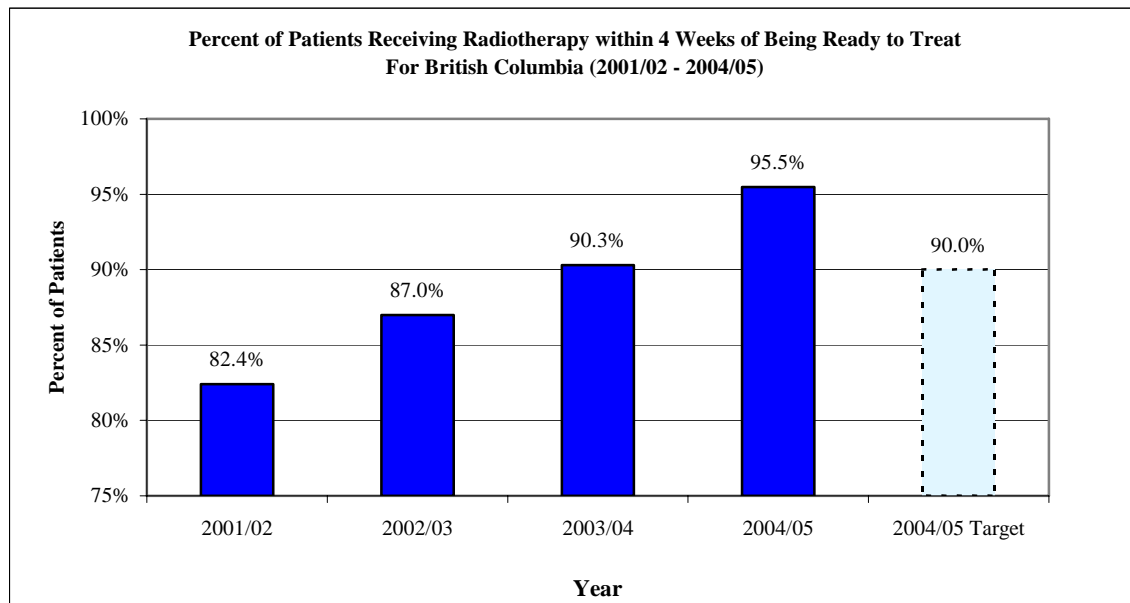
While most of the strategies that fall under this objective focus on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high quality manner.

The 2004/05 Performance Agreement targets include reasonable waiting times for key services, such as radiology and chemotherapy. Monitoring wait times for these key services helps ensure patients diagnosed with cancer are treated as early as possible to achieve the best outcomes. As well, the Ministry of Health has established two priority projects to address acute care services, the Provincial Emergency Services Project and the Provincial Surgical Services Project. Both projects focus on key activities to improve the quality and efficiency of services.

Performance Measure: Waiting times for key services: Radiotherapy

In BC, radiation therapy is provided through the BC Cancer Agency at four regional cancer centres: Fraser Valley, Vancouver, Vancouver Island and Southern Interior. The 2004/05 target for radiotherapy wait times is for 90% of patients to receive radiotherapy within 4 weeks of being ready to begin treatment. Chart 3 shows that the 2004/05 target was met.

Chart 3: Radiotherapy Wait Times (2001/02 – 2004/05)



Source: Provincial Radiation Therapy Program, December 12, 2005, BC Cancer Agency.

Performance Measure: Waiting times for key services: Chemotherapy

In BC, chemotherapy can be provided in BC Cancer Agency (BCCA) cancer centres or in a number of community cancer centres, including hospitals throughout the province. The 2004/05 target for chemotherapy is for 90% of patients to receive chemotherapy within two weeks of being ready to begin treatment. In 2004/05, chemotherapy wait times (from ready-to-treat to treatment dates) were not available from hospitals providing

chemotherapy nor were they reported from BCCA specifically as outlined in the health authority performance agreements. However, BCCA has confirmed that in 90% of cases, clients in their centres receive treatment within 14 calendar days of the written physician's order. During the fiscal year, PHSA reported being on track in supporting the collection of chemotherapy information from all health authorities by the end of the 2004/05.

However, the process implemented on April 1, 2004 to collect information, was restricted to the four BCCA Centres. Because of data integrity issues, the information could not be utilized in monitoring the performance of PHSA. Despite the absence of applicable data there is no indication patients are not receiving services within a timely manner. Currently PHSA is working to improve the data collection involved in assessing chemotherapy wait times.

BCCA has indicated that they will improve the data collection as of April 1, 2005 to capture the appropriate data elements in the four regional cancer centres. This represents about half of all chemotherapy treatments provided in the province. Information for 2005/06 will remain unavailable for treatment provided in the BCCA satellite centres and in hospital settings.

The BCCA is, however, able to provide median wait times of patients receiving consultation with a medical oncologist within two weeks and four weeks of their initial referral from their physician as reported in the following table.

BCCA Centres and satellites	Median wait time* (referral to consultation with medical oncologist) for 2004/05*
Fraser Valley	11 days
Kamloops	15 days
Nanaimo	12 days
Penticton	13 days
Southern Interior	12 days
Vancouver	9 days
Vernon	11 days
Vancouver Island	9 days
British Columbia	11 days

*median wait time calculation based on 2004/05 fiscal year

Source: Provincial Systemic Therapy Program & Communities Oncology Network, BC Cancer Agency by way of Information Resource Management, Knowledge Management & Technology Division, Ministry of Health. Project: 2005_0108, last updated 13 April 2005

c) Priority Project: Provincial Emergency Services Project

In 2002, the Ministry of Health and the health authorities established the Provincial Emergency Services Project (PESP) to improve the access, utilization and effectiveness of emergency health services in BC. The PESP includes representatives from each of the health authorities and is under the leadership of the PHSA; the Emergency Services Steering Committee oversees the project.

In 2002/03, the committee recommended both short and long-term strategies to improve BC's emergency health services. The Short-Term Task Group identified emergent issues⁷ and recommended solutions that could be implemented within a year by the health authorities. The Long-Term Task Group identified redesign options that were intended to influence long-term change in the provincial emergency services system.

During 2003, the Emergency Services Steering Committee was reconfigured to form the Critical Services Steering Committee, which assumed responsibility for trauma care and working relationships with *bcbedline*⁸, *BCNurseline*⁹ and *BC Health Guide*¹⁰ as well as emergency health services.

The PESP outcomes in the regional health authorities' 2004/05 Performance Agreements were as follows:

- (1) To implement Short-Term Task Group's recommendations, which are deemed to have significant value by the Steering Committee;
- (2) To undergo feasibility planning for the Long-Term Task Group's recommendations; and,
- (3) To initiate reporting of emergency room performance indicators to the Ministry of Health.

The PESP project areas include:

- A Coordinated Regional Emergency Services Program.
- Integration and alignment of PESP and health authorities emergency planning.
- Redesign of care in the community.
- Rural Emergency Department Initiative.
- Emergency Department Protocol Implementation.
- Emergency Department Outflow Study.
- Emergency Department Information System.

The health authorities met the 2004/05 milestones and outcomes as outlined in the project charter for the PESP.

⁷ For a full list of the Short-Term Task Group recommendations refer to the Emergency Services Short-Term Task Group Progress Report found online at: www.phsa.ca/HealthPro/pep.htm

⁸ For more information on *bcbedline* refer to the website at: <https://www.bcbedline.ca/info/index.shtml>

⁹ For more information on *BCNurseline* refer to the website at: <http://bchealthguide.org/nurseline.stm>

¹⁰ For more information on *BC Health Guide* refer to the website at: <http://bchealthguide.org/kbaltindex.asp>

d) Priority Project: Provincial Surgical Services Project

Reducing waiting times and wait lists for surgical services continues to be a priority in BC. The number of surgical procedures done in the province has increased significantly in recent years.

The Provincial Surgical Services Project (PSSP) is a collaborative initiative that involves all of the health authorities, but is under the direction of PHSA. The purpose of the PSSP is to improve BC's system of surgical services by:

- Developing standards and guidelines for provincial surgical services;
- Creating data collection processes for better planning and decision-making; and,
- Disseminating best practices resources and information to health authorities to help them improve their surgical services.

The performance expectations in the 2004/05 Performance Agreement were as follows:

- (1) The substantial implementation of components of the provincial surgical plan evaluated to be of highest value and benefit to the health authorities by the Steering Committee and evidence of indicators that will demonstrate the status of improvement of the performance of surgical services within health authorities; and,
- (2) The development/adoption of best practices in surgical services care and management, which are determined to be of greatest benefit by the Steering Committee.

The health authorities met these required performance expectations.

e) Home and Community Care Performance Measures

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 1 – Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care

Priority Strategy 4 – Alternatives to Institutional Care: Help elderly and disabled individuals avoid institutionalization and remain as independent as possible in their own homes and communities by increasing the range of supportive housing environments and community care options while reserving residential institutions for patients with the most complex care needs

The Ministry of Health can help the elderly and people with disabilities avoid unnecessary institutionalization by ensuring they receive the appropriate level of care. Health authorities are expected to have a variety of service options available for elderly and disabled individuals; from residential care facilities for clients with advanced and complex chronic care needs, to affordable assisted living residences or home support options for seniors or people with disabilities who want to, and can, live independently.

Providing both home and residential care clients with appropriate services requires objective, sensitive, standardized, and comprehensive methods for assessing client needs. Implementation of standardized assessment tools is an important step toward improving the appropriate placement of clients, as well as providing the data needed for accurate care planning, resource allocation, and policy-making.

Priority Project: Home and Community Care Classification Tools Project

To meet the needs of people who require complex care, the Ministry of Health has established a priority initiative: the Home and Community Care Classification Tools Project. The expected performance for 2004/05 was for health authorities, excluding PHSA, to have fully implemented the new assessment tool for home care (MDS-HC). All health authorities met this target. With the implementation of this tool complete, the health authorities have started implementing the residential care assessment tool (MDS V2.0). The revised target for completion of this tool is 2008. By implementing these comprehensive assessment tools, the health authorities can identify the needs of home and community care clients and develop care plans to ensure these clients receive an appropriate level of care in an appropriate setting.

Performance Measure: Percentage of clients with high care needs living in their own home rather than a facility.

Previous evidence suggested that a significant number of clients receiving residential care did not require the 24-hour care and supervision available in a facility. Factors such as social isolation and lack of community alternatives resulted in a greater reliance on long-term care facilities in certain geographic areas. Health authorities have expanded and enhanced home and community care services, including assisted living and independent housing. These services are more appropriate options for clients who do not require the higher intensity of service provided in a residential care facility.

Throughout 2004/05, health authorities created more opportunities for people to live independently with appropriate supports in place. As health authorities create more community care options, there should be an increase in both the number and percent of high-needs clients receiving services in their own homes, rather than residential care facilities.

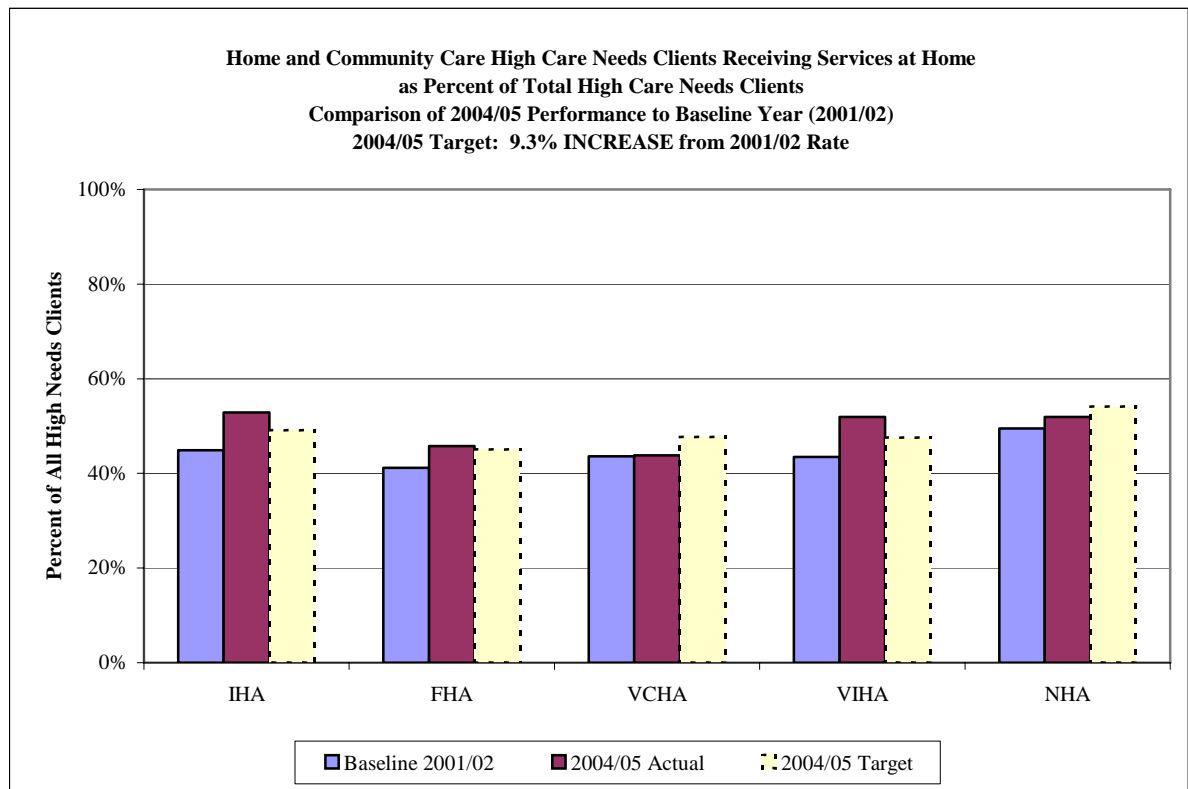
The 2004/05 Performance Agreements called for regional health authorities - with the exception of NHA - to increase both the number and percentage of high-needs clients receiving services at home when compared to 2003/04. This type of increase is dependent on a number of factors, including the availability of alternatives to residential care.

Chart 4 shows not all health authorities achieved the proposed percent increase for 2004/05. VCHA did not meet the 2004/05 target of a 9.3% increase in the percent of home and community care, high care needs clients who are receiving services at home. VCHA did not meet the target mainly due to previously high utilization rates in both

residential care and home support services. As a result, VCHA has implemented a number of activities. During 2002/03 and 2003/04 a regional review was conducted, the provincial policy was implemented and home support services were adjusted accordingly. VCHA developed regional guidelines to assist clinicians in determining the needs of and resources for clients with chronic and complex health conditions. Concurrently, VCHA experienced delays in successfully tendering and constructing new beds for assisted living units and made the decision to slow the reduction of residential capacity until alternate services were available. This is reflected in part by VCHA having the lowest ALC¹¹ rate in the province and short wait times for residential care. The Ministry of Health anticipates that VCHA will increase the number and proportion of high needs clients receiving home-based services in the future.

As stated, NHA's Performance Agreement did not include an increase to the number of high care needs clients receiving services at home, only to the percent. While NHA did not achieve the target of a 9.3% increase from the baseline rate, it did achieve an increase of 4.8%. As well, the NHA ranks second highest of the regional health authorities with respect to the absolute percentage of high care needs clients receiving services at home.

Chart 4: High Care Needs Clients Receiving Services in their own Home (2001/02 and 2004/05)



Source: CCData Warehouse, September 2005 Refresh, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

¹¹ For more information on ALC rates for health authorities refer to page nine.

f) Mental Health and Addictions Performance Measures

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 1 – Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care

Priority Strategy 5 – Build the foundation for integrated care networks: i) Connect physicians and other health care professionals to diagnostic services, hospitals, and each other, and; ii) Provide a “continuum of services” in each health authority for mental health and addictions patients that better integrates primary, secondary, community and tertiary care and is integrated with the larger care networks

The intent of integrated care networks is to improve the health outcomes and quality of life for people with mental illness or addiction issues. This involves providing appropriate care in communities, minimizing the time clients spend in institutions and, improving access to a range of health professionals.

To assess overall progress in this area, the 2004/05 Performance Agreements looked for:

1. Increases in community or physician follow up after discharge from hospital;
2. Decreases in hospital ALC days used by mental health or addiction clients; and,
3. Increases in the proportion of services received in a client's own health authority.

In addition to these performance measures, a priority system improvement project - The Riverview Replacement Project - ensures that the devolvement of patients and services from the Riverview site continues to advance in each regional health authority.

Performance Measure: Improved continuity of care measured by the proportion of persons (aged 15 to 64) hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.

This indicator measures the percent of mental health and addictions clients who have received follow-up care within 30 days of discharge. Most people who are hospitalized for a mental health diagnosis require follow-up services once they are discharged from hospital. To maintain continuity of care and to prevent readmission to hospital, clients should have at least one outpatient contact within 30 days of discharge. This indicator measures the health system's responsiveness and the continuity of care for people with a mental health diagnosis. A high percent of community or physician follow-up care indicates that hospital and community services are well coordinated and that community services are available and accessible to those clients who require it. As well, a high percentage of clients receiving follow-up care reduces the likelihood that a mental health client will suffer a relapse and have to be readmitted to hospital.

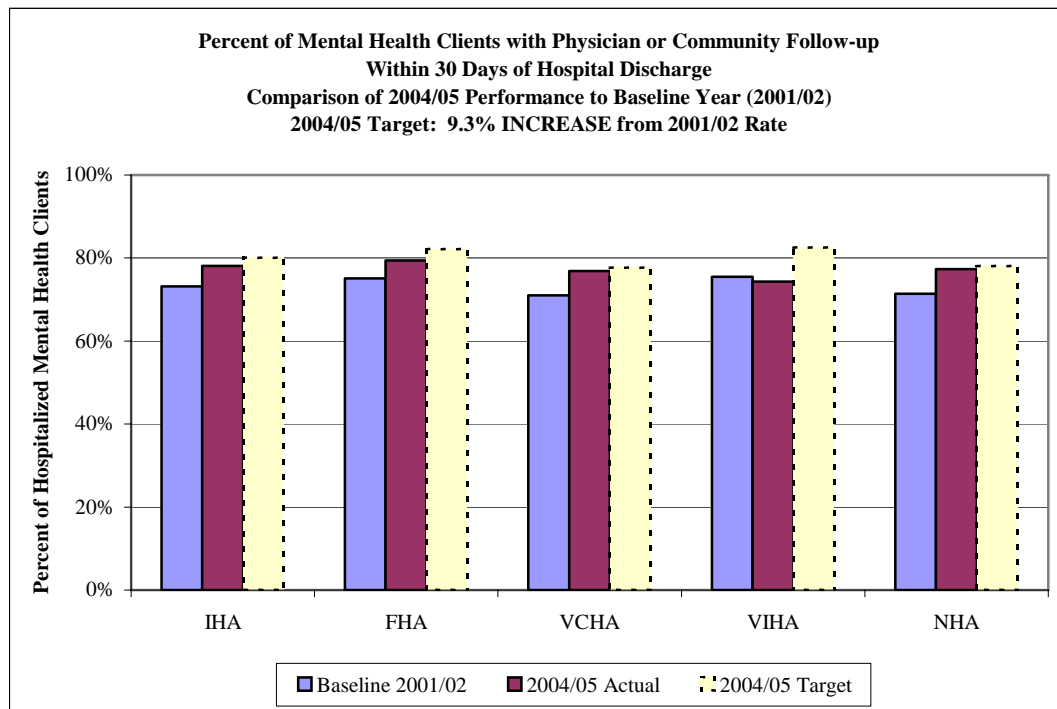
Chart 5 shows that while increases were made, none of the health authorities reached the 2004/05 target of a 9.3% increase from 2001/02 in the percent of mental health and addiction clients receiving a community or physician follow-up within 30 days of hospital discharge. However, VCHA and NHA substantially met the cumulative target

with an increase of 8.3% since 2001/02 in both health authorities. IHA and FHA partially met the target with increases of 6.7% and 5.7% respectively. VIHA missed the target, as data shows the percentage of clients followed up decreased rather than increasing. Under reporting of data, especially in VIHA, makes it difficult to assess accurately the health authorities' progress with this measure. In response, health authorities are currently integrating all data sources in their regions and instituting a minimum requirement for reporting data.

There are other factors to consider when reviewing the progress on this measure. For example, approximately 25% of the mental health discharges from acute care hospitals have a primary diagnosis of substance abuse. These clients generally receive follow up care in the community addictions services system, which is not included in the above analysis. In addition, clients can be counted more than once as the calculation is based on hospital discharges, not unique client encounters. There are also several reasons why some patients may not receive follow-up within 30 days. For some patients there may not be a clinical need, while others may refuse follow-up treatment or fail to show up for scheduled appointments.

VIHA and the other health authorities continue to build networks of services to ensure mental health and addictions patients receive the appropriate care. Strategies include: implementing Shared Care models of service where psychiatrists and general practitioners provide joint services, and telepsychiatry in rural and remote regions to enhance early intervention, discharge planning and follow-up.

Chart 5: Mental Health 30-Day Follow Up (2001/02 and 2004/05)



Source: Mental Health Research Database: November 29, 2005 Refresh, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

Performance Measure: Improved availability of community services measures by: Percentage of days spent by mental health patients (aged 15 to 64) in hospital after the need for hospital care ends. This measure is the same as the previous ALC¹² measure, (PS- PM3), but focuses on people who are hospitalized for a mental health diagnosis.

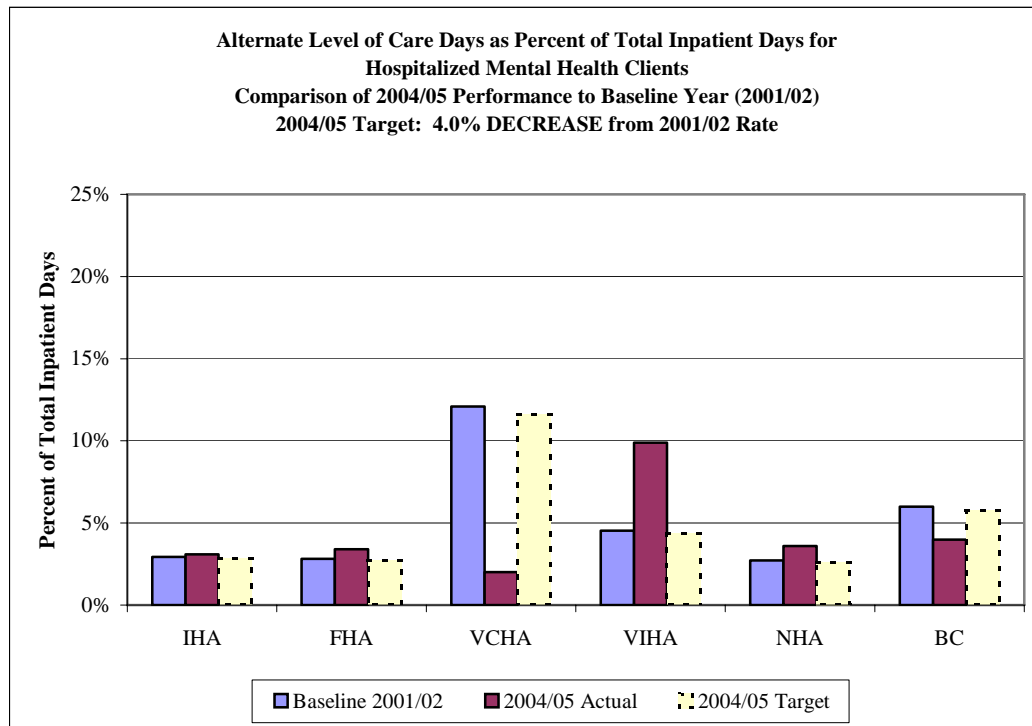
This indicator measures the percent of ALC days spent by mental health and addictions clients in hospitals. The 2004/05 target was a 4% decrease from 2001/02. This indicator reflects the availability of community services and the provision of services that are consistent with the needs of clients. A low percent of ALC rates could indicate the efficiency and effectiveness of hospital and community resources for mental health and addictions clients. Conversely, a high percent of ALC days may suggest a lack of appropriate community-based alternatives, such as supportive housing, case management and residential services.

Chart 6 shows that VCHA was the only health authority to meet the 2004/05 target of a 4% decrease in mental health and addictions ALC days. A substantial part of the decrease in VCHA resulted from a change in reporting. Clients awaiting transfer to Riverview Hospital are no longer designated as ALC as they are transferring to the same level of care. VIHA continues to have the highest mental health ALC rate of all health authorities as well as the highest average length of stay for mental health ALC clients.

All health authorities that did not meet this target have initiatives underway to improve this outcome in the following years. Initiatives include: implementing discharge/transition tracking and planning positions, increasing outpatient alternatives to hospitalization, and undertaking reviews of acute mental health services available health regions. The Ministry of Health will continue to monitor the progress on decreasing mental and health addictions ALC days in next year's performance agreements.

¹² Note: Refer to definition of ALC on page 9.

Chart 6: Mental Health Alternate Level of Care Days (2001/02 and 2004/05)



Source: Discharge Abstract Database (DAD), January 5, 2006, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

Performance Measure: Proportion of mental health services (community, physician and acute care) received by mental health clients (aged 15 to 64) that are obtained in their own health authority.

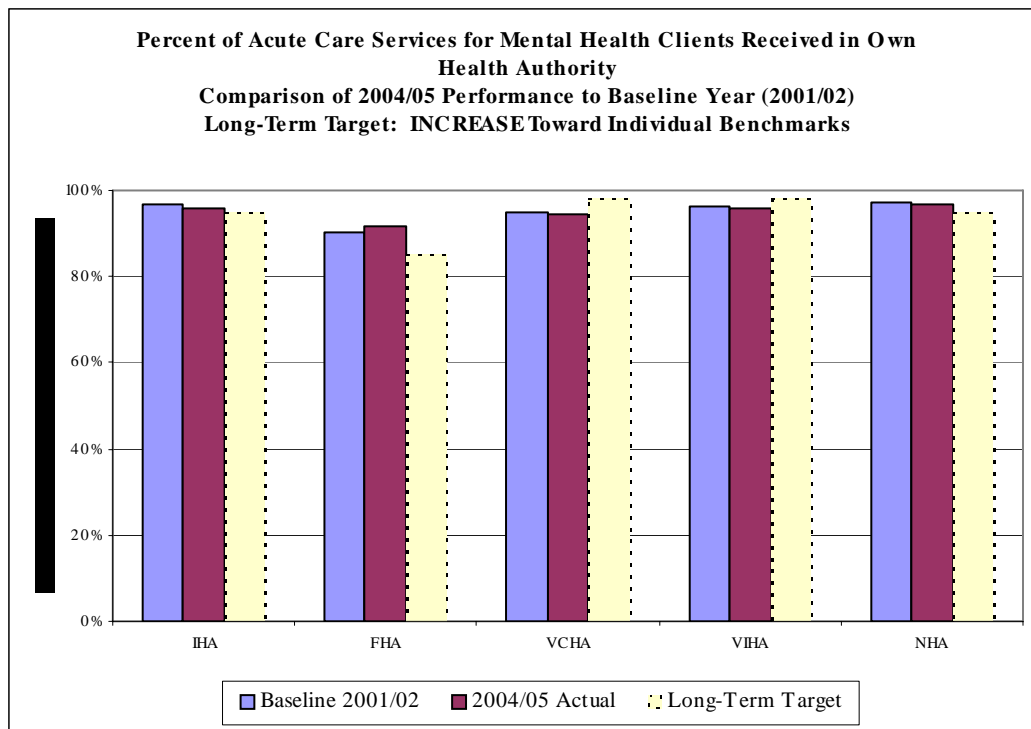
This indicator measures the percent of mental health services (acute and community) received by clients in their own health authority. For acute mental health services, the 2004/05 target was to increase - from 2001/02 levels - the percent of clients receiving services in their own health authority towards long-term individual health authority targets. For community mental health services, the 2004/05 target was to increase - from 2001/02 levels - the percent of clients receiving services in their own health authority towards the long-term target of 98%.

This measure indicates the extent to which mental health clients can be treated in their own communities or regional health authorities. The establishment of a mental health continuum of care in each health authority reduces travel and distance issues for patients and their families, and provides a higher quality of patient care for BC's residents where they live.

Chart 7 shows the percentage of acute mental health services clients received in their own health authority. IHA, FHA, and NHA have all met their respective 2004/05 targets. Although NHA has exceeded their benchmark, the health authority has noted there are still gaps in the continuum of care, given the geographic challenges of their region.

VCHA and VIHA have not increased over the baseline year and therefore missed their respective 2004/05 targets. To address this, VCHA has implemented five core addiction services at community health centres, providing more access to services for patients and clients in their region. Over the next three years, VIHA will invest in developing an integrated spectrum of mental health services following best practice standards of treatment, using an integrated service approach, and finding an appropriate balance of community and hospital based care.

Chart 7: Mental Health Acute Care Self-Sufficiency (2001/02 and 2004/05)

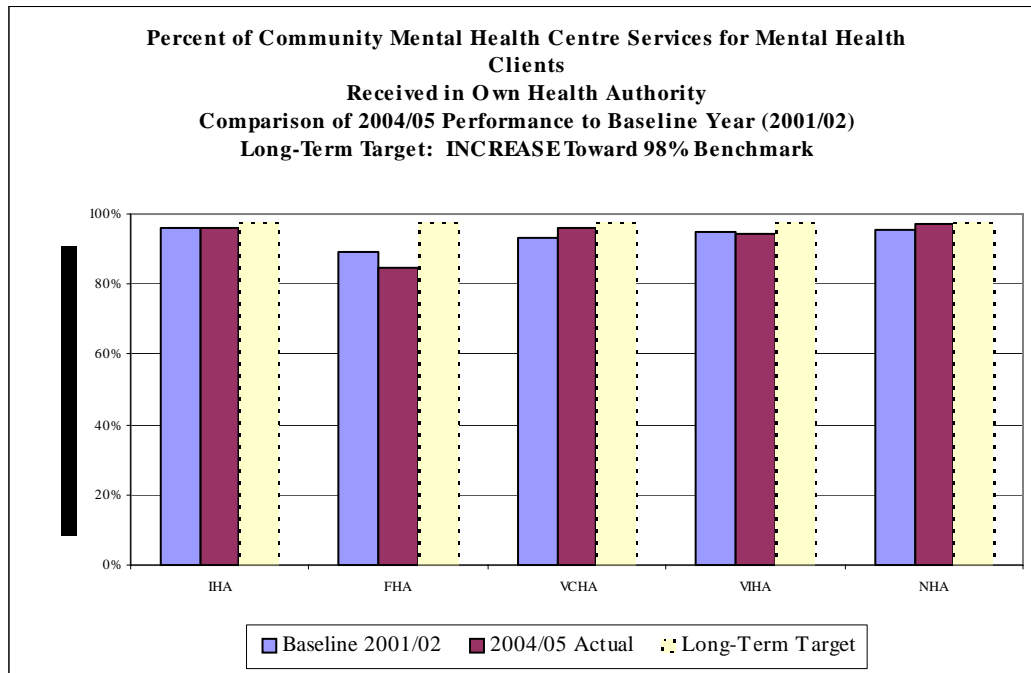


Source: Mental Health Research Database: November 29, 2005 Refresh. Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

Chart 8 below shows the percent of community mental health services clients received in their health authority of residence. Both VCHA and NHA have met their 2004/05 targets with increased rates of community mental health services for clients in their own health authorities. IHA, FHA, and VIHA did not meet their 2004/05 targets.

A key priority for IHA’s mental health strategy is to address client flow and effectively address upstream interventions, including services that span the entire continuum of mental health and addiction services. FHA is experiencing an ongoing shortage of psychiatrists. It has implemented a shared care program with family practitioners providing mental health and addictions services with support from psychiatrists and mental health and addictions teams. As well, the observed decline in FHA’s self-sufficiency may be due to under-reporting of community mental health services. VIHA is developing additional capacity in the community through a variety of services including supported housing and community transition care.

Chart 8: Mental Health Community Care Self-Sufficiency (2001/02 and 2004/05)



Source: Mental Health Research Database: November 29, 2005 Refresh. Information Resource Management, Knowledge Management & Technology Division, Ministry of Health.

g) Priority Project: Riverview Replacement Project

The Riverview Replacement Project is an integral part of the Ministry of Health’s strategy of establishing a continuum of mental health services in each health authority. Riverview Hospital is a care facility for clients with specialized or long-term mental health conditions. The site consists of buildings that are in poor physical condition and outdated designs that do not correspond with best practices in mental health service delivery. This project assists in developing Riverview replacement units in regional health authorities over a three-year period (2004/05 – 2006/07).

The Riverview Redevelopment Project will provide the highest quality of patient care by placing clients in secure and modern community facilities that will effectively meet their complex mental health needs. In addition, clients will be able to access up-to-date mental health facilities, which are in line with best practices in mental health treatment. Clients will soon be able to access the full continuum of mental health services in the region where they reside.

During 2004/05, health authorities initiated the implementation of the necessary infrastructure to support the development of mental health services capacity throughout the province. IHA added 18 tertiary mental health beds by March 2005, and will add another 14 beds (for a total of 32 beds) by June 2005¹³. Six of these beds are to meet the requirements of last year’s performance agreement.

¹³Six of these beds are to meet the requirements of last year’s performance agreement.

FHA completed the transfer of 19 geriatric patients to Delta View Habilitation Centre (an 80-bed purpose built dementia care facility) in mid-June 2004. VIHA has completed the development of 46 beds (25 geriatric tertiary and 21 community geriatric) at Sandringham Lodge in Victoria and in NHA, 20 adult beds were opened in Terrace in March 2005. VCHA did not complete the transfer of 25 units in 2004/05 as per the performance agreement due to concerns on capital and land implications for VCHA. The Ministry of Health is working with all the health authorities to address this issue and to reconfirm targets and operating principles for the Riverview Project.

h) Aboriginal Health Performance Measures

Ministry of Health Services' 2004/05 Service Plan

Goal 1 - High Quality Patient Care

Objective 2 – Provide tailored care for key segments of the population to better address their specific health care needs and improve their quality of life

Priority Strategy 9 – Improve the Health Status of Aboriginal Peoples: Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care

As a group, Aboriginal peoples have a level of health below that of the non-Aboriginal population. In 2004/05, each health authority worked with Aboriginal communities and organizations to develop an Aboriginal Health Plan that will guide service delivery in their regions and improve the health of Aboriginal people.

The Performance Agreements measured Aboriginal health improvement by both infant mortality and life expectancy rates. These rates and measures are established using Vital Statistics data and methodology, and reported as a five-year rolling average. Status Indians, a subset of Aboriginal people, is used as a proxy measure for the total Aboriginal population as they are the only Aboriginal people identified in Vital Statistics databases.

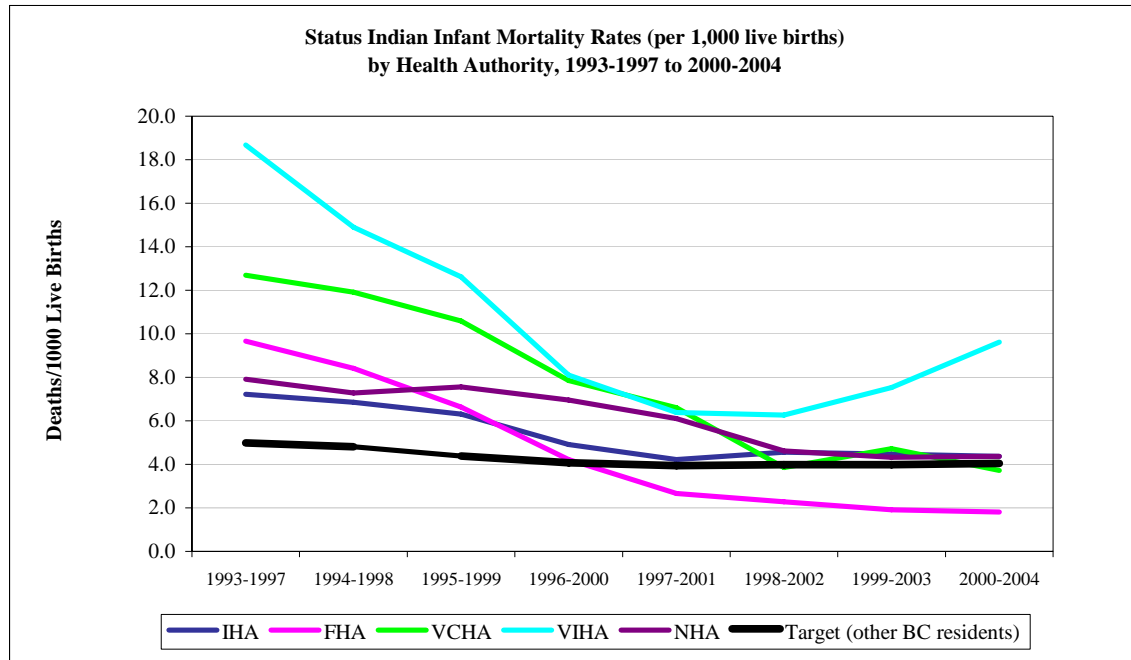
The 2004/05 target for infant mortality was to have no significant statistical difference between the Status Indian and non-Aboriginal rates. The 2004/05 target for Status Indian life expectancy was at least 74.2 years.

Performance Measure: Improved health status for Aboriginal peoples measured by infant mortality.

Chart 9 depicts the infant mortality rates for Status Indians residing in each health authority and the rate for other BC residents. For all health authorities - with the exception of VIHA - there was no significant statistical difference between the infant mortality rates of Status Indians and the non-Aboriginal population.

This performance measure has been replaced in the 2005/06 Performance Agreements with a new one that requires Status Indian post-neonatal mortality rates to decrease toward, or be maintained at or below, the long term target of 1.1 per 1,000 population.

Chart 9: Aboriginal Health—Status Indian Infant Mortality Rate (1993-1997 to 2000-2004)¹⁴



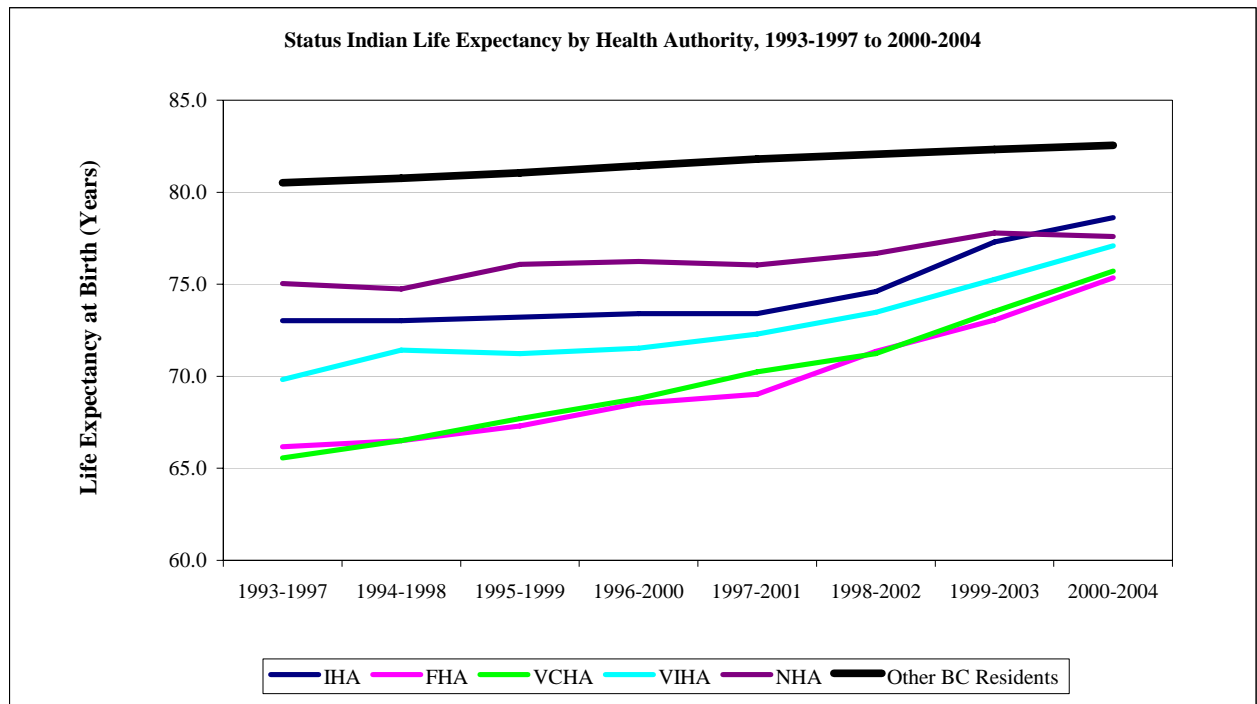
Source: BC Vital Statistics Agency, November 24, 2004, Knowledge Management & Technology Division, Ministry of Health.

Performance Measure: Aboriginal Health – Improved health status for Aboriginal peoples measured by life expectancy.

Chart 10 depicts the life expectancy rates for Status Indians residing in each health authority compared to the rate for other BC residents. All health authorities were successful in reaching their 2004/05 target of a Status Indian life expectancy of at least 74.2 years.

¹⁴ Note: The Status Indian Events for 2004 are flagged without the use of the Status Verification File (SVF) from the First Nations and Inuit Health Branch, Health Canada. This has had an impact on ascertaining First Nations status, resulting in an estimated reduction of deaths attributed to First Nations infant population of about 0.5% in 2004.

Chart 10: Aboriginal Health – Status Indian Life Expectancy (1993-1997 to 2000-2004)¹⁵



Source: BC Vital Statistics Agency, November 24, 2004, Knowledge Management & Technology Division, Ministry of Health.

Ministry of Health Services' 2004/05 Service Plan

Goal 2 – Improved Health and Wellness for British Columbians

Objective 3 – Keep people as healthy as possible by preventing disease, illness and disability and slowing the progression of chronic illness to minimize suffering and reduce care costs in the future

Priority Strategy 11 – Protection from Disease or Injury: Protect public health by implementing core public health prevention and protection programs (e.g., food and water safety programs, immunization programs, falls)

i) Priority Project: Core Public Health Functions/New Public Health Act Project

The public health core functions are the areas of public health identified as having the greatest potential for positive impact on people's health. These functions will form the legislated, long-term programs that represent the minimum level of public health services health authorities will be required to provide. Public health core functions will be part of the new *Public Health Act*, and will have clear goals, measurable objectives, and an evidentiary base that shows they can improve or protect people's health.

¹⁵Note: The Status Indian Events for 2004 are flagged without the use of the Status Verification File (SVF) from the First Nations and Inuit Health Branch, Health Canada. This has had an impact on ascertaining First Nations status, resulting in an estimated reduction of deaths attributed to First Nations population of about 9.0% in 2004.

The 2004/05 Performance Agreements outline the expected performance for all six health authorities in regard to this priority system improvement project: Development of Core Public Health Functions/new *Public Health Act* Project.

The 2004/05 expected performance included continued collaboration with all other health authorities and the Ministry of Health in the:

- Development of core prevention and protection programs;
- Review of literature; and,
- Research of best practices and performance in other jurisdictions.

As well, the PHSA (through the BC Centre for Disease Control [BCCDC]) was expected to assist the regional health authorities in reaching their rate of immunizations performance targets and to cooperate in the development of a monitoring and reporting system to track these immunizations.

The health authorities met these required performance expectations through the creation of working groups that reviewed evidence papers and best practices, established benchmarks and identified performance measures.

j) Immunizations Performance Measures

Performance Measure: Immunizations for two-year-olds

This performance measure involved the collaboration of the BCCDC and the health authorities to meet targeted immunization rates and to monitor and report on immunizations.

Immunization programs for children are a cost-effective way to improve population health, prevent illness and reduce health care costs. By measuring the effectiveness of an immunization program, the Ministry of Health can determine whether there are barriers to accessing these services.

During 2004, two-year olds had access to the following routine immunization schedule: DPTP/HIB (Diphtheria, Pertussis, Tetanus, Polio and Haemophilus Influenza Type B), MMR (Measles, Mumps and Rubella), and Hepatitis B. Immunizations are administered in health units by public health nursing staff or through physician offices. The percent delivered by public health nursing staff can vary greatly by health service delivery area; it can range from 7% in some areas and up to 100% in others.

Because immunizations received in physician offices are not specified in the physician billing records as a vaccination, there is no means to determine the complete number of immunizations occurring in these settings.

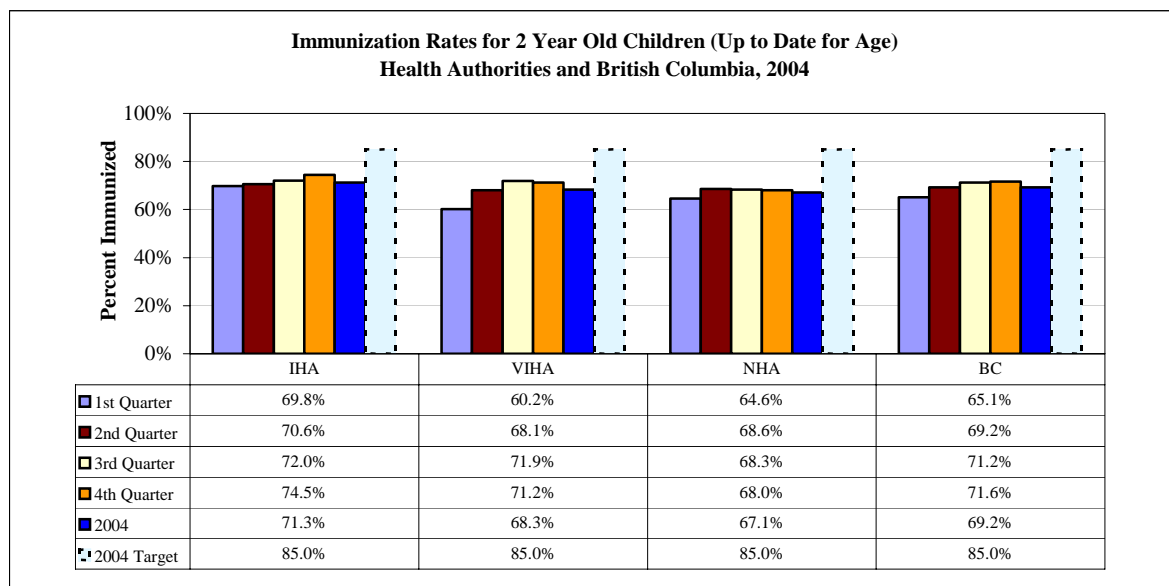
In the 2004/05 Performance Agreements, IHA, VIHA, and NHA were required to reach the target of 85% of two-year olds with the routine immunization schedule. FHA and VCHA were required to implement a monitoring plan for two-year old immunizations.

Chart 11 below reflects immunization rates for IHA, VIHA, and NHA as captured by public health data. In general, immunization rates for two-year-old children in were consistently below desired target rates, with the lowest rates in immunizations occurring in rural, isolated or remote areas.

According to BC’s Provincial Health Officer, concerns over data quality and variations in reporting practices make it difficult to assess the reasons for these lower than expected rates. The Ministry of Health is currently collaborating with the BCCDC and health authorities to analyze further the immunization data and data collection issues.

FHA and VCHA are committed to increasing immunization rates for two year olds and have successfully implemented their monitoring plans. FHA expects to collect useable data for the 2005/06 fiscal year, whereas VCHA expects to be able to collect useable data by Spring or Summer 2006. Both health authorities, in collaboration with the Ministry of Health, are creating an operational framework to develop best practises and strategies to support immunization programs.

Chart 11: Immunizations for Two-Year Olds (2004)



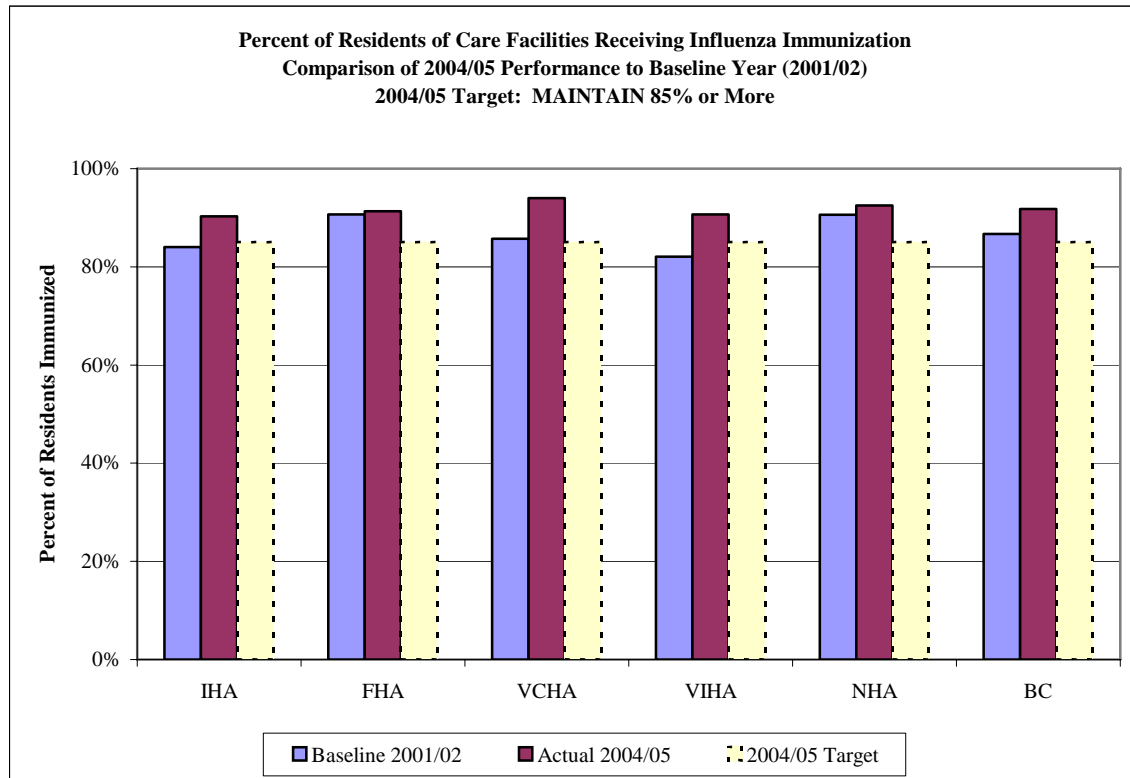
Source: Public Health Information System (iPHIS), BCCDC, May 6, 2005.
Note: BC data consists of IHA, VIHA, and NHA only.

Performance Measure: Influenza Immunizations for Residents of Care Facilities

Influenza is a major cause of illness, hospitalization and death among older adults. Annual influenza vaccination for the residents of care facilities reduces the risk of disease and may lessen the severity of illness. Increasing influenza immunization rates can reduce the number of deaths, hospitalizations and physician visits attributable to this common and largely preventable illness.

While there are still concerns regarding the number of facilities that routinely report influenza immunization data, current immunization rates appear to be the highest in five years, with about 90% of residents being immunized annually, as shown in Chart 12 below. All health authorities met their 2004/05 performance targets of maintaining influenza immunizations at a minimum of 85%.

Chart 12: Immunizations for Influenza of Residents of Care Facilities (2001/02 and 2004/05)



Source: Data are submitted by Health Authorities (Annual Influenza Immunization Program Survey).
 Compiled by: Population Health and Wellness Division, BC Ministry of Health Services for 1999/2000 to 2002/2003; BCCDC for 2003/2004 and 2004/05. April 26, 2005.

k) Annual Expenditures for Administrative and Support Services

Ministry of Health Services' 2004/05 Service Plan
Goal 3 – A Sustainable, Affordable Health Care System
Objective 4 – Manage within the available budget while meeting the priority needs of the population
Priority Strategy 13 – Managing within Budget Allocation: Manage the delivery of services within budget

In their 2004/05 Performance Agreements, the Ministry of Health directed the health authorities to manage administration expenses effectively within the available budget to ensure that maximum financial resources are directed to patient care.

Performance Measure: Annual Expenditures for Administrative and Support Services

First, the health authorities were required to reduce their annual expenditures for administrative and support services by at least 7% from 2001/02. Second, they were required to manage and deliver programs and services with financial results not exceeding their 2004/05 budgets.

All health authorities reported exceeding the 7% reduction of annual expenditures for administrative and support services. As well, all health authorities have met the 2004/05 target to manage and deliver their programs and services within their pre-determined budgets. All health authorities completed the 2004/05 fiscal year with a surplus.

5. Conclusion

Since the release of the Office of the Auditor General Report in 2003, the annual health authority Performance Agreement with the Ministry of Health has undergone extensive revision. The recommendations from the Office of the Auditor General provided guidance and direction for advancing the development of the 2004/05 Performance Agreement.

This annual report reflects these improvements made in the Performance Agreements by clarifying the role that they play in the relationship between the Ministry of Health and health authorities. In addition, the distinction between priority projects and performance measures has been refined, and the linkages clarified between the Ministry of Health's Service Plan and the Performance Agreements.

The 2004/05 Performance Agreements increase the accountability of specific health service goals, strategies and priority projects. They are a key factor in identifying, analysing and addressing many of the issues that affect the overall performance of the health care system.

During 2004/05, the health authorities, in conjunction with the Ministry of Health, worked diligently to reach performance targets and meet agreed upon deliverables. All the health authorities met their targets in five key areas:

- A 15.4% reduction in the provincial rate for hospital visits by people who may appropriately be treated in an ambulatory setting rather than the hospital.
- Ensuring 90% of patients receive radiotherapy within 4 weeks of being ready to receive treatment.
- Improving Aboriginal infant mortality and life expectancy rates.
- Influenza vaccination of 90% of residents of care facilities.
- A 7% reduction in expenditures for administrative and support services.

In addition, the individual health authorities reached a substantial amount of the performance measure and priority project targets of the 2004/05 performance agreements.

However, the health authorities did not fully meet some of the 2004/05 targets in the areas of community health care, mental health, home and community care and core public health care. As well, persistent challenges with data availability and quality make effective monitoring of health authority performance difficult in some areas. The Ministry of Health will continue to work closely with its health authority partners to refine measures and address areas where anticipated performance hasn't been achieved.

The Ministry of Health is committed to transparent performance reporting in the health sector and will continue to work with the health authorities to develop meaningful performance indicators.