

2003/04 Health Authority Performance Agreement Report

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1. Executive Summary

British Columbia is one of the most diverse provinces in Canada both in geography and population. The Ministry of Health Services and B.C.'s health authorities are working together to make sure B.C.'s health system provides the right care at the right time to all British Columbians, no matter where they live.

With the establishment of six health authorities in 2002, British Columbia 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. B.C. was the first province in Canada to implement this process, and is leading the country in health care system and resource accountability.

The *2003/04 Health Authority Performance Agreement Report* shows the great strides health authorities have made in meeting their performance measurements. For the second year in a row, health authorities are showing balanced budgets. They are evolving and strengthening the accountability process while meeting the needs of their populations. And they have shown improvements in areas such as:

- Aboriginal health outcomes - ten years ago, life expectancy and infant mortality rates for Aboriginal people fell far below that of the general population. In the case of infant mortality, rates were almost double. Health authorities have worked directly with Aboriginal people to address their specific health needs; life expectancy for Aboriginal people is showing significant improvements and there is now virtually no difference in infant mortality rates between the Aboriginal and general populations.
- More effective use of resources - health authorities have increased patient access to general practitioners, specialists and other community care providers, in turn making better use of hospital resources. The provincial rate for hospital visits by people who did not require a bed has dropped by 11 percent since 2001/02, increasing accessibility to beds for patients who do require hospitalization.
- Strengthening disease prevention - in 2003/04, 90 percent of residents of care facilities received an influenza vaccination. This exceeded the provincial target by 5 percent and helped to reduce the number of deaths, hospitalizations and physicians visits attributed to this common illness.

It is recognized there is still work to be done and challenges to be met for B.C.'s health care system. By working collaboratively, the ministry 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.

2. Introduction

The 2003/04 fiscal year was the second year of a three-year process to achieve a more accountable and integrated system of health care in BC.

The formation of six health authorities in 2002/03 created a strong foundation for making fundamental improvements to the management and delivery of hospital and community-based health services. These improvements are based on the three goals set out in the Ministry of Health Services Service Plan:

- High quality patient-centred care
- Improved health and wellness for British Columbians
- A sustainable, affordable public health system

In 2003/04, health authorities took significant strides toward meeting the specific expectations set out in their performance agreements¹ and began to fully assume their role in shaping BC's overall health care system.

Health Authority Profiles

British Columbia has six health authorities that, in conjunction with the Ministry of Health Services, 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 geographically defined health authorities (profiled below) whereas one other health authority (the Provincial Health Services Authority) has responsibility for provincial and specialized services, such as cancer care.

Interior Health Authority (<http://www.interiorhealth.ca/default.htm>)

Interior Health Authority provides a full range of health care services to approximately 691,000 (2003) residents in the interior of British Columbia. Interior Health covers a region that stretches from Williams Lake to the U.S. border and from Anahim Lake in the Chilcotin to the Alberta border.

Fraser Health Authority (<http://www.fraserhealth.ca/Home/Default.htm>)

Fraser Health Authority provides a full range of health care services to approximately 1.44 million (2003) residents, predominantly within the Lower Mainland. It's borders stretch eastward from Delta to Burnaby to Boston Bar and southward to the U.S. border.

¹ In April 2002, the government introduced performance agreements between the new health authorities and the BC Ministry of Health Services as a means of increasing accountability for the delivery of patient services, health outcomes and health care spending. The performance agreements define expectations, performance deliverables and service requirements in the areas of emergency care, surgical services, home and community care, and mental health services for three fiscal years.

Vancouver Coastal Health Authority (http://www.vch.ca/home_page/index.htm)

Vancouver Coastal Health Authority provides a full range of health care services to approximately 1.04 million (2003) residents in Vancouver, Richmond, the North Shore and communities in the coastal region, including: Squamish, Whistler and Pemberton in the Sea-to-Sky; Gibsons and Sechelt on the Sunshine Coast; and Powell River. Through denominational agreements, Vancouver Coastal Health serves the residents of Bella Bella and Bella Coola and also partners with Providence Health Care in Vancouver.

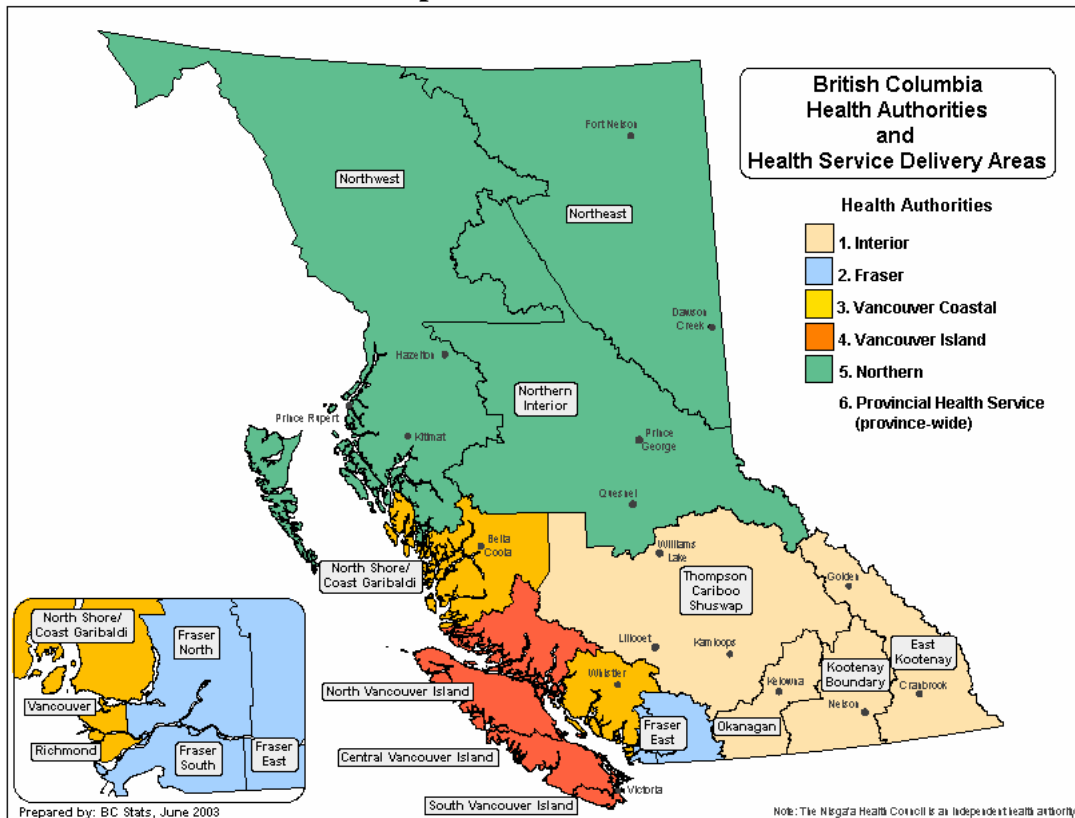
Vancouver Island Health Authority (<http://www.viha.ca/>)

Vancouver Island Health Authority provides a full range of health services to approximately 698,000 (2003) residents of Vancouver Island, the Gulf and Discovery Islands and to the residents of the mainland located adjacent to the Mount Waddington and Campbell River areas.

Northern Health Authority (<http://northernhealth.ca/>)

Northern Health Authority provides a full range of health care services to approximately 302,000 (2003) residents in northern British Columbia. It covers almost two-thirds of B.C., bordered by the Northwest and Yukon Territories, the B.C. interior, Alberta, Alaska and the Pacific Ocean.

Map of BC Health Authorities



Provincial Health Services Authority (<http://www.phsa.ca/default.htm>)

The PHSA mandate is to support effective and high-quality delivery of selected province-wide health care programs and services. The PHSA achieves this through either directly providing services (the PHSA has nine constituent agencies including the BC Cancer Agency, BC Centre for Disease Control, BC Transplant Society and the BC Children's and Women's Hospitals), or supporting the regional health authorities in their service delivery (PHSA has a leadership role, in support of the Ministry, in developing the most effective service delivery practices for specific programs and services and the accompanying change management).

While recognizing the unique circumstances and challenges of each health authority, this report outlines the progress made in achieving the common goals and strategic objectives established for BC's publicly funded health care services.

For the past several years, health jurisdictions across the country have been struggling to find a balance between meeting ever-increasing demands for health care services and containing public healthcare spending.

Through grants from its Regional Health Sector budget, the Ministry of Health Services is the major funding agency for health authorities. Over the three-year period from 2001/02 through 2003/04, these grants increased by almost \$850 million. Compensation costs to health authorities (as required under collective agreements or benefit plans) increased by approximately \$800 M over the same period.

Through the redesign process, BC's health authorities have made improvements to the health system that have increased efficiency and redirected savings to patient care.

Health authorities have been guided in this exercise by the priority strategies outlined by government through the Ministry of Health Service's three-year Service Plan. While health authorities have responsibility for, and influence over, a vast array of health services, this report focuses on those strategies directly reflected in the 2003/04 performance agreements.

3. Understanding Performance Targets, Monitoring & Evaluation

Evolution

In 2002, British Columbia became one of the first provinces in Canada to define specific performance expectations and targets for the management and delivery of hospital and community-based health services through formal performance agreements with its health authorities.

Recognizing that these agreements would necessarily mature with time and experience, the province constructed the performance agreements as three-year rolling documents. This was done in order to provide the stability needed to undertake multi-year system reforms. The intent was to create a framework that would combine consistent direction with enough flexibility to evolve with time and experience.

For the most part, the 2003/04 performance agreements maintain the overall framework, goals and objectives set by government the previous year, while incorporating some adjustments to specific expectations, measures and targets.

Significant input and feedback on the original agreements was received throughout 2002/03 from various sources, including the BC Auditor General² and health authorities themselves. This input is reflected in revisions to the 2004/05 performance agreements now in effect. (Similarly, experiences from 2003/04 will shape the 2005/06 performance agreements and so forth.)

² “A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities” Office of the Auditor General, May 2003. In November 2004, the Ministry of Health Services published a progress report on the implementation of recommendations made in the review.

Strategic & Interconnected

Since 2002, BC has been developing comprehensive monitoring and evaluation processes to track the progress and benefits of health service redesign efforts.

While health authorities themselves measure a great deal of service activity at a patient and operational level, the ministry's monitoring and evaluation activities are focused on the progress made toward achieving government's broad goals for the system (i.e. improved health and wellness, high quality patient centered care and a sustainable and affordable health care system).

When looked at collectively, the performance measures in the performance agreements help create a picture of the direction in which BC's health system is moving.

These measures are focused in those health sectors largely administered by health authorities, such as hospital and residential care, mental health and public health services. Looking at shifts in care patterns across this spectrum of health services helps administrators, care providers, government decision-makers—and the public—see the extent and impact of service redesign changes.

The performance agreements contain both *quantitative* and *qualitative* targets (expected performance), which specify the direction and amount of change expected. As a starting point, the quantitative performance targets were set largely by looking at current provincial norms and averages³. Qualitative targets are used in areas where multi-year planning and new levels of collaboration and cooperation between health authorities are desired.

The performance *targets* in the performance agreements are meant to stimulate redesign and quality care. More than reflecting current activity, the targets are meant to challenge each health authority to achieve its maximum potential in key service areas while taking into account their unique geographic and demographic challenges.

Constructive

Performance *evaluation* is meant to be a constructive, ongoing process that increases transparency about health authority achievements and challenges. Evaluation efforts in the ministry focus as much on *how* and *why* targets were or were not met as *whether* they were achieved.

Regular evaluation against standard criteria is meant to identify accomplishments and highlight initiatives that have successfully overcome challenges and may be transferable

³ BC is an active participant in the ongoing and complex process to establish national standards and benchmarks for performance in key service areas. In the meantime, BC will continue to establish quantitative targets for performance agreements based on evidence and discussions with health authorities.

to other regions, as well as areas for further focus and work. Performance *improvement* is concerned with understanding what specific strategies or actions may be implemented within a region to enhance performance levels and achieve the service trends desired over time.

One of the main benefits of consolidating responsibility for most health services into six, largely autonomous authorities is their increased ability to make the significant, strategic shifts required to address any shortcomings in performance. Although they have been formal organizations for less than three years, the new health authorities have demonstrated both a strong *willingness* and an *ability* to address many of the difficult health care challenges that have existed in British Columbia in the past.

4. Intent of 2003/04 Performance Agreements

Focus on Building Capacity; Creating A Contemporary Health System

This report looks primarily at health authority activity in 2003/04 as it relates to the expectations detailed in their performance agreements, and health authority progress in advancing high-level service redesign and capacity-building initiatives started the previous year.

With responsibility for the majority of health care services delivered outside of physician's offices, BC health authorities are always striving to balance many diverse priorities and implement numerous local service improvement initiatives. Much of this activity is captured in regular reports to health authority board members and residents and posted on respective health authority websites. (Links to health authority websites can be found at www.healthservices.gov.bc.ca/socsec/index.html).

In the November 2002 *Picture of Health*, the provincial government described BC's health system as having fallen behind in terms of providing appropriate, patient-centered care in a manner that was efficient, effective and sustainable. Originally designed to respond to short-term, acute care needs, today's health care system was felt to be more expensive and less effective than it should be.

Health authority performance agreements are based on the understanding that government expects a substantial redesign of health care services, while maintaining the priority of patient needs.

The Ministry of Health Service's three-year Service Plan provides a framework for achieving government's goals for the health system and speaks to the role of "partners", such as health authorities, in achieving that vision.

In turn, health authorities outline their strategies for achieving desired results in their own three-year Service Redesign and Budget Management Plans.

The specific expectations in the 2003/04 performance agreements relate to several of the priority strategies detailed in the Ministry of Health Service's three-year Service Plan:

- a) Plan for and manage the demand on emergency health services and surgical and procedural services.
- b) Prevent unnecessary hospitalizations by providing patients with better access to services in the community.
- c) Provide appropriate community health support to enable timely discharge of patients from hospital once the need for acute medical care has ended.

- d) 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.
- e) Protect public health by implementing core public health prevention and protection programs (e.g. immunization programs).
- f) Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care.
- g) Build the foundation for integrated care networks by i) connecting physicians and other health care professionals to diagnostic services, hospitals, and each other and ii) providing a “continuum of services” for mental health patients within larger integrated health networks.
- h) Manage the delivery of services within budget.

Accountability

The Ministry of Health Services annual Service Plan report speaks to the progress made in implementing Service Plan strategies at a provincial level. This report provides more detail on specific health authority-related progress and strategies.

Throughout the year, data and analyses are provided to individual health authorities to help them understand their own progress in achieving performance agreement targets. In addition, the ministry completes annual assessments of health authority Service Redesign and Budget Management Plans to determine whether they appropriately address identified areas of concern, align with Ministry of Health Services Service Plan strategies and present the best opportunity to move the health authority in the direction set out by government.

5. Progress toward Achieving Priority Strategies

Priority strategies are listed in the 2003/04 MOHS Service Plan by health system objective and goal (high quality patient care, improved health and wellness for British Columbians and a sustainable, affordable public health system). Priority strategies are current initiatives conducive to attaining the long term goals of the BC health system.

Priority Strategy: Plan for and manage the demand on emergency health services and surgical and procedural services.

Emergency Services

Emergency Services are a critical entry point to the health care system, with Emergency Departments often the place where ambulances, family doctors, specialists and hospitals intersect.

In 2002/03, the Emergency Services *Short-Term* Task Group released a report identifying opportunities to improve access to, and effectiveness of, emergency services. (website: www.phsa.ca/HealthPro/pesp.htm)

Late in 2003, an Emergency Services *Long-Term* Task Group, with broad practitioner and health authority representation that included community, primary care and chronic disease experts, began working to create a strategic plan for ongoing reform, improvement and evaluation of the emergency services system.

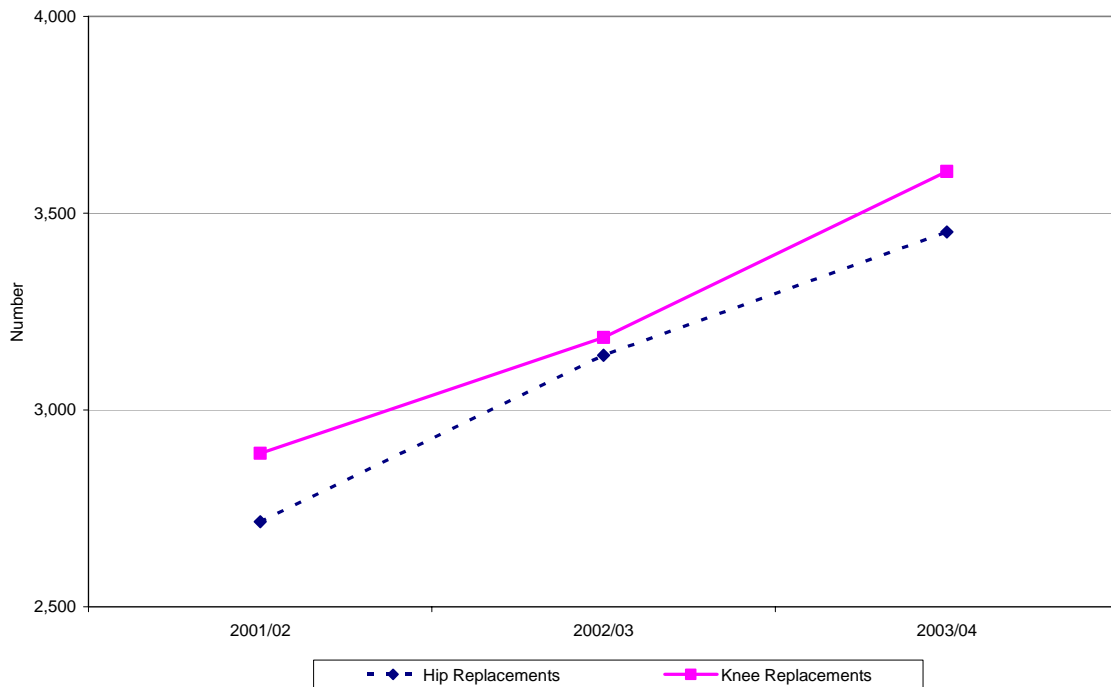
In 2003/04 health authorities began to implement high-priority recommendations from the Short Term Task Group Progress Report. Over the past year, it has become clear that the focus of health authority activity must be to work collaboratively on two key areas of concern: emergency room overcrowding and patient outflow (the transfer of patients from the Emergency Department back into the community or into hospital).

A Provincial Critical Services Steering Committee was established to develop the guidelines, best practices and performance measures that will achieve the results desired in these areas. This information will be incorporated into future service plans and health authority performance agreements.

Surgical and Procedural Services

The issue of waiting times and wait lists for surgical services continue to be important for health care in BC, and the number of procedures done in the province has increased significantly in recent years.

**Hip and Knee Replacement Surgeries on BC Residents
2001/02 - 2003/04**



Source: Discharge Abstract Database (DAD), Ministry of Health Services.

The goal of the Surgical & Procedural Services Project is to develop and implement province-wide improvements in surgical and procedural services to provide high-quality services in a reasonable time and within available resources.

In 2003/04, work began in the development of province-wide definitions for elective, urgent and emergent surgical cases, standards and definitions for measuring wait times, guidelines for surgical concentration and location of core specialty services and reporting requirements and information resources for continuous improvement of surgical and procedural services.

Developing common standards, definitions and reliable data collection methods are key elements to guiding good decisions of resource allocation and setting meaningful long-term performance targets for individual health authorities.

Priority Strategy: Prevent unnecessary hospitalizations by providing patients with better access to family physicians, specialists, other providers and services in the community.

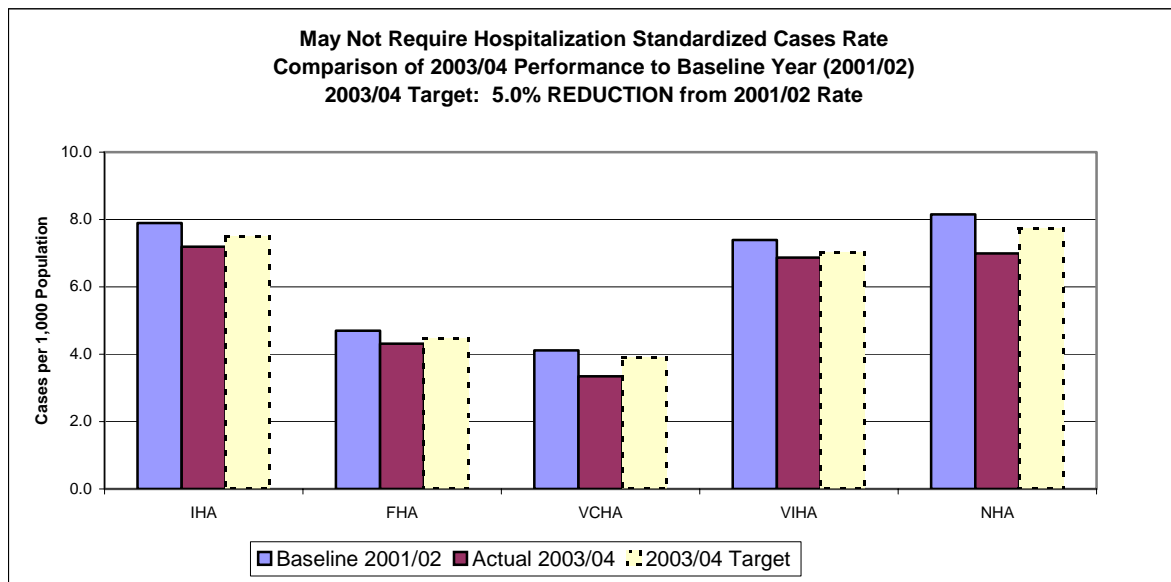
Enhancing primary care is the key to achieving this strategy. Primary care is a patient’s first and most frequent point of contact with the health system and supports individuals and families to make the best decisions for their health. Patients access primary care when they visit their doctor, medical clinic, or public health unit.

When patients are 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 treated with a community-based alternative.

A low MNRH rate is considered more likely to reflect the efficient use of hospital beds than a higher rate. (However, it is important to note that some specific cases within the broad MNRH category will require hospitalization because of their clinical circumstances or the unavailability of a community resource, as may be the case in isolated rural communities).

Generally, BC wants to see low MNRH rates as an indication of both the efficient use of hospital beds and improved access to community resources.

All health authorities have been successful in reducing MNRH rates to below their respective targets, with the overall provincial rate dropping about 11% since 2001/02. This means about five cases in every 1,000 cases are currently classified as MNRH. There is some variation among health authorities as shown in the graph below.



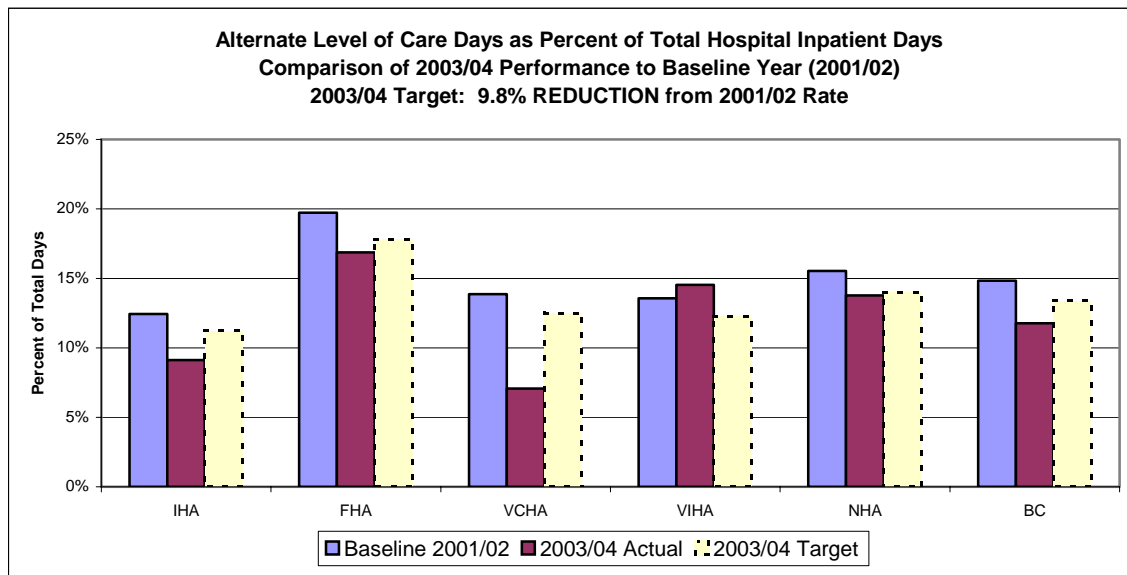
Source: Discharge Abstract Database (DAD), November 26, 2004, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services

Priority Strategy: Provide appropriate community health support to enable timely discharge of patients from hospital once the need for acute medical care has ended.

For the past two years, health authorities have been actively working to ensure patients do not remain in hospital longer than necessary. There are a number of factors that result in delayed discharge, including a lack of available capacity in residential facilities or insufficient community resources to support discharge.

Health authorities have focused on better use of hospital resources as a key priority and have implemented specific strategies to reduce ALC (Alternate Level of Care) days. Health authorities have added new hospice and convalescent care beds to the continuum of care as well as enhanced community supports, which include post hospital inpatient care provided by home care nurses, therapists and home support aides. They have also increased access to adult day care and assisted living — a relatively new care option that offers housing, hospitality and personal care services. More appropriate care and timely discharge from hospital have resulted from regional access lists for residential care and the creation of convalescent beds for patients who require a range of health services on a short-term basis before returning home.

The days that a patient spends in hospital after the need for hospital care has ended are called ALC days. This means the patient needs some level of care, but not hospital care. Reducing ALC days in hospitals has the dual benefit of getting patients care that is more appropriate for their needs (like community-based rehabilitation services) and freeing acute care beds for patients who truly need that intensity of service.



Source: Discharge Abstract Database (DAD), November 26, 2004, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health Services

While the Fraser Health Authority has the highest ALC rates in the province, it has been moving to provide more appropriate community supports, and has reduced its ALC rates in each of the past three years. While part of the reduction for Vancouver Coastal Health Authority was due to a change in reporting practice, both the Fraser and Vancouver Coastal health authorities have developed clinical practice guidelines and patient flow strategies to further improve the efficient use of acute care beds in their regions.

While the ALC rates of Vancouver Island Health Authority increased in 2003/04, the authority has created an action plan for reducing ALC rates that includes decreasing the number of inappropriate admissions, increasing residential and community-based care options, and improving internal flow patterns for admitted patients.

Priority Strategy: 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.

In 2003/04, health authorities continued the extensive work previously begun in the home and community care sector.

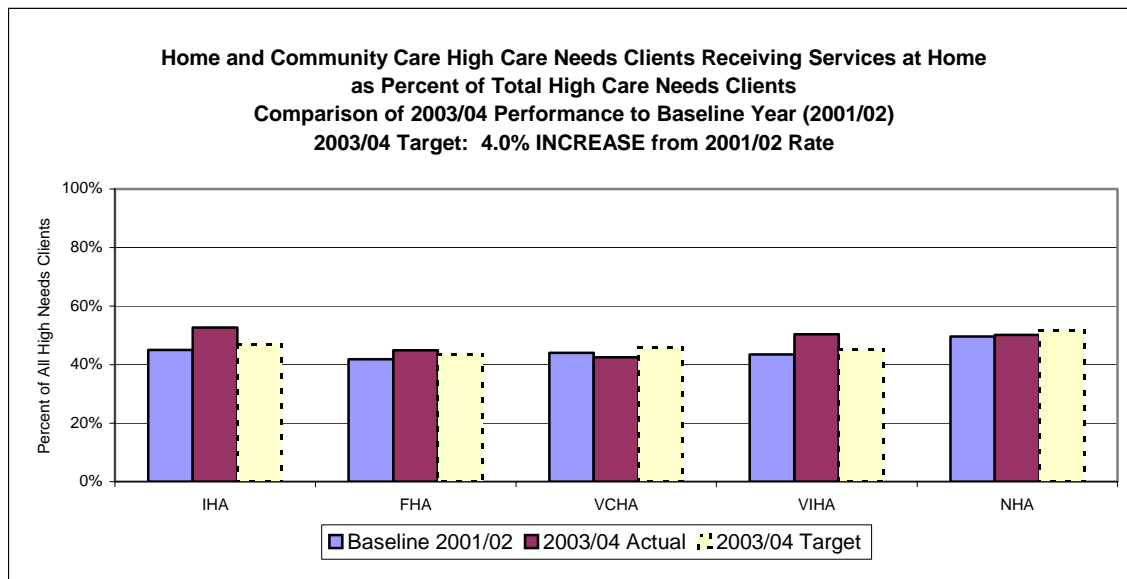
To ensure more efficient use of these residential beds, health authorities have established priority access systems that coordinate the use of beds throughout each region and allow faster transitions from hospitals to residential care settings. They have also been working to shift care for many clients from traditional residential care facilities to home and community options, such as assisted living.

Health authorities introduced innovative home support services, including cluster care — a more efficient, effective way of delivering support by assigning a home care aide to an apartment building to meet clients' needs throughout the day. They also expanded adult day care programs to monitor people at risk, keep them engaged in their community and allow them to remain in their homes for as long as possible. Networks of Excellence for Geriatric Services, including community outreach, were expanded. Specialized programs for Aboriginal clients and people with brain injuries were developed to allow clients to remain in the community. Finally, end-of-life care strategies were implemented, including appropriate supports to give people the choice to die in their homes, rather than an institution.

As health authorities create more opportunities for people to live independently with appropriate supports in place, the performance agreements should reflect an increase in both the number and percentage of high-needs clients receiving services in their own homes, rather than residential care facilities.

The 2003/04 performance agreements called for three health authorities in particular (Interior, Fraser and Vancouver Island) to increase the number of high-needs clients receiving services at home when compared to 2001/02 numbers. All three health authorities achieved their targets in this area.

Achieving an increase in the percentage of high-needs clients receiving services at home rather than in residential care facilities is dependent on a number of factors, including the availability of residential care alternatives. While not all health authorities achieved the percentage increase desired in 2003/04, all regions are undertaking activities to move toward this target.



Source: CCData Warehouse, November Refresh, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health Services

Priority Strategy: Protect public health by implementing core public health prevention and protection programs (e.g., falls prevention, immunization, and food and water safety programs).

Core Public Health Programs

The identification and implementation of the public health core functions is designed to ensure public health capacity within the health authorities remains focused on the most critical areas (i.e. those areas of public health with the greatest potential for positive impact).

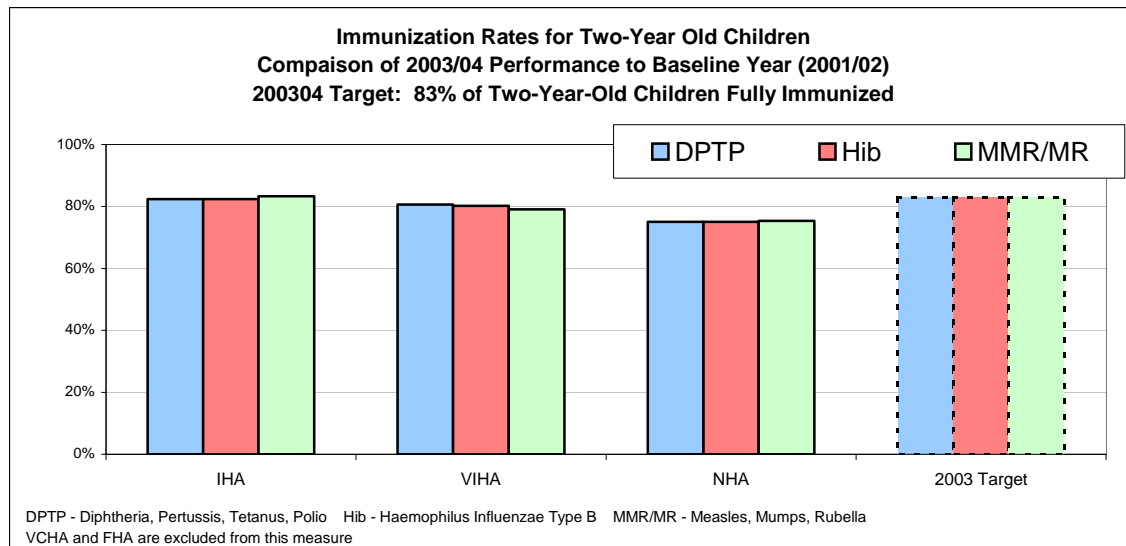
The development of core public health functions has afforded a number of opportunities for the ministry and health authorities to engage in the type of collaboration called for in the 2003/04 performance agreements.

This work has resulted in the finalization of a framework for core public health functions that includes core public health programs in four areas: health implementation; prevention of disease, disability and injury; environmental health; and health emergency management.

Immunizations for two-year-olds

Immunization programs for children are among the most cost-effective ways to improve population health, prevent illness and reduce health care costs.

The graph below reflects immunization rates in the Interior, Northern and Vancouver Island Health Authorities as captured by public health data. In general, immunization rates for two-year-old children in BC appear to be consistently below desired target rates, with the lowest rates in immunizations occurring in rural, isolated or remote areas.



Source: Data are submitted by health authorities and based on an audit of Child Health Record (may be electronic or paper). Compiled by the Population Health and Wellness Division, BC Ministry of Health Services.

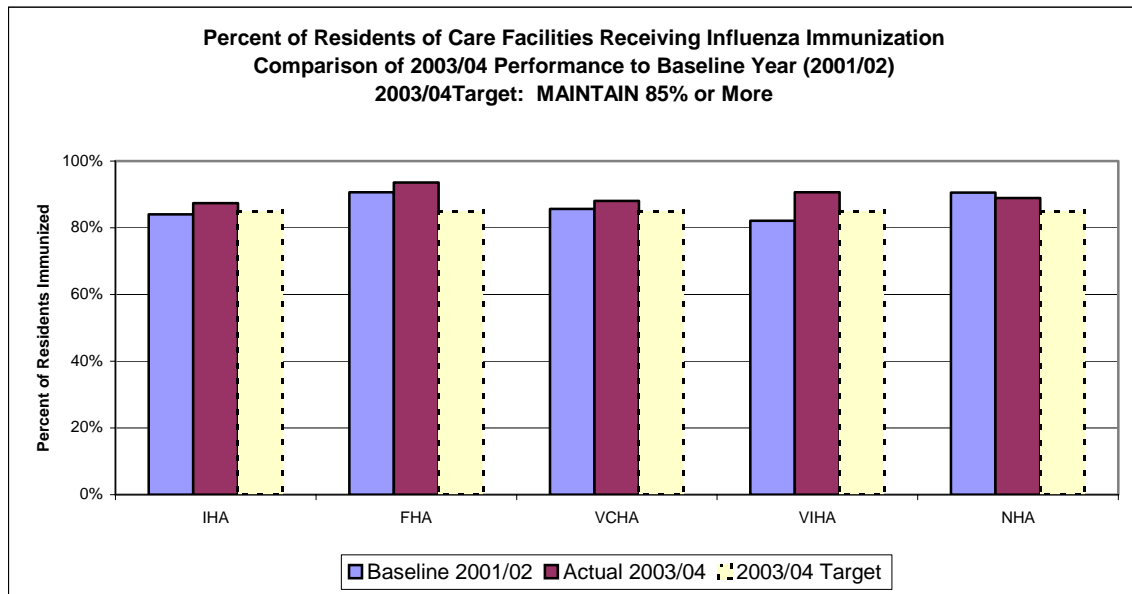
According to BC's Provincial Health Officer, concerns over data quality and variations in reporting practices make it difficult to assess the reasons for these lower than expected rates. The Ministry is currently collaborating with the BC Centre for Disease Control and health authorities to further analyze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

In the Vancouver Coastal and Fraser health authorities, the majority of immunizations are done in individual physician offices and not captured in the public health data. Those two health authorities have submitted plans to build capacity to monitor two-year-old cohort immunization coverage of the routine immunization schedule. In 2005 the Fraser Health Authority will report immunization rates of two-year-olds through the I-Public Health Information System. Vancouver Coastal Health Authority plans to report these rates also in 2005 via the British Columbia Centre for Disease Control's coverage survey. Additionally, in 2005/06 a strategic framework will be developed that will outline best practises and strategies to support immunization programs and increase the proportion of two-year-olds immunized.

Immunizations for Influenza of Residents of Care Facilities

In addition to protecting the overall health of the population within residential care facilities, increasing influenza immunization rates is designed to 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 data⁴, current immunization rates appear to be the highest in five years, with about 90% of residents being immunized annually, as shown in the graph below.



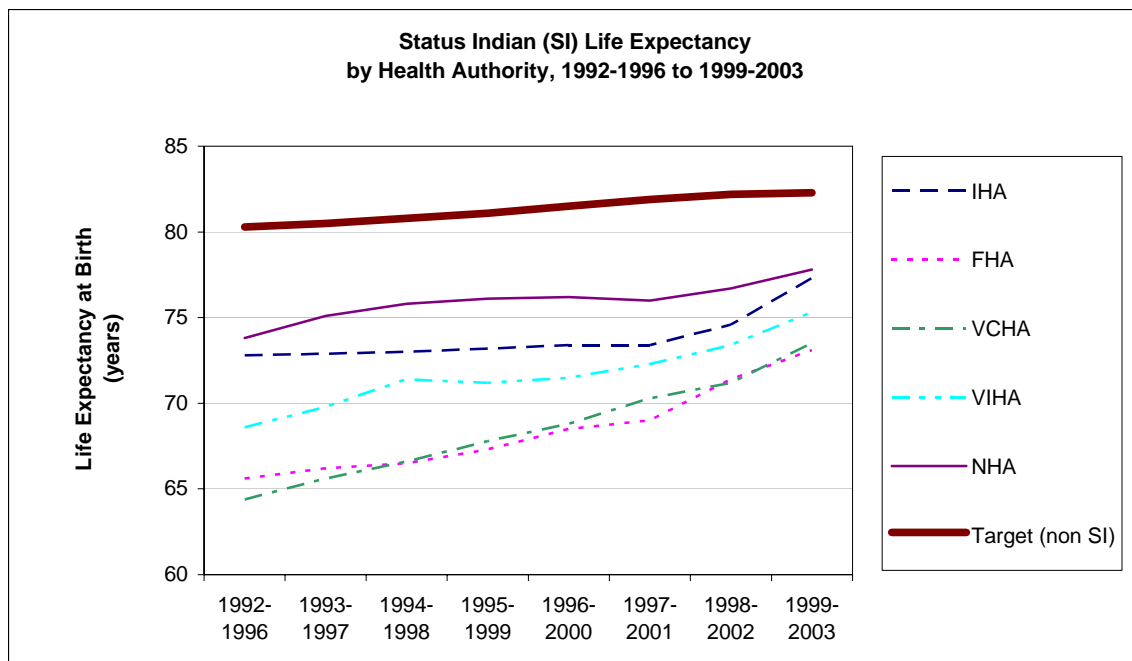
Source: Data are submitted by health authorities (Annual Influenza Immunization Program Survey). Compiled by Population Health and Wellness Division, BC Ministry of Health Services for 1999/2000 to 2002/2003. The BC Centre for Disease Control analysed data for 2003/2004.

⁴ As with immunization for children, BC's Centre for Disease Control has been given a mandate to analyze and improve collection of influenza vaccination data.

Priority Strategy: Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care.

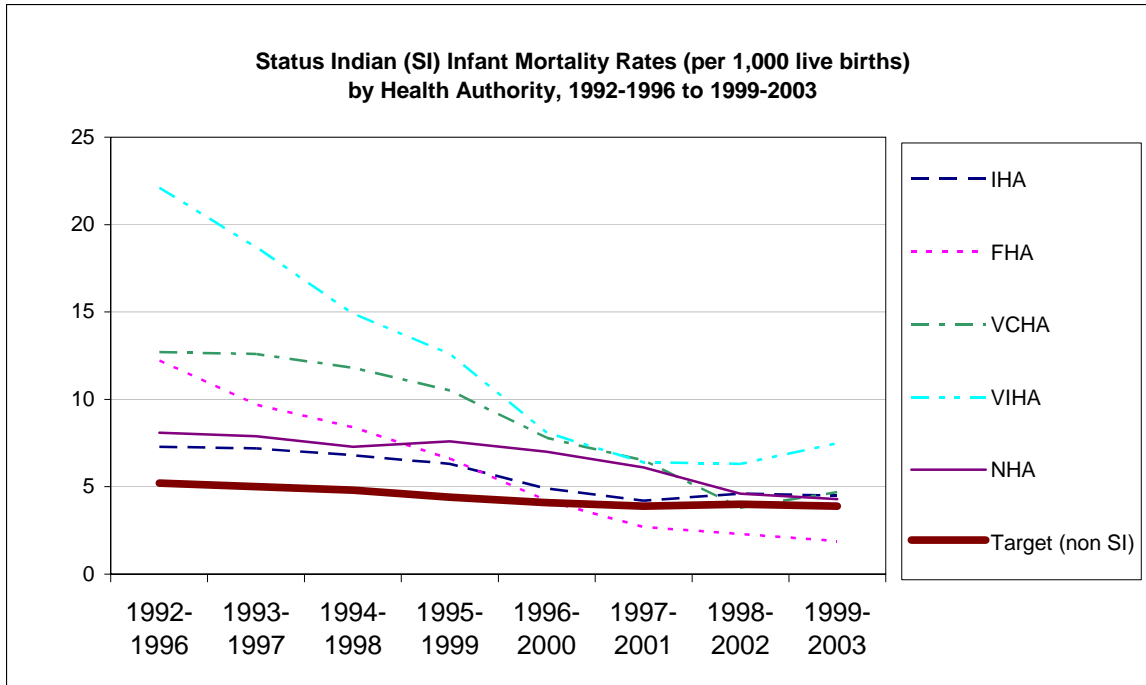
As a group, Aboriginal peoples have a level of health below that of the general population. In 2003/04, each health authority worked with Aboriginal communities and organizations to develop an Aboriginal health plan that will guide service delivery in their regions.

Aboriginal health improvement is measured in the performance agreements by reduced infant mortality and increased life expectancy of Status Indians. Rates are established using Vital Statistics data, and are reported as pooled rates for five calendar years.



Source: BC Vital Statistics Agency, November 24, 2004.

Adding the five-year period 1999-2003 clearly shows that the difference between the life expectancy of non-Status Indians and Status Indians has continued to narrow in every health authority. From the period 1998 – 2002 to the period 1999 – 2003 the life expectancy for non-Status Indians increased by just 0.1 years to 82.3 years, while for Status Indians life expectancy increased by over one year in every health authority.



Source: BC Vital Statistics Agency, November 24, 2004.

In all health authorities, with the exception of Vancouver Island Health Authority, there is no statistically significant difference between the infant mortality rates of Status Indians and non-Status Indians. The increase in the infant mortality rate for Vancouver Island and Vancouver Coastal health authorities was troubling, but is unlikely to represent a change in the downward trend in these health authorities as the increase was not statistically significant.

Priority Strategy: Build the Foundation for Integrated Care Networks:

- a) Connect physicians and other health care professionals to diagnostic services, hospitals, and each other.**
- b) Provide a continuum of services in each health authority for mental health patients that better integrates primary, secondary, community and tertiary mental health care and is integrated with the larger care networks.**

Mental Health Services

The intent of Integrated Care Networks is to improve the health outcomes and quality of life for people with mental illness or addiction issues by providing appropriate care in communities, minimizing their time spent in institutions and improving their access to health professionals.

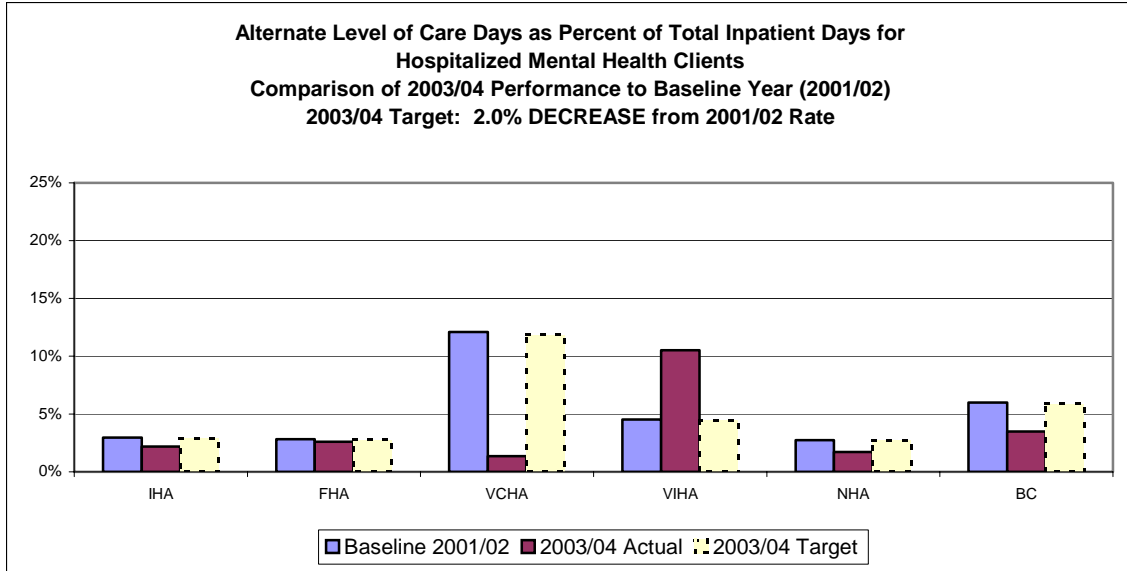
Each health authority is working to integrate care networks into the range of health services they offer, including creation of community-based facilities. Health authorities have been implementing strategies to improve discharge planning and utilization management, bolster community services and strengthen networks of care. These strategies should contribute to keeping the ALC rate low and help ensure mental health patients are treated in the most appropriate settings.

To assess overall progress in this area, the performance agreements look for decreases in hospital ALC days used by mental health or addiction clients, increases in community or physician follow up after discharge and increases in the proportion of services received in a client's own health authority.

While it is sometimes difficult to determine if mental health or addiction patients are receiving the care they need in the community (for example, some patients may decide not to follow-up with treatment or fail to show up for scheduled appointments), high rates of follow-up are indicative of well-coordinated hospital and community services and the availability and accessibility of community services.

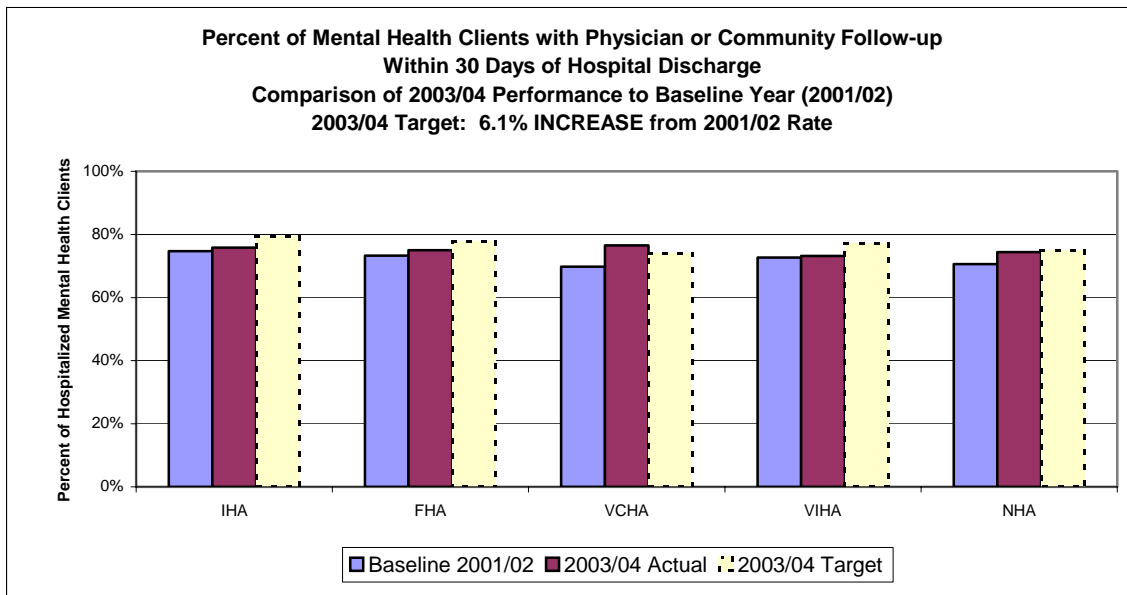
Conversely, a high proportion of hospital ALC days used by patients with mental illness or addictions disorders may suggest a lack of appropriate community-based alternatives, such as supportive housing, case management and residential services.

The graph below shows ALC as a percentage of total inpatient days for mental health clients. The reduction for Vancouver Coastal Health Authority is partly due to a change in reporting to exclude patients awaiting some hospital-to-hospital transfers. Vancouver Island is currently investigating the reason for its increase in this rate.



Source: Discharge Abstract Database (DAD), November 26, 2004, Information Resource Management, Knowledge Management & Technology Division, Ministry of Health Services

Unfortunately, historic under-reporting of data in some health authorities, combined with a revised data methodology, make it difficult to accurately assess 2003/04 health authority performance regarding community follow-up and compare it to previous years.



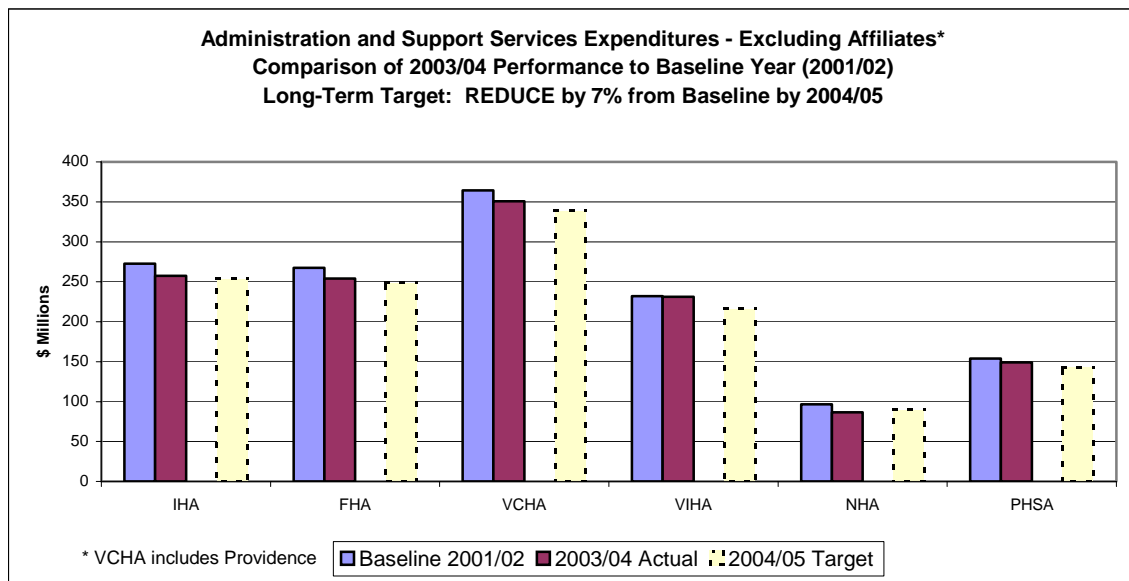
Source: Mental Health Research Database: November 2004 Refresh. Information Resource Management, Knowledge Management & Technology Division, Ministry of Health Services

Priority Strategy: Manage the delivery of services within budget.

As part of their fiscal management of health resources, health authorities are expected to achieve balanced budgets over the two-year period from 2002/03 through 2003/04. In addition, the performance agreements call for health authorities to achieve a 7% reduction in administration and support services compared to 2001/02 spending.

The savings realized from this reduction will assist health authorities in meeting their financial performance targets and will ensure the maximum investment of public funding on priority health care issues within each region.

Although inflationary pressures and operational demands continue to present significant challenges, all health authorities achieved their budget targets in 2003/04 and are on track to meet their 7% administrative and support services reduction targets by March 31, 2005.



Source: Health Authority Management Information System (HAMIS), 25 Aug 04, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services

6. Conclusion

Establishing, monitoring, evaluating and reporting on the 2002/03 and 2003/04 performance agreements has been a valuable learning experience for both the Ministry of Health Services and the province's health authorities.

While the performance agreements have been an important vehicle for increasing accountability regarding specific program outcomes, they have also provided an important opportunity to understand, analyse and address many of the interrelated issues that affect overall health system performance.

It has become increasingly clear, for example, that building capacity in the community will not only increase the ability to provide frail seniors or people with mental illness with services appropriate to their needs, but will help free up the specialized hospital resources needed to better meet acute emergency and surgical requirements.

It has also become clear that there is a strong need to better manage and capitalize on the extensive knowledge that exists throughout the system, both in terms of statistical data and human expertise.

And finally, it has strengthened the understanding that the specific improvements desired must be conducive to the overall goals set for BC's health care system – providing high quality patient-centred services, improving the health and wellness of the population and creating a health care system that is affordable and sustainable over the long term.

The BC Auditor General's report⁵ (based on the first performance agreements between the MOHS and the six health authorities) calls for greater clarity of purpose of the performance agreements and that included measures should be strictly linked to objectives and improvement priorities and confined to those critical for decision making. The 2004/05 performance agreements reflect these recommendations and the experience of the previous two years by more clearly describing the reciprocal responsibilities of the MOHS and the health authorities and by focusing on a limited number of priority projects designed to achieve significant system-wide improvement.

These are some of the ways that performance measuring, monitoring and evaluation processes continue to evolve, as the Ministry of Health Services and health authorities work to fulfill government's commitment of improved health care, and a more accountable health care system, for British Columbia.

⁵ A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities, May 2003.