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Aligning Health Authority Accountability

in Alberta's Health System

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Alberta

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1.0 Introduction

The purpose of this document is to describe the structure, processes and alignments supporting accountability between the Minister of Alberta Health and Wellness (AHW) and Alberta's health authorities. This publication outlines the responsibilities, broad roles and reporting relationships of health authorities and describes the overall process and key mechanisms supporting health system accountability.

The Government of Alberta's (GOA) vision for the future is "A vibrant and prosperous province where Albertans enjoy a superior quality of life and are confident about the future for themselves and their children." This vision foresees a province where all Albertans can realize their full potential and work together as stewards of Alberta's natural beauty and resources, and where sustained economic growth leads to continued prosperity and realized opportunity. The vision builds on the shared values that Albertans hold – values such as fiscal discipline, community spirit and self-reliance.

All individuals, communities, industry, non-profit organizations and businesses, in close collaboration with the Alberta government, play an important role in achieving this vision. Government leadership provides a framework of fiscal, economic, social and regulatory policies that position Alberta to respond to opportunities and address challenges.

The minister of Alberta Health and Wellness (AHW) represents the government in putting in place and maintaining a health system which, within available resources, meets the health needs of Albertans. The public wants to know what health services can be expected and what results have been achieved. Government and the public expect all participants in the health system to be accountable for their responsibilities, acts and decisions.

The AHW vision, "A high-performing, effective and accountable health system" is a broad, long-term vision that includes the importance of promoting and protecting good health for individuals and for Alberta as a whole, as well as ensuring access to and the delivery of quality of health services. The mission of the Ministry, "Lead and manage the health system in helping Albertans to be healthy and well" anticipates purposeful action to ensure attainment of responsible and accountable health system performance.

Accountability is defined as *the obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities*. Improvement in the quality of Alberta's health system requires a continued focus on accountability.

Alberta's accountability framework is structured on formal lines of authority – areas where responsibilities have been delegated and accepted, expectations are clear, reporting is required and performance is evaluated. Reports about performance are an important element in accountability and appropriately represent prior agreement on delegated responsibilities, performance expectations, including related measures used to monitor progress and report on activities and performance outcomes.

The accountability framework between the minister and the health authorities is an important tool for managing the health system and informing health system stakeholders, including the public, about how the system is managed. This framework continues to evolve as the health system changes in response to new challenges.

2.0 Health Authority Accountability Structure: Roles, Responsibilities and Reporting Relationships

The structure of accountability – roles, responsibilities and reporting relationships of Alberta's health authorities is based on legislation.

2.1 Minister of Health

The minister of Health and Wellness is responsible to the Legislative Assembly for reporting on the health of Albertans.

Within this context, the minister sets overall direction, including priorities, requirements and expectations for the provincial health system. The minister develops the legislative, planning, and policy framework within which health authorities plan and deliver services. Therefore, the minister seeks assurance that regional and provincial health authorities' work is co-ordinated with government. This co-ordination is necessary to achieve the best health outcomes for Albertans, to avoid duplication of effort and expense and to promote commitment to the five principles of the *Canada Health Act*.

Resources are made available to health authorities and health service providers to enable them to perform their responsibilities. The accountability framework and supporting processes ensure overall health system performance and account for results.

The minister monitors the overall health of Albertans and factors affecting health status, assesses the quality of service delivery and evaluates the overall performance of the health system. The minister assesses whether or not the health system is making satisfactory progress and is effective in promoting government priorities.

2.2 Provincial Health Boards

There are three provincial health boards in Alberta's health system: the Alberta Cancer Board, the Alberta Mental Health Board and the Health Quality Council of Alberta.
Below are brief descriptions of these provincial health authorities.

Alberta Cancer Board
The Alberta Cancer Board (ACB) is the provincial health authority responsible for coordinating all cancer research, prevention and treatment programs in Alberta.

Section 4 of the *Cancer Programs Act* identifies the objects of the board as:

(a) to establish and operate provincial cancer hospitals, outpatient clinics and programs for:
  (i) the prevention, detection and diagnosis of cancer;
  (ii) the treatment and care of cancer patients, and
  (iii) cancer research.

(b) to co-ordinate, in co-operation with others, the planning, development and delivery of services for cancer patients;

(c) to educate persons about cancer.

Alberta Mental Health Board
The Alberta Mental Health Board (AMHB) is a provincial health authority that oversees and advances Alberta's mental health system, serves in an advisory capacity to government and works with health regions and public and private organizations to address system-wide mental health

priority issues that span national, provincial regional and organizational boundaries.

Section 3*, Alberta Mental Health Board Regulation* identifies the following purposes of the board on a provincewide basis:

- (a) to promote, preserve and restore the mental health of Albertans and work towards the prevention of mental disorders;
- (b) to assess the mental health of Albertans on an ongoing basis;
- (c) to deliver or co-ordinate delivery of mental health services in Alberta;
- (d) to promote and act as an advocate for the provision of mental health services in a manner that is responsive to the needs of individuals and communities, and supports the integration of services and facilities;
- (d.1) to develop and monitor standards for, and monitor performance in, the delivery of mental health services;
- (e) to determine priorities in the provision of mental health services in Alberta and allocate resources accordingly;
- (f) to ensure reasonable access to quality mental health services;
- (g) to engage in and promote research in matters related to mental health.

In April 2004, the government approved a provincial mental health plan for Alberta, Advancing the Mental Health Agenda, in which the roles and responsibilities for mental health services was further clarified. The key areas identified for the Alberta Mental Health Board include: the provincial policy framework, strategic data assessment, measuring progress, consumer advocacy, and the support and coordination and facilitation of provincial mental health initiatives and functions.

Health Quality Council of Alberta

The Health Quality Council of Alberta (HQCA) is a provincial health authority engaged in gathering knowledge and translating it into practical actions that can improve the quality, safety and performance of Alberta's health system. Through partnerships and collaboration, HQCA is committed to achieving excellence in all dimensions of quality and safety across Alberta's health system.

Section 7 of the *Health Quality Council of Alberta Regulation* sets out the objects of the council, which are to promote and improve patient safety and health service quality on a provincewide basis are to undertake the following activities in cooperation with health authorities and in accordance with an approved health plan,

- (a) measure, monitor and assess patient safety and health service quality;
- (b) identify effective practices and make recommendations for the improvement of patient safety and health service quality;
- (c) assist in the implementation and evaluation of strategies designed to improve patient safety and health service quality;
- (d) survey Albertans on their experience and satisfaction with patient safety and health service quality.

2.3 Regional Health Authorities (RHAs)

A regional health authority (RHA) is a corporation consisting of members and is responsible for the administration of its designated health region.

RHAs have responsibilities conferred on them by the Legislative Assembly, primarily through the *Regional Health Authorities Act*. Section 5 of the *Regional Health Authorities Act* defines the following key responsibilities of RHAs:

- i) promoting and protecting the health of the population in the region and working toward the prevention of disease and injury;

ii) assessing the health needs of people living in the region;
iii) determining priorities for the provision of health services in the region and allocating resources accordingly;
iv) ensuring reasonable access to quality health services is provided in and through the region, and
v) promoting the provision of health services in a manner that focuses on the needs of individuals and communities and supports integration of services and facilities in the region.

RHAs also have responsibilities under other legislation, including:

- the *Hospitals Act* respecting the operation of hospital programs;
- the *Nursing Homes Act* respecting the operation of nursing home programs;
- the *Mental Health Act* respecting the admission, detention, administration and treatment and control of mental health patients;
- the *Public Health Act* respecting home care and the prevention of communicable diseases and health hazards, and
- the *Government Accountability Act* respecting the preparation of business plans and annual reports.

RHA boards are responsible for governing: providing vision, direction and leadership and establishing policies and bylaws for the organization to ensure its mandate is achieved. It is the responsibility of management and staff to implement the policies and bylaws developed by the board.

RHAs are expected to work collaboratively with other health authorities to improve Alberta's health system. RHAs are expected to proactively engage other organizations and stakeholders to address emerging issues concern the health of its residents. The health status of Albertans is a shared responsibility. It starts with individuals and extends to include community services, health providers and government.

Functional RHAs Responsibilities

Conduct Needs Assessments
RHAs are responsible for planning and delivering services in ways that respond to the unique needs of those who live in each region. To do this, regional health authorities must assess the health needs of communities and residents within their health region.

Emphasize Wellness
RHAs are responsible for developing policies and programs which promote good health and emphasize wellness. This includes working with the ministry of Alberta Health and Wellness and following the policy direction outlined in a *Framework for a Healthy Alberta* (this report sets objectives and targets to guide the Government of Alberta's action in promoting health and preventing disease and injury). It also includes working with organizations outside the health system to improve health and providing Albertans with information and skills to take greater responsibility for their own health.

Provide Information
RHAs are responsible for providing information to Albertans that allows them to make informed decisions about their health and health services. This includes making information available about the cost and effectiveness of health services as well as about health choices and treatment options.

Solicit Community Input and Dialogue
RHAs are responsible for soliciting community input on service expectations, the responsiveness and effectiveness of health services, and the regional delivery system overall. Each region is responsible

for establishing at least one community health council to provide a mechanism for public participation in the health system.

Plan and Deliver Services
RHAs are responsible for planning and delivering services as specified by legislation and the minister of Health and Wellness. They must also submit a health plan to the Minister for approval, and an annual business plan for information. RHAs are also responsible for developing a health workforce plan that forecasts future health workforce needs and strategies to meet these challenges.

RHAs are responsible for organizing and delivering services in ways that reflect their regions' unique characteristics, responding to individual and community needs, and supporting the integration of services and facilities in the health region. RHAs are responsible for providing off-reserve health services to members of First Nations. Health services on-reserve may be subject to negotiated agreements with First Nations.

While most health services can be provided regionally, some services are specialized, and more centrally delivered. These province-wide services include, among others: organ and bone marrow transplants, heart surgery and angioplasty, special drug programs, renal dialysis, neurosurgery and intensive care for severely ill infants and patients with severe trauma or burns. Funding and delivery of these services is a collaborative effort between the ministry of Health and Wellness, RHAs and other health authorities to ensure they are planned and delivered in the interests of the province as a whole.

Ensure Reasonable Access to Services
RHAs are responsible for providing or facilitating reasonable access to health services. The service delivery system should ensure Albertans have access to quality health services, based on need; it should also strive for ease of access to services from the client's perspective. This includes developing client-centred approaches, planning for referrals to and from services in other regions, communicating with residents about how to access health services and about service eligibility criteria, and monitoring and reporting wait times through the Alberta Waitlist Registry. Expectations about reasonable access are being developed over time through discussions among Alberta Health and Wellness, RHAs, physicians and other stakeholders.

Allocate and Manage Resources
RHAs are responsible for determining service priorities and for allocating and managing human, capital and financial resources based on regional needs assessments and a provincial framework of legislation and policies. RHAs, like other health system stakeholders, are stewards of public funds and must prudently manage their resources.

Monitor, Report on, and Evaluate Services and Regional System Performance
RHAs monitor and evaluate health services in their region, including the performance of contracted organizations and contracted health professionals. Performance during the year is monitored through ongoing and ad hoc reporting processes. On a quarterly basis, the minister requires financial reports and service performance reports for key programs from all health authorities.

RHAs submit information about wait lists for surgical services and MRI/CT scans on a monthly basis, which is published in the web-based Alberta Waitlist Registry.

RHAs submit annual reports to the minister of Health and Wellness. These are tabled in the Legislation Assembly of Alberta. Information from annual reports and many other sources helps RHAs make decisions about future directions and plans. RHAs are also responsible for communicating with their residents on results achieved relative to plans.

Delegating Responsibility
To carry out their activities, RHAs must provide direction to and work with service providers and health professionals who are directly employed, contracted or privileged (i.e., have been granted hospital privileges) by the RHA.

Consult with Other Sectors
In order to improve the health of residents, RHAs are responsible for consulting and working closely with other organizations and individuals in the health region including:

- Alberta Alcohol and Drug Abuse Commission
- Alberta Cancer Board
- Alberta Mental Health Board
- ambulance services
- Child and Family Service Authorities
- community pharmacies
- community physicians
- lodges
- municipal governments
- Persons with Developmental Disabilities Boards
- provincial ministries
- schools, and
- social service agencies.

Since RHAs refer patients to, and receive patients from, other local, regional and provincial agencies that provide complementary services, they need to consult and work with these agencies to address common concerns.

RHAs must also work with groups such as regulatory bodies and academic health centres to ensure the authorities' services are of high quality.

RHAs are responsible for providing health services and planning for the full continuum of health services in conjunction with other health authorities, service providers, other provincial ministries, and local agencies. RHAs are responsible for finding the right mix of physician and non-physician professionals to meet the health needs of their regions, taking into account the knowledge, skills and costs of different professionals.

Maintain a Concerns Resolution Process
RHAs are responsible for establishing a well-publicized process to receive complaints, concerns and questions from the public. This process ensures people with concerns about specific treatment problems or general health issues will have a simple and effective appeal route in place.

3.0 Mechanisms Supporting Accountability

The primary mechanisms supporting accountability between the minister and health authorities include board and committee appointment processes, the ministry business plan, and key accountability documents, including health plans, business plans and annual reports, performance agreements, and performance reports.

3.1 Board Member Appointments

The Minister formally appoints qualified individuals to the governing bodies of regional health authorities. Board governance effectiveness depends on members collectively having skills and

experience in relevant areas, including: financial, organizational, human resource, communication, information management, legal, audit, quality/safety/risk management and business.

Members of health authorities may be appointed, without salary, for a three-year term. Honoraria and travel expenses are paid. Commitment to improving the health system involves working collaboratively to address health system challenges, including service delivery quality, recruitment and sustainability. Performance as a member is regularly assessed.

3.2 Health and Wellness Ministry Business Plan/Policy Direction

The AHW business plan provides vision and direction for Alberta's health system. This plan identifies the ministry's core businesses, business goals, key performance measures and targets, and outlines strategies AHW will implement to achieve its goals.

The minister of Health and Wellness requires health authority health plans to align with the Ministry's goals as set out in the ministry business plan. The minister provides overall direction to the health authorities on essential requirements for the preparation of their health plans or performance agreement, and business plan.

Health system objectives can be communicated through ministry and government policy direction and, as appropriate, health authorities should demonstrate in key accountability documents or other specified reports how alignment with policy direction is attained.

3.3 Key Accountability Documents

Health plans, business plans and performance agreements are the primary means used by the Ministry to hold health authorities accountable for legislated responsibilities and government direction. These plans outline an organization's vision, goals and strategies, as well as its corresponding performance targets. Annual reports complete the accountability loop by providing information about actual achievements and performance relative to the goals and targets set out in the plans. Annual reports are submitted yearly and are audited by the Office of the Auditor General.

RHAs and provincial health boards are responsible for carrying out their plans, reporting on their performance, and explaining any variation between planned and actual performance.

3.3.1 Health Plans

Section 9 of the *Regional Health Authorities Act* requires an RHA to submit for approval a proposed health plan to the minister, and to submit annually to the minister a proposal to amend an approved health plan.

The health plan is a three-year strategic document that communicates how a health authority intends to carry out its obligations under Section 5 of the *Regional Health Authorities Act.* The health plan indicates how the health authority has aligned its strategic direction with the ministry's business plan and what steps the health authority has planned to meet government expectations.

Health authorities must ensure their health plans address the health needs of people in their area of jurisdiction and meet the key expectations of the minister. The health plan must contain statements addressing how the health authority proposes to carry out its responsibilities, information on the key strategies to be implemented and the measures and targets to be used to assess and monitor performance.

Draft health plans covering the three-year period, beginning with the next fiscal year are submitted to the ministry for review by November 30 of each year. Following review, final submissions are board approved and submitted to the minister in time for approval prior to the commencement of that next fiscal year.

Once approved by the minister, the health plans represent an agreement between the minister of Health and Wellness and a health authority on what is to be accomplished and how it will be monitored and measured.

3.3.2 Performance Agreements

Performance agreements are a key accountability mechanism with two provincial boards, the Alberta Cancer Board and the Alberta Mental Health Board. These performance agreements indicate the minister's expectations in relevant performance areas and include performance measure and expected results information for each fiscal year covered by the performance agreement.

Once approved, performance agreements represent the agreement between the minister of Health and Wellness and a provincial health board on what is to be accomplished and how it will be monitored and measured.

3.3.3 Business Plans

Health authority business plans are public documents and are submitted to the minister of Health and Wellness in compliance with legislation as follows:

- Regional health authorities: *Government Accountability Act*
- Alberta Mental Health Board: P*rovincial Mental Health Board Regulation* authorized by the *Regional Health Authorities Act*
- Alberta Cancer Board: *Government Accountability Act.*

The business plan is provided to the minister in the form and manner prescribed by the minister. Business plans include a financial plan and describes key tactical actions the health authority will take in deploying its available resources to achieve expected results in the next fiscal year. Business plans must include performance measures and targets against which actual results can be compared.

Detailed program and service plans, implementation plans and work plans are not required to be submitted, although the business plan may make reference to significant aspects of those plans. Health authorities may choose to release other documents that complement the business plan for a variety of audiences.

3.3.4 Annual Reports

A health authority is required to prepare and submit to the minister of Health and Wellness an annual report in compliance with legislation as follows:

- Regional health authorities: *Government Accountability Act* and the *Regional Health Authorities Act* and *Regional Health Authorities Regulation 17/95*
- Alberta Mental Health Board: P*rovincial Mental Health Board Regulation* authorized by the *Regional Health Authorities Act*
- Alberta Cancer Board: annual report submitted in accordance with the *Alberta Cancer Programs Act.*

Annual reports are provided to the minister in the form and manner prescribed and are key public accountability documents for reporting how a health authority has discharged its legislated responsibilities and any other responsibilities delegated by the Minister.

Annual reports are approved by the board before submission and provide information on key areas fundamental to good accountability including legislated requirements, governance, organizational effectiveness and financial results. It includes information on achievements relative to government expectations, including an explanation for any significant variation between actual and planned results, and financial results.

As a matter of good business practice, health authorities may require business plans and annual reports from the organizations with which they contract for service delivery.

3.3.5 Performance Reports

Reporting and monitoring mechanisms provide assurance that reasonable levels of performance are achieved relative to expectations and resources used. Performance reports are approved by the Board before submission and include a statement indicating the health authority's overall assessment and satisfaction with its performance progress.

There are two forms of quarterly reporting. Quarterly performance reports provide narrative updates on actions a health authority has started, continued, or completed relative to the strategies presented in its three-year health plan and the tactical initiatives identified in the annual business plan. Quarterly financial reports are prepared and submitted in accordance with the requirements set out in financial directives.

Health authorities are responsible for carrying out their plans, reporting on their performance, and explaining any variation between planned and actual performance. Except where specifically indicated, performance measures are reported annually and progress on identified performance strategies is reported quarterly.

4.0 Appendices

Two appendices are attached as further reference.

- *Appendix A: Specific 2008-2011 Health Plan Government Expectations* provides information on the specific factors and measures regional health authorities are to address in the 2008-2011 health plan submissions.

- *Appendix B: Planners' Guide to Accountability Documents* expands on key principles and processes for health authority planners engaged in the preparation and submission of accountability documents. Included is the *Health Plan Reference,* a quick reference to health plan purposes, processes and expectations.

Appendix A

Specific Expectations

2008-2011 Health Plans

(Aligned with core businesses identified in the Alberta Health and Wellness 2008-11 Business Plan)

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1.0 Core Business One: Lead and direct the health system

Improved performance in the health system depends on sound governance, management and effective mechanisms for ensuring accountability and stewardship. The ministry sets policy, provides direction to health authorities and holds them accountable. The ministry continues to contribute to long-term sustainability of the health system by improving the efficiency of health services and operations.

1.1 Workforce

Rationale:
The government requires the health authorities to plan for, employ and appropriately and effectively utilize the optimal number of health service personnel within healthy workplace environments to support the provision of population-based needs within the health authority.

Goal:
Health authorities will report on performance metrics established in collaboration between Alberta Health and Wellness and health authorities that will support the ability of the ministry to identify and develop strategies related to provincial health workforce trends and issues.

Documents and references :
- Section 5 (a) (v) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- Direction as contained in government business plans and strategic plans

Factors	Measures
Building Planning Capacity Report on collaborative health workforce planning capacity strategies.	Participation of human resource, clinical and financial leaders in: ▪ The development of health authority workforce plans. ▪ The completion of the annual Collaborative Health Workforce Template.
Adequate Supply Report on supply and demand gaps, recruitment and retention strategies and performance metrics (established collaboratively with health authorities) that indicate effectiveness of health authority recruitment and retention efforts.	▪ Health Workforce plan, as outlined in the health authority's health plan, identifies three year workforce requirements as well as recruitment and retention strategies to address any current and projected gaps between supply and demand. ▪ Overall workforce metrics for the fiscal year: o Separation rates; o External hire rates; o Internal transfer rates; o Vacancy percentage; o Average length of time to fill a vacancy – difficult to recruit positions by classification.
Healthy Workplaces Report on workplace environment metrics (established collaboratively with health authorities) that have an affect on the employer's ability to recruit and retain health service personnel.	Overall workforce metrics for the fiscal year: ▪ Comparison of health authority WCB premium rate to WCB industry rate for hospitals, acute care centres, health units an LTC centres, ▪ Hours of sick leave usage as a percentage of total earned hours, ▪ LTD incidents per 1000 insured persons.

1.2 Information Technology

Rationale:
A provincial information management/information technology (IM/IT) strategic plan includes the provincially interoperable electronic health record (EHR). This will provide a secure and confidential lifetime record of an individual's key health information critical for future health service delivery and to enhance patient safety, increase the efficiency of the health system, facilitate team-based care and improve patient health outcomes.

Goal:
Privacy and security measures and technology and data/message standards will enable sharing of information through a provincewide interoperable EHR. As the EHR is not a single system, there are interdependencies to be managed, through a common understanding of the disparate systems that comprise the whole EHR.

Documents and references:
- Alberta Health and Wellness Three Year Business Plan
- Provincial IM/IT Strategic Plan
- Government Expectations

Factors	Measures
Security Standards Adopt the ISO 17799 controls regarding health system security.	▪ Number of ISO 17799 controls implemented.
Privacy Alberta's privacy legislation, the *Health Information Act* (*HIA*) defines the rules of access to and disclosure of information to promote a secure and confidential electronic health record.	▪ Number of staff who have received *HIA* training in the region.
Service Management Standards For Information Technology (IT) to function effectively, numerous linked processes have to be identified and managed. The Information Technology Infrastructure Library (ITIL/ISO 20000) defines operational processes that, once implemented, will provide ongoing control, greater efficiency and operational consistency; ISO 20000 is emerging as an EHR operational standard.	▪ Number of ISO 20000 controls implemented.
Data Quality As information is increasingly shared across regions and provincially, data integrity becomes an issue. ▪ Develop regional data quality plans that include: o Accountability for the plan/data; o Complete data asset inventory; o Documented audit plan/schedule; o Documented remediation strategy; o Data quality targets, audit/remediation schedule and protocols.	▪ Regional data quality plan completed. ▪ Data quality targets (inpatient and ambulatory care data) for 2008/2009. ▪ Number of audits/remediation reviews completed.
Health Information Standards Health Information and technology standardization are required in the interest of international (market) collaboration, provincial interoperability and cross-regional comparability and consistency. ▪ The Health Information Standards Committee for Alberta (HISCA) defines and maintains the provincial standards.	▪ Number (and names) of the HISCA standards (data set level) approved and/or being ready for use or already adopted.

▪ New and evolving standards under review for the Alberta health system include: o ISO 11179 (metadata); o Vendor Conformance and Usability Requirements 2006-2008; o Integrating the Healthcare Enterprise (IHE); o Clinical vocabularies such as SNOMED CT and LOINC.	
Technology Renewal There needs to be renewal of existing technology as well as investment in new development to ensure continued interoperability and information sharing capability.	▪ Current documented regional technology renewal plan in place. ▪ Evidence of funding allocated for technology renewal. ▪ Percent of overall IT budget for capital (development) expenditure. ▪ Percent of overall IT budget expended for operations.

1.3 Cost of Services

Rationale:
Government requires reliable, appropriate and relevant cost and activity information from health authorities in order to facilitate analysis of the use of health dollars.

Goal:
Reliable, appropriate and relevant cost of service information is available to advance efficient and cost-effective delivery of health care services.

Documents and references:
- Section 9 (4) (d) *Regional Health Authorities Act*
- Health Authority Schedule of Health Services Guideline for Reporting (October 2006)

Factors	Measures
▪ A Schedule of Health Services, per Guideline and templates developed through cooperation with AHW initiatives to capture and report expenditures along all health care continuums (including mental health). ▪ A review of the *Health Authority Schedule of Health Services Guideline for Reporting*, due December 31, 2007, will determine the required steps to improve consistency in cost and activity measurement and will identify measures of efficiency at an operational unit level. ▪ Take specific steps to develop/maintain costing capabilities including patient specific costing, or other appropriate costing that can be incorporated into ongoing decision making.	▪ First year of pilot project is completed. Next schedule of health services due to AHW in December 2007. ▪ Definitive measures will be developed following a thorough review and analysis of the initial submissions. ▪ Planning document and action steps that set out time frame for expanded capability due by March 31, 2008.

2.0 Core Business Two: Mobilize people and partners to improve wellness

The health of Albertans is affected by lifestyle behaviours, employment status, education, environment, early childhood development and genetic factors. The actions and choices that people make in their daily lives and the decisions made by business leaders, industries and communities play a large role in creating a healthy society.

2.1 Health Needs Assessment

Rationale:
Regional health authorities' planning decisions must address their populations' needs.

Goal:
Current and relevant health needs information is used in development of the region's three-year health plan.

Documents and references:
- Section 5 (a) (ii) *Regional Health Authorities Act.*

Factors	Measures
▪ Demonstrate health assessment is an ongoing, developmental process linked to the regional business planning cycle, rather than a one time event. ▪ Communicate the extent and level of consultations to assess the needs of the population and include input from Community Health Council(s) in plan development. ▪ Factor in relevant information to provide context about the region's needs. ▪ Discuss extent of collaboration with AMHB, partners and other stakeholders to assess mental health needs in the region.	▪ The health plan has factored in current health needs assessment information relevant to the region's communities and key stakeholders. ▪ Refer to Health Needs Assessment Manual as a guide at http://www.health.gov.ab.ca/

2.2 Community Health Councils (CHCs)

Rationale:
In order to foster the role of the community in planning for health needs, CHCs should be used as a source of program planning and service delivery information for regional health authorities (RHAs) on geographic, population and issue based areas.

Goal:
RHAs are required by legislation to establish one or more CHC's to solicit input and dialogue with resident population.

Documents and references:
- Section 9 (4) *Regional Health Authorities Act*
- Section 10 *Regional Health Authorities Act*

Factors
▪ Describe the number and role of CHCs in the RHA. ▪ Report how the RHA intends to continuously improve the role and relationship with CHCs in providing effective input. ▪ Share issues addressed by CHCs and actions taken.

2.3 Wellness and Healthy Living

Rationale:
Chronic diseases, such as heart disease, diabetes, cancer and chronic obstructive lung disease, are the leading causes of death in Alberta. The most common chronic diseases are linked by a few risk factors – unhealthy diets, lack of exercise, tobacco use, substance abuse and other risk-taking behaviours. These risk factors reflect choices we make in our daily lives. The *Framework for a Healthy Alberta* sets objectives and target to guide regional health authorities in policies, programs and services at the following webside address http://www.health.gov.ab.ca/key/reform_framework.html..

Goal:
Regions will set targets and implement strategies to achieve the objectives and targets set out in the *Framework for a Healthy Alberta.*

Documents and references:
- Section 5 (a) (i) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- *Framework for a Healthy Alberta*
- *Health Policy Framework 2006*
- Direction as contained in government annual business plans and strategic plans

Factors c	Reporting
▪ The health plan should report strategies to promote the *Framework for a Healthy Alberta.*	▪ The RHA should report annually on its efforts to promote the *Framework for a Healthy Alberta* consistent with the measures therein. http://www.health.gov.ab.ca/key/reform_framework.html.

2.4 Mental Health

Rationale:
Over 20 per cent of Albertans are estimated to experience mental illness in their lifetime yet many will not seek help due to a variety of factors.

Targeting specific situations and communities, RHAs should advance mental health awareness and public education services within their regions and provide clinical and evidence-based service delivery that improves mental health programming and outcomes for residents.

Goal:
Mental health services are integrated with RHA operations to improve access to meet demand for mental health services in accordance with the Provincial Mental Health Plan (PMHP).

Documents and references:
- Section 9 (4) (d) *Regional Health Authorities Act*
- Provincial Mental Health Plan (PMHP)
- Alberta Health and Wellness Ministry Business Plan
- Direction as contained in government business plans and strategic plans
- Regional mental health plans

Factors	Reporting
▪ RHAs collaborate with key stakeholders to advance mental health priorities as identified in the PMHP. ▪ Regional research and evaluation plans align with the provincial research plan. ▪ RHAs have processes in place to support and implement best/leading practices. ▪ Mental health programs have ongoing evaluations. ▪ Implement strategies to collaborate with forensic services provided through the Provincial Forensic Psychiatry Program (e.g. Community Geographic Team and Community Justice). ▪ Implement strategies to collaborate to advance the priorities of the PMHP.	▪ The RHA reports annually on at least its top three priorities to improve mental health services with specific reference to its provincial mental health plan as well as results of participation in provincial promotion and awareness strategies.

2.5 Aboriginal Health

Rationale:
Aboriginal Peoples within Alberta continue to have poorer health status than other Albertans. Many long-standing and complex factors contribute to this disparity including:

- multi-faceted health issues such as high injury and suicide rates;
- alcoholism and diabetes;
- social and economic factors such as inadequate and overcrowded housing;
- lower rates of educational attainment and labour participation;
- over utilization of acute and chronic care services;
- lower participation rates for preventative and screening programs.

AHW promotes initiatives to address aboriginal health in key areas and several cross ministry initiatives focus on aboriginal health needs. Information provided from RHA business plans contribute to AHW being able to support the cross ministry initiatives with qualitative and quantitative information.

Goal:
RHAs partner with First Nations, Métis and Inuit stakeholders and communities to reduce the disparity in Aboriginal Albertans' health outcomes.

Documents and references:

- Section 5 (a) (i) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- Direction as contained in government annual business plans and strategic plans
- The First Nations in Alberta – A Focus on Health Service Use (2004) Report (from Surveillance Branch, AHW) validates the disparities in health outcomes for Aboriginal Peoples.
- Data on Aboriginals is often difficult to collect accurately or is not available since only First Nations peoples can be identified from administrative databases. Nevertheless, programs and initiatives must be implemented to start addressing these health issues while data sources are under development. For the most part, activity-based output data provided by each health region can act as a starting point while health regions work with the Health Surveillance Branch of AHW to develop more accurate quantitative performance measures over time. Examples of such activity-based data are provided in the measures section of the attached table.

Factors	Measures
Diabetes prevention Identify key strategies to provide diabetes programs and report progress. **Suicide prevention**: Identify strategies to prevent suicide, e.g. youth resiliency program. **Infant mortality**: identify strategies to reduce infant mortality. **Fetal Alcohol Spectrum Disorder (FASD)**: identify initiatives planned/in place to prevent FASD.	Examples: ▪ Incidence of diabetes in First Nations population. ▪ Incidence of First Nations suicide attempts; and increase in the use of clinical telehealth applications with First Nations patients in the areas of psychiatry and mental health. ▪ Percentage of First Nations children born with a healthy birth weight (> 2500 grams and < 4000 grams). ▪ Number of First Nations women who report consumption of alcohol during pregnancy and percentage of First Nations women receiving formal pre and post-natal care.

3.0 Core Business Three: Monitor and manage health system performance and risks

The ministry continuously monitors compliance with accepted standards and performance targets. The ministry also promotes the adoption of improved practice norms, technological and scientific advances. Progress in achieving system-wide improvement requires clear goals and the active engagement of health system leaders and stakeholders.

3.1 Quality of Service

Rationale:
Albertans need to be confident in the quality of the health services provided to them. Quality means that services are people-centered and meet accepted standards of acceptability, accessibility, appropriateness, effectiveness, efficiency and safety. Albertans expect to see effective processes for continuous quality improvement and the avoidance of error or harm.

Accreditation is a mechanism to demonstrate that quality improvement is pursued.

Goal:
Health authorities deliver people-centered, quality health services through accreditation.

Documents and references:

- Section 5 (a) (iv) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- *Alberta Cancer Programs Act*
- Health Policy Framework 2006
- Health Quality Council of Alberta (HQCA) Quality Matrix
- Governance Expectations of Alberta's Health Authority Boards, 2001
- Alberta Health and Wellness, *Provincial Review of Infection Prevention and Control*, August 2007
- Alberta Health and Wellness, *Provincial Methicillin Resistant Staphylococcus Aureus Infection Prevention and Control Guidelines*, August 2007

Factors	Measures
Accreditation ▪ Accreditation provides independent assurance to the board, the minister and the public that a care- provider site or program is able to provide appropriate quality services to protect the public and to demonstrate that quality improvement is pursued.	▪ Report on the current accreditation status of the health authority and contracted facilities/services. ▪ Number of sites/programs, by type, that were accredited during the year, by which accrediting body, and years of accreditation achieved. ▪ Report on initiatives to address issues identified in the accreditation review.
Satisfaction with Health Care Services ▪ The HQCA prepares an annual survey of Albertans on satisfaction with health care services. The council works with government and RHAs on strategies to make sure Albertans are well served by the health system including identifying best practices, and reviewing and monitoring health care quality.	▪ In response to the HQCA survey, results outline plans and actions to address specific initiatives for improving patient quality. ▪ Outline *Safer Healthcare Now* initiatives.

Patient Concerns Resolution Process ▪ Patient Concerns Resolution Process Regulation has been implemented. The regulation focuses on the resolution of patients' concerns. ▪ Health Quality Network of HQCA developed a Patient Concerns Resolution Framework. The aim of the framework is to improve the links between complaints/concerns management, patient safety and quality improvement.	▪ Outline strategies undertaken to implement the Patient Concerns/Complaints Resolution Framework across the region, including contracted facilities/services.
Mortality Ratio ▪ In November 2007, Canadian Institute for Health Information (CIHI) will be releasing a report on hospital deaths using the Hospital Standardized Mortality Ratio method of analysis and reporting.	▪ Outline strategies for reducing unexpected deaths.
Disclosure of Harm Framework. ▪ Health Quality Network of HQCA developed a Disclosure of Harm Framework. The framework provides information to health care providers throughout the province about engaging in effective and supportive disclosure processes with patients and families.	▪ Outline strategies undertaken to implement the Disclosure of Harm Framework across the region, including contracted facilities/services.
Access: **Provincial/Territorial (P/T) Benchmarks** In 2004, P/T ministers of ealth established benchmarks in five priority areas in an effort to reduce wait times: ▪ Coronary Artery Bypass Graft (CABG) o Level 1: 2 weeks; o Level 2: 6 weeks o Level 3: 26 weeks ▪ Hip and Knee Replacement (all cases within 26 weeks). ▪ Cataract removal surgery (priority cases within 16 weeks). ▪ Percentage of hip fractures repaired within 48 hours of admission. ▪ Cancer wait times for radiation therapy (all cases within four weeks of readiness to treat).	▪ Report on initiatives to meet the P/T Benchmarks by March 2008. Annually, outline specific strategies and action to reduce wait times and the number of people waiting. ▪ Report on targets for the next three years. ▪ If the RHA does not provide service, identify strategies being undertaken to ensure residents are getting timely access in another region. ▪ Report on progress in implementing the Wait Time Management Steering Committee projects and the Access to Services Business Strategy.
Children's Mental Health Services ▪ **The Alberta access goal is** 12 weeks for "Scheduled" category services.	▪ Report on initiatives to meet the Alberta goals by 2008/2009. Annually, outline specific strategies, action and targets to reduce wait times and the number of people waiting.
Radiation Therapy ▪ Expanding radiation therapy capacity	▪ The ACB and affected regions to report on strategies to implement the radiation corridor by 2010.

Emergency Room (ER): ▪ Demand for ER services and overcrowding affects timely access to care within the department and the continuity of care beyond the ER.	▪ Report on initiatives to improve timely access to ER services and the outcome of strategies to address ER overcrowding.
Infection Prevention and Control (IPC) Provincial IPC Review ▪ Implement strategies to address issues identified in the provincial IPC review.	▪ Report on strategies/actions to address IPC in these categories: o Accountabilities and clarifying roles. o Quality improvement or accreditation initiatives. o Policies/guidelines/ standards and monitoring. o Human resource complement. o Training for staff. o Health surveillance. o Planning new facilities, renovations and maintenance of existing facilities.
▪ Provincial (Methicillin-Resistant Staphylococcus aureus (MRSA) guidelines. ▪ Implement the Provincial MRSA Guidelines	▪ Report on actions taken to implement the MRSA Guidelines in these areas: o Assessment of risk. o Decreasing risk of transmission. o Medical transport. o Surveillance. o Screening. o Outbreaks. o Decolonization. o Disclosure. o Education. o Occupational health and safety.
▪ Requirements for reporting surgical site infection (SSI) 2008/2009 (see Safer Healthcare Now! Campaign)	▪ To be developed.

3.2 Primary Health Care Reform

Rationale:
Primary health care is the first point of contact people have with the health system, where health services are mobilized and coordinated to promote health, prevent illness, care for common illness and manage ongoing problems.

Primary health care is important. Available evidence shows a strong primary health care system improves the health of individuals and overall health of populations. Good primary health care increases access to health services, improves preventative care such as blood pressure screening, and reduces rates of hospitalization and use of emergency rooms.

Primary health care is not a single program that can be designed, developed and implemented. Primary health care reform is about fundamental change across the entire health care system. It is about transforming the way the health system works today by:

- taking away the almost overwhelming focus on hospitals and medical treatments
- breaking down barriers that too frequently exist between health care providers, and
- putting the focus on consistent efforts to prevent illness and injury and improve health.

The overall aim of primary health care reform is to significantly increase the importance of the first line of care and those who deliver "first contact" services. In effect, primary health care should be the central function and main focus" of the health care system (WHO 1978). Federal, provincial and territorial governments agreed to five components of primary health care reform, which are the basis for the factors and measures identified below.

Goal:
RHAs will facilitate implementation of primary health care reform.

Documents and references:
- Section 9(4)(d) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- *Health Policy Framework 2006*
- Direction as contained in government annual business plans and strategic plans
- Primary Care Network (PCN) Management Reports
- RHA Self reporting
- Health Link Alberta
- Health Quality Council of Alberta surveys
- Master Agreement, Schedule G

Factors	Measures
Service to a Defined Population Increase the proportion of the population having access to primary care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population. **Examples:** ▪ Support and encourage development and implementation of PCN, Alternate Relationship Plans and Academic Alternate Relationship Plans in both rural and urban communities. ▪ Support and encourage primary care physicians to use tools such as paneling to optimize performance in primary care.	▪ Percentage of regional residents enrolled in a PCN (source – PCN Management Reports). ▪ Percentage of primary care physicians participating in a (source – PCN Management Reports). ▪ Number of primary care physicians participating in an alternate relationship plan or an academic alternate relationship plan (source – RHA self-report).
Increased health promotion and disease prevention Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases. **Examples:** ▪ Encourage PCN to offer clinics that emphasize health promotion and disease prevention such as well-women clinics. ▪ Expand patient self-management in chronic disease management through initiatives such as the Stanford Self-Management Leader Training Program.	▪ Number of Self-Management Leader Training Sessions (source – RHA self-report).

Self-management training increases the skills necessary for patients to manage chronic conditions and work effectively with health care professionals. ▪ Expand role of home care in chronic disease management to serve a broader scope of patients who would benefit from earlier interventions (National Home Care and Primary Health Care Partnership Project).	
Expanded 24/7 access to care Expand 24/7 access to essential primary care services **Examples:** ▪ Encourage patient use of Health Link Alberta for after hours care. ▪ Encourage Health Link Alberta to direct unattached patients to primary care physicians accepting new patients. ▪ Encourage PCN to expand after-hours coverage to evenings/week-ends.	▪ Percentage of regional residents who called Health Link Alberta (source – Health Link Alberta). ▪ Percentage of regional residents who said they have a personal family doctor (source – HQCA survey).
Multidisciplinary teams Establish interdisciplinary primary care teams of providers, so that the most appropriate care is provided by the most appropriate provider. **Examples:** ▪ Increase primary care physician participation in shared mental health care programs wherein a team of mental health professionals (including psychiatrists, psychologists, nurses and social workers) would support primary care physicians to diagnose and treat patients with mental illness. ▪ Encourage PCN to develop interdisciplinary teams to work with primary care physicians. ▪ Support PCN to attract and retain health professionals through innovative solutions such as allowing RHA employees to be seconded to PCNs. ▪ Implement strategies to optimize multidisciplinary teams such as reallocating work to appropriate level of skill, expertise and licensure and implementing pre-approved protocols to delegate care tasks.	▪ Number of primary care physicians participating in shared mental health care programs. (Source – RHA self-report) Target: 10 per cent annual increase).
Coordinate and integrate with rest of the health care system Facilitate coordination and integration with other health services, i.e. in institutions and in communities. **Examples:** ▪ Align home care case managers with primary care physicians through formalized and structured partnership to create health teams uniquely equipped to provide optimal patient/client care (National Home Care and Primary Health Care Partnership Project) ▪ Align public health nurse immunization clinics with routine physician office visits at 2, 4, 6, 12, and 18 months.	▪ Percentage of regional residents who said that their personal family physician has been informed about treatment received at the hospital (source – HQCA survey). ▪ Percentage of regional residents who said that their personal family physician has been informed about treatment received in the emergency room (source – HQCA survey). ▪ Percentage of regional residents who said that their personal family physician has been informed about treatment received from a specialist

▪ Improve capacity to share information with primary care physicians about care received in hospital or emergency rooms or from specialists. ▪ Improve capacity to share results of diagnostic imaging testing with primary care physicians. ▪ Work to better integrate walk-in clinics with the rest of health care system.	(source – HQCA survey). ▪ Percentage of regional residents who said that their family doctor had received the results of diagnostic imaging testing (source – HQCA survey).

3.3 Continuing Care

Rationale:
Continuing care services quality of care and standards have been of concern to the public over the last few years. In 2005, the Auditor General's Report recommended the updating and implementation of new continuing care standards. In 2006, the MLA Task Force report recommended the enhancement of quality of care in continuing care and implementation of the standards as a priority. New continuing care standards were released by AHW on May 3, 2006. The major emphasis for continuing care in the health plan over the next three years is to implement the new standards and improve quality of care in continuing care settings.

Improvement to access and of aging in place strategies have been implemented by RHAs since 2000, and they have proven to be effective in improving access and ensuring effective use of continuing care services. These strategies will continue to remain as key factors for the health plan for the next three years.

Goal:
To improve quality of continuing care services, implement new standards and ensure compliance with standards.

Documents and references:
- Section 9 (4) (d) *Regional Health Authorities Act*
- Alberta Health and Wellness Three Year Business Plan
- *Health Policy Framework 2006*
- Direction as contained in government business plans and strategic plans
- No AHW sources for these data - measurement and outcomes generated by RHAs.
- Provincial Coordinated Access Policies – July 2004\
- Continuing Care Health Service Standards, May 2006
- Health Policy Framework:
  - Action 1 – Put the health of Albertans first
  - Action 4 – Strengthen inter-regional collaboration
- Alberta Continuing Care Information System Reporting Requirements, May 2006
  - Alberta Continuing Care Information System Frequency of Submission Specifications
  - Alberta Continuing Care Data Element Specifications:
    - Appendix A – Facility Data Element Specifications
    - Appendix B – Community Care Data Element Specifications
  - Alberta Continuing Care Information System Data Submission Guidelines
- Resident Assessment Instrument (RAI)– Home Care (RAI – HC), Canadian version, 2nd edition, October 2002, Canadian Institute for Health Information (CIHI)
- Resident Assessment Instrument Minimum Data Set (MDS) 2.0 and Resident Assessment Protocols (RAPs) User Manual, , Canadian Version, March 2005, CIHI
- The MLA Task Force on Continuing Care Health Service and Accommodation Standards, *Seniors Report*
- Health Quality Council of Alberta surveys

Factors	Measures
Quality of Care Personal care and nursing care hours.	▪ Increase average paid hours for personal and nursing care in long-term care (LTC) facilities to a minimum of 3.7 paid hours per resident per day in 2008/2009, 3.8 in 2009/2010, and 3.8 in 2010/2011. ***Report progress quarterly*** *(*AHW template*)*
Aging in Place Strategy Actions: ▪ Continue to shift continuing care clients from facility living to supportive living and home living as appropriate. ▪ Update long-term strategies for achieving ten-year continuing care service plan and integrate them as part of health plan and provide rationale for any changes.	▪ Number and percentage change in the LTC (LTC) resident ratio: LTC facility residents 75+ per 1000 population 75+ ▪ Number and percentage change in Designated Assisted Living (DAL) ratio: DAL clients per 1000 population 75+ ▪ Number and percentage change in long-term home care client ratio: long-term home care clients per 1000 population 75+. ***Report on measures quarterly.*** ***Report on progress in implementing the 10-year continuing care plan & projections annually.***
Continuing Care System Project Actions: ▪ Enhance care planning, quality of care practice and quality measurements by completing the implementation of MDS 2.0 and MDS Home Care as specified by AHW. ▪ Submit data to AHW by health authorities and LTC facilities according to timeline set up by AHW.	▪ Number and percentage change of LTC facilities that have completed implementation of the MDS 2.0. ▪ Progress report on the region's work to implement the MDS Home Care in its community care programs. ▪ Number and percentage change of facilities and RHAs each submitting MDS data to AHW. ***Report progress quarterly.***
Access to Continuing Care Services Actions: ▪ Regions fully implement coordinated access policies and inter-regional transfer policy to remove barriers for residents to access services in another region by March 2007. ▪ Full implementation of system case management by 2008/2009. ▪ Develop strategies to reduce the number of Albertans waiting for LTC beds and high level supportive living sites that have contracts with RHAs (known as designated assisted living). ▪ Implement removal of the $3000 limit in the Co-ordinated Home Care Regulation.	▪ Number and percentage change in waitlist for LTC beds. ▪ Number and percentage change in wait list for designated assisted living spaces. ▪ Number of home care clients re-assessed from $3000 limit to higher amount. ***Report progress quarterly***
Implementation of Health services standards Actions: ▪ Continue to implement continuing care health service standards.	▪ All staff is educated on new continuing care health service standards by March 31, 2008.

▪ Implement education program on new continuing care standards for all continuing care staff and contracted operators/agencies. ▪ Plan for improvement in medication management in continuing care, consistent with collaborative AHW/HQCA project. ▪ Develop plan and action strategies to improve infection control practices.	
Compliance to health service standards Actions: • Establish goals and measurements to monitor LTC facilities, supportive living operators, home care providers and contracted agencies for compliance to the continuing care health services standards. • Establish and initiate processes and mechanisms for regularly reviewing all contracted continuing care service providers. • Establish and monitor risk factors pertaining to continuing care critical incidents.	• Action plan in place that addresses: - Compliance to mandatory standards. - Frequency of audits. • Report on initiatives to meet regular review schedules. • Number of audits/remediation reviews completed. • Identify risk factors and monitor frequency.

Appendix B:

Health Authority Planners' Guide to Accountability Documents

Introduction
Key accountability documents promoting health authority governance and management, health authority accountability to the minister, and an informed public include:
- Three-year Health Plans
- Annual Business Plans
- Performance Agreements
- Quarterly Performance Reports
- Annual Reports

Health authorities are to prepare and submit these key accountability documents using the following information.

Three-year Health Plans
The purpose of the three-year health plan is to:
1. Enable the health authority to document its plans to meet its accountability obligations for effective governance of the health region.
2. Ensure and commit to the minister that the health authority has aligned its strategic direction with the AHW ministry's business plan.
3. Document what strategies the health authority has planned to meet government direction.

Each health authority is accountable to the minister for meeting its responsibilities as set out in the *Regional Health Authorities Act*. Health authorities are to submit for approval a proposed health plan to the minister, and annually to submit to the minister a proposal to amend an approved health plan. Section 9 (4) requires a proposal for a health plan to contain:
- A statement of how the regional health authority (RHA) proposes to carry out its Section 5 responsibilities and to measure its performance in carrying out those responsibilities. Under Section 5 an RHA is required to:
  - Promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
  - Assess on an ongoing basis the health needs of the health region;
  - Determine priorities in the provision of health services in the health region and allocate resources accordingly;
  - Ensure that reasonable access to quality health services is provided in and through the health region; and,
  - Promote the provision of health services in a manner responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.
- Provisions for the establishment of one or more Community Health Councils (CHCs).
- Provisions setting out the role of the CHCs in their relationship to the RHA.
- Information respecting the health services to be provided and the anticipated cost of providing those health services.
- Any other information required in the regulations or by the Minister.

Health plans indicate the key strategies to be implemented and the measures and targets to be used to assess performance to meet legislated obligations and government direction. As a public document, the health plan is a key communication vehicle for informing stakeholders of RHA plans. (Reference: *Regional Health Authorities Act, Health Quality Council of Alberta Regulation*)

The minister is most interested in the content of the health plan, not in its form. The development and form of the health plan should flow from a health authority's governance responsibilities, management systems and existing planning processes.

As an aid to increasing stakeholder awareness and understanding, the health plan should include key descriptive information about the health authority and the environment within which it operates. Typically, areas of interest include:

- The health authority's vision, mission and values statements.
- Identification of health authority opportunities and challenges.
- Other information the health authority deems important to communicate.

Health plans should be specific about planned achievements. For each legislative responsibility and government expectation the health plan should identify relevant performance information.

Performance information reflects discussions with RHAs, and is evolving; and to some extent, subject to available data and data collection processes. Based on stated priorities, health authorities are to identify measures and targets to track performance accomplishments and select strategies that can best accomplish priorities.

The health plan highlights and presents intended actions and accomplishments for the respective period covered in the long-term plans (i.e. Continuing Care Plans, Mental Health Plans, 10-year Healthy Living Plan). Appropriate reference to these plans is sufficient; there is no requirement they be submitted with the health plan.

In addition to addressing legislative responsibilities and government expectations, the health plan should identify any further priorities and initiatives the health authority intends to pursue, complete with related goals, measures, targets and strategies.

The health plan must contain a statement of accountability, signed by the chair of the health authority. The required wording is:

> "This three-year health plan for the period commencing April 1, ____ was prepared under the board's direction in accordance with the *Regional Health Authorities Act* and direction provided by the Minister of Alberta Health and Wellness (AHW).
>
> The strategic direction and priorities of the {*health authority*} have been developed in the context of legislated responsibilities, the AHW' business plan, and provincial government expectations as communicated by the minister.
>
> Performance measures are included as the basis for assessing achievements.

The board and administration of the (*health authority)* are committed to achieving the planned results laid out in this three-year health plan.

Respectfully submitted on behalf of (*health authority)*,

Signed by *(health authority)* Board Chair"

Submission of the draft health plan to the ministry is required by November 30 of the year preceding the three-year period covered by the health plan. Following review by the ministry, final submissions are board approved and submitted to the minister in time for approval prior to the commencement of the next fiscal year.

The board submission is in effect a proposed amendment to a previously approved health plan. (Reference: section 9 (7) of the *Regional Health Authority Act)*

The minister will approve, amend or refer the revised proposal back with further directions. If a proposed health plan is not approved, it must be resubmitted as directed by the minister. Once approved, a health plan is a public document. The health authority will publish the approved health plan and make a copy available, upon request, to any person requesting a copy. The health authority's web site may post the approved health plan.

A key reference dates list is included at the end of this appendix.

Performance Agreements

Two health authorities, the Alberta Cancer Board and the Alberta Mental Health Board, have signed *Performance Agreements* with the minister. *Performance agreements* are to be discussed and approved by the minister prior to the fiscal year(s) covered by the agreement. These performance agreements indicate the minister's expectations in relevant performance areas and include performance measure and expected results information for each fiscal year covered by the performance agreement.

Annual Business Plan

Required by legislation, the *annual business plan* communicates how the health authority expects to achieve the results in the first year of its three-year health plan or performance agreement, describes planned tactical and operational approaches and implementations, and indicates how available financial and other resources are to be deployed. (Reference: *Government Accountability Act; Provincial Mental Health Board Regulation; Health Quality Council of Alberta Regulation.)*

Detailed program and service plans, implementation plans and work plans are not required to be submitted, although the business plan may make reference to significant aspects of those plans. Health authorities may choose to release other documents that complement the business plan for a variety of audiences. Expected information in the business plan includes:

- Province wide services**:** Health authorities that deliver province wide services shall include, as part of its business plan, information outlining the intended approaches, budget and expected results in its delivery of province wide services.

- Surgical contracts under the *Health Care Protection Act:* Health authorities with contracts or with plans, over the next business plan cycle, that enter into contracts for surgical services with facilities pursuant to the *Health Care Protection Act* are to include relevant information regarding the type, volume and costs of these services to facilitate assessment of the plan. A comprehensive proposal including analysis of public benefit is required when seeking ministerial approval of the proposed contracts.
- Financial information: The business plan must include a financial plan that is compliant with existing legislation related to operating deficits. Financial plan form and content are set out in templates and guidelines provided by the ministry.

When submitting the annual business plan, a health authority is also required to submit to the minister a statement of *Assumptions, Risks and Implications* as advice to the minister. Development of this statement considers analysis of the current and projected future of the health authority, its external environment and key internal variables. As a guide:

- **Assumptions** describe the significant underlying factors, current and anticipated, that provide the foundation, rationale and strategic direction for the annual business plan.
- **Risks** focus on key variables and challenges that could affect a health authority's planning decisions, performance targets and strategies, including information on the degree of certainty and what contingency plans are in place to deal with key risks.
- **Implications** address what affect the planned deployment of financial resources is expected to have on programs, people and infrastructure and the extent to which these effects may affect local communities.

Upon approval of the provincial government budget, the health authority will finalize the business plan and submit it to the Minister each year by March 31. As a public accountability document, the health authority is required to publish the annual business plan.

Quarterly Performance Reports

Health authorities are responsible for carrying out their plans, reporting on their performance, and explaining any variation between planned and actual performance. Except where specifically required, performance measures are reported annually and progress on identified strategies is reported quarterly. There are two forms of quarterly reporting.

Quarterly performance reports, due 45 days after the quarter, provide narrative updates on what action the health authority has started, continued, or completed relative to the strategies stated in its three-year health plan and the tactical initiatives identified in the annual business plan.

Quarterly financial reports, due 30 days after the quarter, are prepared and submitted in accordance with the requirements set out in financial directives. The submission of an annual report eliminates the need for a fourth quarter financial report.

As accountability documents between a health authority and the minister, these reports should be approved by the board before submission and include a statement indicating the health authority's overall assessment and satisfaction with its performance.

Annual Report

The *annual report* is a key public accountability document for reporting how a health authority has discharged its legislated responsibilities and any other responsibilities delegated by the minister. The annual report provides information on: key areas fundamental to good accountability including governance, organization and legislated requirements, achievements relative to government expectations, and financial results. The minister is required to table health authority annual reports in the Alberta Legislative Assembly. (Reference: *Government Accountability Act; Regional Health Authorities Act; Regional Health Authorities Regulation 17/95;* P*rovincial Mental Health Board Regulation; Alberta Cancer Programs Act; Health Quality Council of Alberta Regulation.)*

As guiding principles, the content of the annual report should focus on achievements rather than on activities that have not yet yielded results, objectively report quantitative or qualitative evidence directly relevant to the performance measures laid out in the annual business plan and health plan and provide all explanations on any variance to expected achievements and targets.

The following minimum elements are to be included when preparing the annual report:

- **Letter of Accountability from Health Authority Chair** required wording is:

  We have the honour to present the annual report for the {health authority} for the fiscal year ended March 31, ____.

  This annual report was prepared under the board's direction, in accordance with the Government Accountability Act, Regional Health Authorities Act and directions provided by the Minister of AHW. All material economic and fiscal implications known as of July 31, ____ have been considered in preparing the annual report.

  Respectfully submitted on behalf of (health authority).

  Signed by *(health authority)* chair.

- **Board Governance:** Convey to the readers of the annual report how the board directs and governs the business of the health authority in accordance with the *Expectations for Board Governance* set out by the minister. Include information such as board structure and process.

- **Organizational and Contact Information**: Describe the current organizational and advisory structure, and identify any changes that occurred to these structures during the year. Provide an overview of the Community Health Councils, including names, dates established, mandate, and accomplishments. Include information sufficient to enable a reader to contact the health authority for information about the operations or services of the health authority.

- **Service Delivery Information**: Provide sufficient information to inform a reader about the responsibilities of the health authority and the services it provides within the region.

- **Activities and Accomplishments**: Describe the major strategic directions for the past year as set out in the three-year health plan and expected activities and accomplishments relative to the annual business plan. Items discussed should include highlights of major initiatives and accomplishments during the past year that promoted achievements of the health authority's strategic, capital, information management and technology, and health workforce plans. A discussion on accomplishments of provincewide services should also be provided if applicable.

- **Performance Report:** Include a performance report section describing key results relative to the expectations set out in the three-year health plan and the annual business plan, and provide comparison of actual results to expected achievements. Include a brief explanation of variance against targets and any other facts relevant to aid understanding of performance. Relevant facts may include community needs assessment findings, social, economic or political changes, health authority resources, and factors affecting the health status of the health region's population.

  Conclude this section with the board's overall assessment of performance during the year, and specifically highlight strategic activities that have promoted collaboration among regions, innovation and effective practices. The minister of AHW may use the health authority information in public communications.

- **Financial Summary**: Include the following documents:
  - A complete set of audited financial statements prepared in accordance with financial directives.
  - A Statement of Management Responsibility for Financial Reporting.
  - Management Discussion and Analysis.
  - The following financial indicators as calculated per financial reporting guidelines:
    1. Adjusted working capital ratio
    2. AHW funding coverage
    3. Remaining useful life of capital equipment
    4. Equipment reinvestment to consumption
    5. Internally-funded equipment
    6. Externally-funded equipment
    7. Remaining useful life of facilities
    8. Distribution of expense ratios
  - Explanation of significant variance from budget.
  - Any additional information to improve the communication value of the annual report.

- **Surgical Contracts under the Health Care Protection Act**: Summarize results from the annual performance reports submitted during the fiscal year to the health authority by surgical facilities under an agreement. For each broad service area, discuss the extent to which expected public benefit anticipated in the proposal to the Minister was achieved. Include references to any improvements in the operations of the health authority, reduction in wait-lists and costs, flexibility to patients and any other matters relevant to the strategy for contracting out surgical services. The discussion is to closely relate to the rationale provided in the request to the minister for approval of the proposal.

The ministry will provide updated data to support health authority annual reports by June 15. Annual reports approved by the board are to be submitted to the minister by **July 31** following the end of the fiscal year to which they relate. Fifteen bound copies of the approved annual report are to be provided to the ministry.

Once approved by the Board, an annual report is a public document. A health authority will publish the annual report and make a copy available, either in hard copy or electronic medium on request to any person requesting a copy.

Key Reference Dates (Note: some changes in dates may occur in subsequent fiscal years)
This table identifies expected due dates for documents required for the 2008-09 fiscal year.

DATE	ITEM	NOTES
2007		
August 24	▪ 2008/2009 Preliminary Budget Request	Subject to ministry direction
November 30	▪ Draft Health Plan for ministry review ▪ Preliminary Business Plan	Subject to ministry direction
2008		
February 15	▪ board approved Health Plan	Subject to ministry direction
March 14	▪ Final Business Plan	Normally four weeks after provincial budget announcement
March 31	▪ Health Plan approval	minister approval
July 31	▪ 1st Quarter Financial Report ▪ Deficit elimination plan (as required)	30 days after the quarter Legislated requirement
August 15	▪ 1st Quarter Performance Report	45 days after the quarter
October 31	▪ 2nd Quarter Financial Report	30 days after the quarter
November 15	▪ 2nd Quarter Performance Report	45 days after the quarter
2009		
January 31	▪ 3rd Quarter Financial Report	30 days after the quarter
February 15	▪ 3rd Quarter Performance Report	45 days after the quarter
April 30	▪ Draft 2008-09 financial statements and consolidation worksheets	Treasury Board requirements
May 15	▪ 4th Quarter Performance Report	45 days after the quarter
May 16	▪ Substantially completed 2008-09 audited Financial statements and updated consolidation worksheets	Treasury Board requirements
June 30	▪ Audited Financial Report	Legislated requirement
July 31	▪ Annual Report	Legislated requirement

Contact Information: For further information on this document contact:

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