Government of the Northwest Territories
Department of Health & Social Services

Performance Measurement and Accountability Framework

Accountability Report

Final – April 2014

Best Employers in Canada
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1.0 Introduction

1.1 Project Background and Rationale

Nationally, health care expenditures are increasing at a rate that is not considered sustainable. In order to ensure the sustainability of a publicly-funded system through innovative system reform, ***improving the accountability within the system is critical.*** There is an increasing interest across Canada in moving towards consistent, pan-Canadian indicators to monitor and report on health and social services system performance and outcomes. Multiple organizations, associations and scholars have published articles and opinion on Canada"s health and social service system accountability needs. There has been significantly more work done in regard to development of pan-Canadian health indicators than there has been in regard to Child Welfare. Three examples of work that has been done in these two sectors include.

- In 2011, the Canadian Nurses Association in a pre-budget brief to the House of Commons Standing Committee on Finance stressed the need for a comprehensive set of pan-Canadian health system indicators that demonstrate quality improvement across the continuum of care[1].

- In their report, Enhancing Pan-Canadian Health System Performance Reporting, the Canadian Institute for Health Information (CIHI) identify that "many countries are now regularly releasing public reports on the performance of their health system, with an increasing emphasis on measuring outcomes and value for money." This same report highlights that different audiences are interested in different aspects of health system performance. A hospital may require detailed information about surgical programs and care processes, while a policy maker is most interested in system trends, and users of the health and social services system want to understand if they are receiving good care relative to the expense of providing it.

- The National Child Welfare Outcomes Indicator Matrix (NOM) was developed by the provincial and territorial Directors of Child Welfare and Human Resources Development Canada[2]. It provides a framework for tracking outcomes for children and families receiving child welfare services that can be used as a common set of indicators across jurisdictions.

In order to measure the performance of a health and social services system there must be an ability to assess and compare performance. This assessment and comparison of performance is commonly referred to as benchmarking. Benchmarking is an analytical tool that helps determine where a system currently stands so that the system can explore why and how it can get to where it wants to be. Benchmarking is not an end unto itself, but rather a tool that highlights strengths and weaknesses, so that the system can determine what level of performance is possible, and explore how to make changes that promote improvement[3].

It is within this national context that the Northwest Territories (NWT) like other Canadian jurisdictions is actively seeking to enhance accountability with their health and social services system. The NWT health and social services budget now makes up more than 25% of the overall Government of the Northwest Territories (GNWT) annual budget and has increased at a rate greater than health care transfers. In

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[1] Canadian Nurses Association. (2011). Canada"s Health Accountability Plan. Pre-Budget Brief to the House of Commons Standing Committee on Finance. Retrieved from *www.cna-aiic.ca/.../pre-budget_brief_canada_health_accountability_plan*

[2] Trocme, Nutter, MacLaurin and Fallon, 1999), Child Welfare Outcome Indicator Matrix, Toronto, ON: University of Toronto: Bell Canada Child Welfare Research Unit, http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.pdf

[3] The Conference Board of Canada. Report 2012. Measuring Success: A Framework for Benchmarking Health Care System Performance.

addition, the cost per capita of providing access to health care is higher in the NWT than most Canadian jurisdictions. The rising costs of health care is driving the need to implement innovative reform across the NWT health and social services system and to improve overall accountability and performance monitoring in the system.

In 2010, the Office of the Auditor General undertook a program and services review of the NWT Health and Social Services (HSS) system. Among the recommendations coming out of that review was that the Department of Health and Social Services (DHSS):

- Develop a set of system-wide performance indicators;
- Develop a program evaluation plan, setting out areas it plans to evaluate; and
- Regularly inform the Legislative Assembly about the performance of the NWT health care system.

Further, the DHSS‟ Strategic Plan, *Building on our Foundation 2011-2016*, includes commitments to enhance the ability of the NWT HSS system to monitor and report on outcomes. This project is moving forward concurrently with other key initiatives, notably consideration of the potential to reform the NWT system‟s governance structure and exploration of the potential to implement „back office‟ consolidated and collaborative services for the system.

1.2 Project Scope and Approach

The DHSS engaged MNP to assist with:

- The development of an inventory of existing performance monitoring and reporting within the system, and working with primary stakeholders to identify system-wide performance and reporting requirements; and
- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities, and creation of an action plan to implement the accountability framework and performance measurement system.

The desired outcome from this project is: C*lear and appropriate accountabilities and reporting functions within the NWT Health and Social Services System to ensure that credible and timely information on the ongoing relevance and performance of all HSS program spending is available and is used to support evidence-based decision-making with respect to policy development, expenditure management and program quality assurance.*

MNP completed project work in two Phases:

- **Phase 1: Review and Assessment – Inventory & Reporting Requirements.** The work in this phase included:
  - Collecting and reviewing existing documentation and administrative data sets.
  - Reviewing of legislated reporting requirements.
  - Conducting interviews with DHSS representatives, Health and Social Service Authority (HSSA) representatives, and other identified stakeholders.
  - Conducting other jurisdiction and leading practice research.
  - Developing the gap analysis report.
- **Phase 2: Update Accountability Report.** The work in this phase included:
  - Working session with the Accountability Steering Committee.
  - Detailed analysis and development of draft Accountability Framework.
  - Validation session with the Accountability Steering Committee.
  - Development and presentation of final Accountability Framework.

An Accountability Steering Committee (Committee) was established to guide the work of the project and provide feedback to MNP and the NWT Project Manager. The Committee included:

- DHSS Deputy Minister;
- Representatives from four Health and Social Service Authorities;
- DHSS Chief Information Officer;
- DHSS Director of Community Wellness and Social Services;
- DHSS Director, Population Health;
- STHAs Medical Director;
- DHSS Director of Corporate Planning, Reporting and Evaluation; and
- DHSS Chief Medical Officer of Health.

The Committee"s involvement in selecting performance indicators is detailed in Section 7.2 Performance Framework Development Approach.

Phase 1 Consultations

Key stakeholder interviews were completed to inform the work. Specifically during phase 1, key informants provided input regarding:

- What information is currently collected
- What information is believed to be useful
- The challenges with collecting the required information and data
- Suggestions for improvements to the collection and reporting process
- Understanding of the legislative requirements for reporting
- Understanding of future reporting requirements

Individuals consulted included:

- Seven representatives from the DHSS
- CEO"s from each HSSA
- Four quality assurance and risk management coordinators

Phase 2 Consultations

In the spring of 2013 it was determined that additional consultation was required to more fully explore and understand the current capacity of the DHSS to collect, consolidate and report on the measures that were being considered for inclusion in an accountability framework, as well as the technology available to DHSS to capture this information. To develop this understanding a second set of consultations were completed and included representatives from:

- Public Health
- Health Services Administration
- Information Technology
- Territorial Health Services
- Human Resources
- Finance

The opinion of three Aboriginal Government representatives was also sought to gain insight into the needs of Aboriginal government and communities in regard to system performance measurement.

Unfortunately, only one of these interviews was completed due to scheduling conflicts of the Aboriginal representatives.

1.3 Purpose of Accountability Report

This report was developed as an internal document to be used by the DHSS to guide the implementation of a new accountability framework and performance measurement framework for the health and social services system. The intention is to provide the DHSS with an understanding of the current state of accountability and performance measurement for the NWT HSS system, compare that to what the NWT HSS system accountability framework and performance measurement could be in the future, identify the gaps that exist between the current state and potential future state, and finally to propose a new performance measurement framework and associated accountability framework components.

1.3.1 Report Structure

This report documents the work completed for Phases I and II of this project and includes:

- **Phase I (Section 2.0 – 6.0 and Appendices A and B)**
  - Definitions of accountabilities and descriptions of types of performance measurement indicators.
  - A description of NWT HSS accountabilities based on the current accountability framework.
  - An inventory of the current reporting for DHSS and HSSAs (Appendices A and B).
  - An assessment of the current capacity within the NWT HSS system to collect data and monitor performance.
  - A description of health and social services system accountability and performance measurement practices in Alberta, Saskatchewan and Nova Scotia.
  - A description of leading practice for health system accountability and performance measurement.
  - An opinion and description of the critical success factors for a new NWT HSS system accountability framework.
  - An opinion regarding gaps in the current accountability framework.
- **Phase II (Sections 7.0 – 8.0 and Appendices D, E and G)**
  - Recommendations: Accountability framework (Section 7.0 and Appendix D)
  - Recommendations: Performance framework (Section 8.0 and Appendices E and G)

2.0 Accountability Definitions

Accountability is a popular term and concept that is often ill-defined and misunderstood. The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions (Brinkerhoff 2003). There are two aspects to answerability including an informing aspect or transparency to report the activities and outputs of what was done and a justification aspect to provide reasons to explain the why behind the activities and outputs.

In healthcare, being accountable has been defined as taking responsibility for activity and decisions and "accountability implies the promise of responsible and responsive governance, which includes ethical behavior and the ability to stimulate desired performance through control and oversight" (Health Council of Canada 2012). In 2012, the Commission to Promote Sustainable Child Welfare Report: A New Approach to Accountability and System Management, acknowledged the Health Council of Canada"s definitions of accountability indicating, "we find that the Council"s definitions provide a helpful clarification, that brings together the focus on stewardship and control….our understanding is that accountability includes both stewardship and improvement and that both senses of the term are entirely compatible, and should be expected to be a responsibility for all institutional instances within the Child Welfare system…[4]".

However, accountability in the Canadian health and social services context is challenging as it is not always clear as to who is being held accountable, to whom, for what and to what end.

The current Accountability Framework for the NWT HSS system defines accountability as the obligation to report on the actions taken to fulfill one"s assigned responsibilities. Accountability is fundamental to establishing effective relationships and to good management practices.

In order for accountability to be effective, there needs to be clearly defined responsibilities and performance targets, accurate and timely reporting of performance measures, and the power and authority for an overseeing actor to impose consequences for achieving or not achieving performance targets (Health Council of Canada 2012). Accountability with no sanctions is typically considered to be weak accountability (Brinkerhoff 2003).

2.1 Other Terms and Definitions

A number of other terms and concepts are indentified in the Health Council of Canada 2012 report that MNP believes is relevant to the NWT HSS including:[5]

- **Transparency** - the open sharing of information on health care. Transparent reporting of goals, health indicator results, and performance is considered by some to be essential for driving quality improvement, and should be the foundation of quality-focused health care systems.
- **Performance Measurement** - the extent to which the delivery of health care services or health system activity achieves specific standards, benchmarks, or targets.
- **Health Indicators** - summary measures of health and the factors that affect health. Given the appropriate context, health indicators can provide a basis for comparison and performance measurement.
- **Benchmarks** - standards or reference points against which health indicators are measured and compared.

[4] Commission to Promote Sustainable Child Welfare. A New Approach to Accountability and System Management: Report and Recommendations. September 2012.
[5] As defined in the 2012 Health Council of Canada Report

2.2 Indicator Definitions and Fundamentals[6]

Indicators provide critical information on performance, achievement and accountability, which is the cornerstone of effective monitoring and evaluation. In addition, the data from indicators provide the strategic insights that are essential for the effective management of a health system. To be valuable, indicators need to be of high quality and able to collect the right data in the right place at the right time.

2.2.1 What is an Indicator

Fundamentally, an indicator provides a sign or a signal that something exists or is true. It is used to show the presence or state of a situation or condition. In the context of monitoring and evaluation, an indicator is a quantitative metric that provides information to monitor performance, measure achievement and determine accountability. It is important to note that a quantitative metric can be used to provide data on the quality of an activity, project or program.

A good indicator should be clear and concise. It should focus on a single issue that provides relevant information on a situation; particularly information that provides the strategic insight required for effective planning and sound decision-making. Good indicators are also defined by the feasibility of collecting meaningful and credible data for them. In addition, good indicators should actually and accurately measure what they claim to measure. If it is not feasible to collect data for an indicator, or the data that can be collected are not meaningful, the indicator will have little or no utility. Any indicator is only as valuable as the quality of the data it uses and it is crucial that the data are valid, reliable and not biased.

An important but often-overlooked fact about indicators is that they merely indicate. They do not capture or convey the many dimensions of a given situation and/or activity. They are directional such that they provide basic information on the past, present and possible future course of an activity, program and/or behaviour. They are also very context-specific such that higher values or lower values can be either good or bad, depending on the situation. The desired direction of the indicator (i.e. an increase or decrease) is usually determined when the indicator is selected and before data collection begins.

Indicators are not designed to replace more detailed investigations of specific issues, nor should they be used to do so. Consequently, information generated by indicators should always be interpreted within the broader context of the situation and supplemented where necessary by special studies, other evaluation activities and other types of data. Indicators are an essential part of effective monitoring and evaluation. They can provide vital information on performance, achievement and accountability. However, indicators are only one part of a comprehensive accountability framework. They are only one method for collecting and analyzing data and it is imperative that they be used when and where they provide meaningful information and insight.

2.2.2 Essential Components of an Indicator

The following are critical components of an indicator:

- The indicator has a clearly stated title and definition.
- The indicator has a clearly stated purpose and rationale.
- The method of measurement for the indicator is clearly defined.
- The data collection methodology and data collection tools for the indicator data are clearly stated.
- The data collection frequency is clearly defined.
- Any relevant subgroups that collected data can be separated into in order to more precisely understand and analyze the findings are clearly defined.

[6] Based on An Introduction to Indicators. UNAIDS Monitoring and Evaluation Fundamental Series, January 2010.

- There are guidelines to interpret and use data from this indicator.
- The strengths and weaknesses of the indicator and the challenges in it use are identified.
- Relevant sources of additional information on the indicator are cited.

Indicators should always have a proven track record (i.e. demonstrated performance in field-testing or operational use) before they are broadly deployed. It is impossible to underestimate the value of a proven track record. Most importantly, it prevents the allocation of resources on indicators that cannot or will not provide useful data.

2.2.3 What Makes a Good Indicator

Good indicators are:

- **Action focused.** Indicators should lead to action. If stakeholders cannot imagine what to do with the data from an indicator, then it probably isn"t a good indicator.
- **Important.** Stakeholders should agree that the indicator and the data it will generate make a relevant and significant contribution to determining how to effectively respond to the outcome.
- **Measurable.** Not only must the data collection methodology be defined, it must also be feasible to collect the data.
- **Simple.** There are very few indicators if any that are perfect. Rather than pursue the perfect indicator, it is much better to identify good, simple indicators that provide data that can be put to use.

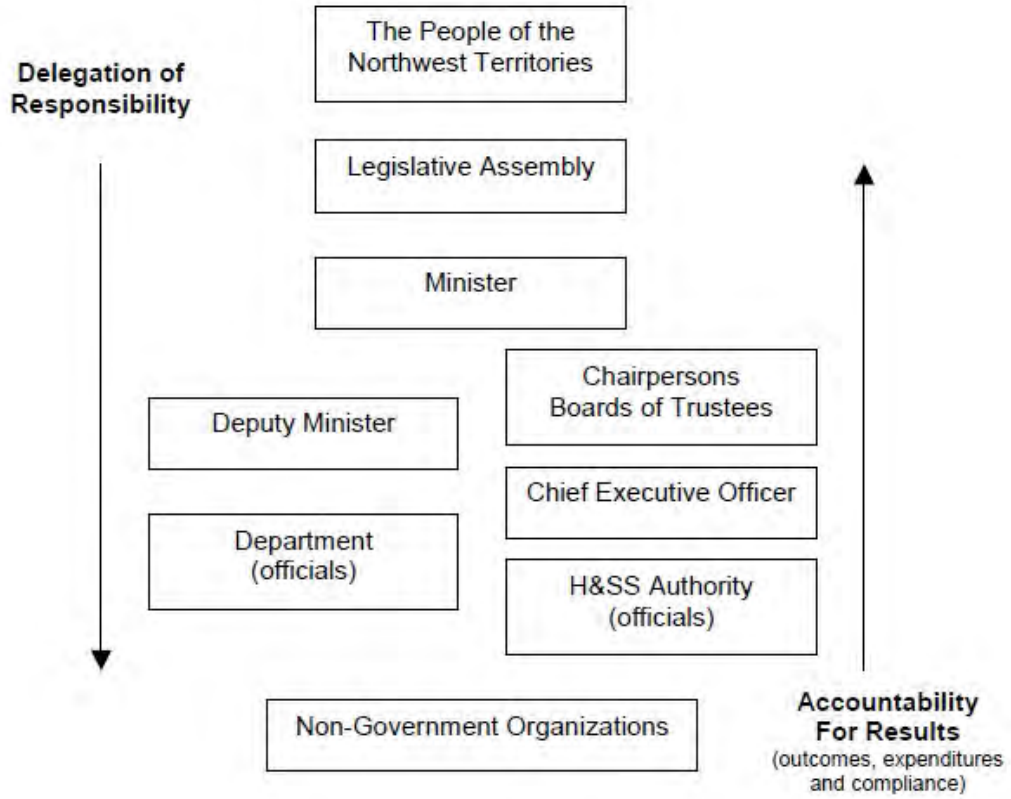
3.0 Current State – What is Now

3.1 Accountabilities – Current Accountability Framework

The current Accountability Framework for the NWT HSS system was developed in 2003. The following section summarizes the key aspects of the current framework.

The current framework makes an important distinction between responsibility and accountability. Responsibility confers an obligation to take action and accountability confers an obligation to report. The delegation of responsibilities and the associated accountabilities for the NWT HSS system under the current framework are articulated in Figure 1.

Figure 1: Outline of Delegated Responsibility and Accountability for Results under Current Framework[7]



The accountability for health and social services extends beyond the boundaries of the NWT. The authority for the Legislative Assembly to deliver health and social services derives from the *Northwest Territories Act* and the *Canada Health Act*, both of which are the responsibility of the Parliament of Canada. Therefore, there is accountability to the Government of Canada.

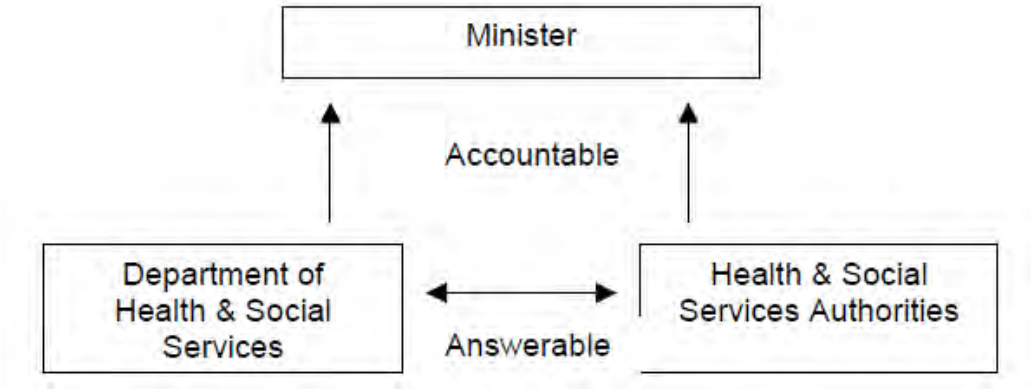
In addition to being accountable to the Government of Canada, the Legislative Assembly is also accountable to the people of the NWT who elect them.

[7] As per graphic included in the 2003 NWT HSS System Accountability Framework.

The Minister of HSS is delegated the responsibility for the delivery of health and services from the Legislative Assembly and is accountable to them (Figure 1). The process of delegating responsibility for health and social services continues on to the Deputy Minister and the Trustees of the HSSAs. The Deputy Minister in turn delegates responsibility to DHSS officials and the HSSA Trustees delegate responsibility to HSSA Executive Officers and officials. Responsibility is also delegated from DHSS and HSSA officials to non-government officials. Each time that responsibility is delegated from one level of the system to another, an obligation to be accountable is created.

Under the current framework, the DHSS and the HSSAs are both accountable to the Minister of HSS, but are also answerable to each other (Figure 2). Answerability is also present within the Joint Leadership Council (JLC) and the Joint Senior Management Committee (JSMC).

Figure 2: Relationship between Minister, DHSS and HSSAs in Current Framework



In addition to outlining how responsibility is delegated within the NWT HSS system, and the associated accountabilities, the current framework also describes the roles and responsibilities amongst partners in the system. The current reporting obligations within the NWT HSS system are summarized in Section 3.2 and detailed in Appendices A and B.

3.1.1 Contribution Agreements with HSSAs

There are annual contribution agreements between the GNWT (as represented by the Minister of HSS) and each HSSA. The contribution agreements document the amount of funding contributed by the GNWT to the HSSA, a budget with how the funds are to be spent to deliver Core Services to NWT residents, funding restrictions, a payment schedule for the funding, the reporting requirements, and insurance requirements.

3.1.2 Contribution Agreement Reporting Requirements

The contribution agreements require that each HSSA submit a number of financial reports including quarterly variance reports, a year end variance report, audited financial statements and an annual budget submission. In 2012 these agreements were modified in response to the 2012 Report from the Auditor General and HSSAs are also required to report: the number of emergency visits (by Canadian Acuity Triage Scale); and the number of scheduled appointments, no shows and visits to family physicians and nurse practitioners.

3.2 Current Reporting

This section provides an overview of the current reporting in the NWT HSS system. Current reporting as outlined through legislation as well as non-legislated reporting was identified by having DHSS representatives update the reporting obligations identified in the 2007 Sierra Systems worksheet from the Data Warehouse Preliminary Analysis Project. Currently, the DHSS lists 66 reports based on the rational identified by each division. A complete inventory of the reporting is provided in Appendices A and B.

Legislated reporting requirements are as follows:

Medical Care Act

- Under the Medical Care Act, the Minister of Health and Social Services is obligated to table a report on the operations of the Medical Care Plan. The Department also meets the reporting requirements under the Medical Care Act through the annual reports.

Child and Family Services Act

- Director of Child and Family Services is required to prepare and submit an annual report to the Minister. The last CFS report was provided to the Minister in 2004, and covered information for the 2001/02 fiscal year.

Mental Health Act

- No annual reporting requirements to the Minister. However, medical practitioners are required under specific circumstances to provide reports to the Minister (such as when a medical practitioner orders the detention of a person).

Dental Mechanics Act; Optometry Act; Veterinary Profession Act; Dental Profession Act

- Boards of Inquiry or Review Officer are required to submit a report to the minister on every complaint they investigate.

Nursing Profession Act

- President must present report to Board of Directors at least once every two years
- Treasurer must present statement of financial position at least once every two years

Tobacco Control Act

- Inspector must submit report to Minister of any seizure of tobacco under the Act.

3.3 Current Performance Measurement

This section provides an inventory of the current performance measures tracked and reported by the DHSS and the HSSAs. The performance measures historically reported by the HSSAs are distinct from the performance measures tracked and reported by the DHSS.

3.3.1 NWT Health and Social Services System

The NWT HSS system has documented performance measures in the 2011–2016 Strategic Plan, the 2011/2012 Annual Report, and the Quarterly Performance Measures Report. An inventory of the performance measurement indicators included in each report is provided below (Table 1).

Table 1: Inventory of Performance Measurement Indicators for the NWT HSS System

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Percentage of no shows for Medical Travel	✓	✓	
Percentage of no shows for specialists	✓	✓	✓
Percentage of no shows for family practitioners and nurse practitioners	✓	✓	✓
Data collected and outcome measures reported on	✓	✓	
No show rate by specialty and location			✓
No show/cancellation rate for elective surgery, overall and by reason			✓
Percentage of children receiving services in their home community	✓	✓	
Percentage of children receiving services in their home or w/ a relative	✓	✓	
Number of communities w/ a CFS committee	✓	✓	
Number of Foster Care Families	✓	✓	
Number of communities where respite is available	✓	✓	
Number of communities w/ a Healthy Family Program	✓	✓	
Self-reported health status - % of NWT pop reporting health as excellent or very good	✓	✓	
Ambulatory care sensitive conditions as proportion of overall hospitalizations	✓	✓	
Rate of hospitalization where a mental health issue was the primary reason	✓	✓	
STI incidence rate (Chlamydia, Gonorrhea, and Syphilis)	✓	✓	
Number of smokers who report being counseled to quit smoking by their primary care provider	✓	✓	
Incidence rate of Diabetes in the population age 45 to 59 years	✓	✓	
Low limb amputation hospitalization rate among people w/ diabetes, age 40 & up	✓	✓	✓
Percentage of obese adults	✓	✓	
Prevalence of smoking (age 15&up)	✓	✓	
Prevalence of heavy (binge?) drinking (age 15 to 24)	✓	✓	
Reduced hospitalizations due to injury (Injury Hospitalization Rate)	✓	✓	
Percent of clients receiving home care in their community	✓		
Number of clients receiving home care in their communities		✓	
Incidence of active TB	✓	✓	
Number of clinical telehealth clients	✓	✓	

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Incidence of community acquired of MRSA	✓	✓	
Percentage of residents satisfied w/ overall health services	✓	✓	
Degree to which mental health and addictions services meets the needs of clients	✓	✓	
Number of Telehealth Clients, overall and by session type			✓
New child welfare cases - ratio of non-court to court involved			✓
Average number of placements per year, per child.			✓
Proportion of children by number of placements of per year			✓
Children receiving services - proportion non-court involved in system			✓
Long-Term Care Facility Occupancy rate			✓
Number of clients on Territorial Admissions Committee Waitlist			✓
Territorial Admissions Committee Clients by Placement Location			✓
Proportion of Emergency Visits Non-Urgent			✓
Proportion of Emergency Visits by level of Urgency			✓
MRSA Incidence rate			✓
STI incidence rate			✓
Population hospitalized for a mental health issue (# per 1,000)			✓
Number and rate of mental health hospitalizations (primary diagnosis)			✓
Proportion of mental health hospitalizations by type of primary diagnosis			✓
Proportion of hospitalizations for alcohol and drug related issues			✓
Hospitalizations for A&D related issues by substance type			✓
Hospitalizations for A&D related issues by clinical state			✓
Hospitalizations for A&D related issues by secondary issue			✓
Secondary Health Issues of A&D Hospitalizations (#, %)			✓
Number of Out of Territory A&D Treatment Referrals			✓
Population Hospitalized for Self-inflicted injuries (#, # per 1,000)			✓
ACSC as a proportion of overall hospitalizations			✓
Proportion of ACSC Hospitalizations by Condition			✓
Change ACSC by condition as proportion of overall hospitalizations			✓
Full Immunization Coverage Rates by Two Years of Age by Birth Cohort			✓
Vaccine by Diseases Protected Against and Coverage Rate			✓
Percentage of total bed days as alternative level of care (MCN)	✓	✓	✓
Territorial Admissions Committee Clients by Placement			✓

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Location (MCN)			
Injury - prevalence of falls in hospitals	✓	✓	✓
Number of Medical Travel Patients and Escorts			✓
Number of standards reviewed and implemented	✓	✓	
Percentage of total biomedical equipment replaced based on recommended life cycles	✓	✓	
Percentage of total value of HSS Centres scheduled for major upgrade or replacement	✓	✓	
Reduce the rates of hospital-acquired infections	✓	✓	
Timeliness of responses to identified adverse events	✓	✓	
Time it takes to staff a position	✓		
Percentage of staffing competitions completed within 8 weeks		✓	
The percentage of employees that indicate that they feel safe and supported in their work environment	✓	✓	
H&SS positions by age group and type			✓
H&SS positions by average years of service			✓
Employees by average age and years of service			✓
Vacancy rate for specialists			✓
Vacancy rate by type of nurse			✓
Vacancy rate by social worker			✓

Table 2: Number of Performance Measures by Document

Report/Document	*Number of Performance Measures*
2011–2016 Strategic Plan	36
2011/2012 Annual Report	36
Quarterly Performance Measurement Report (Spring 2012)	42
Distinct NWT HSS System Total	**75**

A total of 75 current performance measures were identified for the NWT HSS System. Of these 75 performance measures, 42 are included in the Quarterly Performance Measurement report and 36 are included in the most recent 2011-2016 Strategic Plan, and the 2011/2012 Annual Report (Table 2).

Almost all of the performance measures in the 2011/2012 Annual Report are the same as the performance measures in 2011-2016 Strategic Plan. However, most of the performance measures in the Quarterly Performance Measurement Report are different than those contained in the 2011-2016 Strategic Plan and 2011/2012 Annual Report. Although these performance measures are not exactly the same, many are variations of the same theme, creating duplications. This means that the actual number of current distinct performance measures for the NWT HSS system is smaller than 75.

3.3.1.1 Northwest Territories Health Status Report

In addition to the 75 performance measures listed above, the DHSS has provided a Health Status Report in 2005 and then again in 2010. It is intended to inform the public about the wellbeing of the population in general and report on the major determinants of in the Northwest Territories. This report contains approximately 100 health indicators that cover a number of topics including well-being, chronic and communicable diseases, mental health and addictions, child and infant health, health determinants and preventive services. The department is committed to publishing a health status report every 5 years.

3.3.2 Health and Social Services Authorities

Each of the eight HSSAs in the NWT HSS system publishes an annual report that includes performance measures relevant to each region. However, the performance measures reported by each HSSA are not consistent which creates challenges for system-wide reporting. The variation in the types of performance measures reported by each HSSA is a reflection of the different types of programs and services delivered by each HSSA as well as the varying capacities and methods used to collect data.

3.4 Current Capacity

The current capacity to collect the data and information that is required to inform the performance measures for the NWT HSS system varies across the territory, ranging from minimal to adequate. The degree to which data is collected manually versus electronically also varies throughout the territory. Some HSSAs are solely dependent on manual data collection and processing, some have established electronic data collection systems, while others use a combination of electronic and manual data collection. Overall, most client health information is still maintained in paper files at facilities across the territory. MNP was not able to identify any standardization that exists amongst and between the HSSAs. There was general consensus amongst those stakeholders consulted that any update to the accountability framework should not result in additional work effort by "front-line" staff.

3.4.1 Data Collection Challenges

MNP identified eight distinct challenges related to the collection of data and information for performance measurement including[8,9]:

- There is no standardization and consistency in the collection and management of data/information across the territory. Each HSSA collects data/information independently, creates independent data definitions, and uses the data/information collected uniquely. This impacts both the quality and consistency of the data/information collected within the system.
- The process for managing records across the territories is inconsistent.
- There is a mix of ICD-9 and ICD-10 coding systems used in the acute care facilities in the territory and each facility defines data elements differently. This results in data sets that are not consistent.
- The clinical systems implemented by HSSAs in the territory have been configured and deployed inconsistently resulting in fragmented data collection with different systems that are not linked to each other.
- There is no standardized data capture and reporting systems for mental health and addictions programs and services.

[8] Data Warehouse Preliminary Analysis: Current State Assessment Report. Sierra Systems 2007.
[9] Based on consultations with stakeholders.

- The sharing of information between HSSAs is limited.
- The sharing of information along points in the continuum of care for patients is limited.
- The sharing of information between program areas such as public health and home care is limited.
- The cleansing and validation of the data collected is limited.

Stakeholder"s preliminary thoughts for addressing these challenges included:

- Using the interoperable Electronic Health Record (iEHR) to standardize the collection and management of data across the territory.
- Centralizing the collection, cleansing, analyses, and reporting of data.

4.0 Other Jurisdictions Insights

MNP examined the approach to health and social services system accountability in three other Canadian provinces including Alberta, Saskatchewan and Nova Scotia. The information was obtained through a combination of internet research and interviews with provincial representatives. Please note that MNP was unable to interview representatives from the province of Nova Scotia[10]. Indicators that these jurisdictions use were considered when the initial inventory of indicators was developed for the NWT HSS performance measurement framework detailed in Sections 8.2 and 8.3.

Key findings from other jurisdictions that were used to inform development of the recommended accountability framework and performance measurement framework included the following.

- While each jurisdiction articulates their performance measures uniquely, thematically there are significant similarities between them.
    - It should be noted, that the uniqueness of each jurisdictions performance measures are indicative of the current lack of a national focus. Nationally, the health sector is significantly ahead of the child welfare sector in regard to developing a national perspective, led in large part by the work of the Canadian Institute for Health Information (CIHI) discussed in more detail in Section 5.0 of the report. In 2009, Trocme, MacLaurin, Fallon, et al from The Centre for Research on Children and Families & Centres of Excellence for Children‟s Well-Being report that "While this is one of the most high risk groups of children in Canada, there is currently no common framework for tracking how well children receiving child welfare services are doing.[11]" They present a common set of indicators to track outcomes for these children their National Child Welfare Outcomes Indicator Matrix.
- Unlike in the NWT, all three of the other jurisdictions reviewed have a separate accountability frameworks and performance measurement indicators for their respective health and social service sectors.
- The number of performance measures these other jurisdictions use range from 9 for Saskatchewan Health to 21 for Nova Scotia‟s Department of Health and Wellness. These relatively small numbers of indicators across jurisdictions are consistent with what MNP recommends for the NWTs DHSS.
- The currency of each jurisdictions framework supports the national trend for examining health and social service system accountabilities. Each jurisdiction is wrestling with similar issues to that faced by the NWT in regard to establishing an environment of increased accountability and ability to report on system performance.

Collectively, a review of these jurisdictions practices in regard to accountability and performance management validate NWTs focus on this element of their Health and Social Service System and ultimately the accountability and performance frameworks recommended in Sections 7.0 and 8.0 respectively. While unique to NWT, the recommended frameworks were informed by other jurisdictions practices providing a degree of assurance that they are sound and adequately consider what some may define as „common practice‟.

Unique to the performance framework recommended for NWTs Health and Social Service System, and as far as MNP knows, the first of its kind in Canada, is the alignment of the framework with the Canadian Institute of Health Information‟s (CIHI) Health System Reporting Initiative, detailed in Section 5.0. Basing their accountability framework on CIHI‟s work should position NWT well in the national landscape of indicator development.

[10] Detail regarding findings from each jurisdiction is included in Appendix C.

[11] Centre for Research on Children and Families & Centres of Excellence for Children‟s Well-Being.. National Child Welfare Outcomes Indictor Matrix. September 2009.

5.0 Future State – What Could Be

This section provides a description of best practice approaches to health system performance measurement as well as identified principles and critical success factors for the development of a performance measurement system.

5.1 Best Practices

MNP reviewed numerous approaches to health system performance measurement. We believe three of these can be considered best practice and are most relevant to NWT HSS. Located in Canada, the United States and the United Kingdom these best practices provide significant insight into approaches that we believe should be used to guide development of your new performance measurement framework.

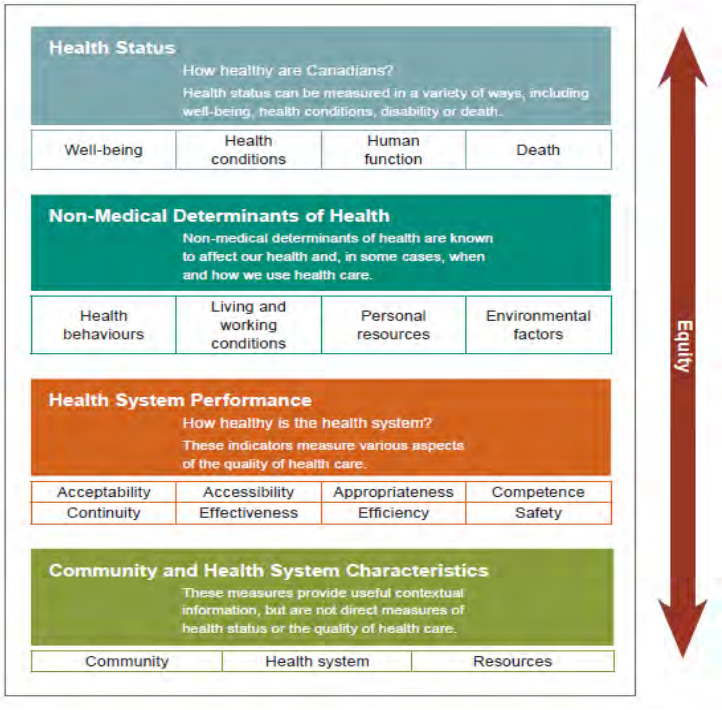
5.1.1 Canadian Institute for Health Information

5.1.1.1 Health Indicators Reporting with Stats Canada

The Canadian Institute for Health Information (CIHI), in collaboration with Statistics Canada, publishes an annual „Health Indicators" report. The report contains performance measures that assist in assessing the health of Canadians and the health of the Canadian health system. „Health Indicators 2012", the most recent version of the report and the 13th in the series, includes updates on more than 40 measures for Canadian regions.

Each of the performance measures included in the 2012 report is grouped into one of the five dimensions of the Health Indicator Framework developed by CIHI and Stats Canada (Figure 3). This framework has been internationally recognized.

Figure 3: Health Indicator Framework developed by CIHI and Health Canada[12]



[12] Taken from the „Health Indicators 2012" report.

5.1.1.2 Health System Performance Reporting Initiative[13]

CIHI recently started working on a Health System Performance reporting initiative (CIHI 2012). The initiative will be completed over a three year period from 2012 to 2015 and has four key objectives:

- To provide structured and coordinated pan-Canadian reporting on health system performance that is tailored to the information needs of different audiences, including the general public, provincial health ministries, regional health authorities and health care facilities;
- To produce analytical tools and products that support provincial and territorial health system improvement priorities;
- To work health system partners to build capacity for using and understanding performance measurements and tools; and
- To reduce “indicator chaos” in the health system by working with partners to identify which health indicators are most important, how they relate to each other, and how they can best support improvements to health care and the health of Canadians.

The initiative has five main work streams including:

- Health system performance measurement framework;
- Health system performance interactive public reporting;
- Integrated analytical environment;
- Research and analysis; and
- Capacity building.

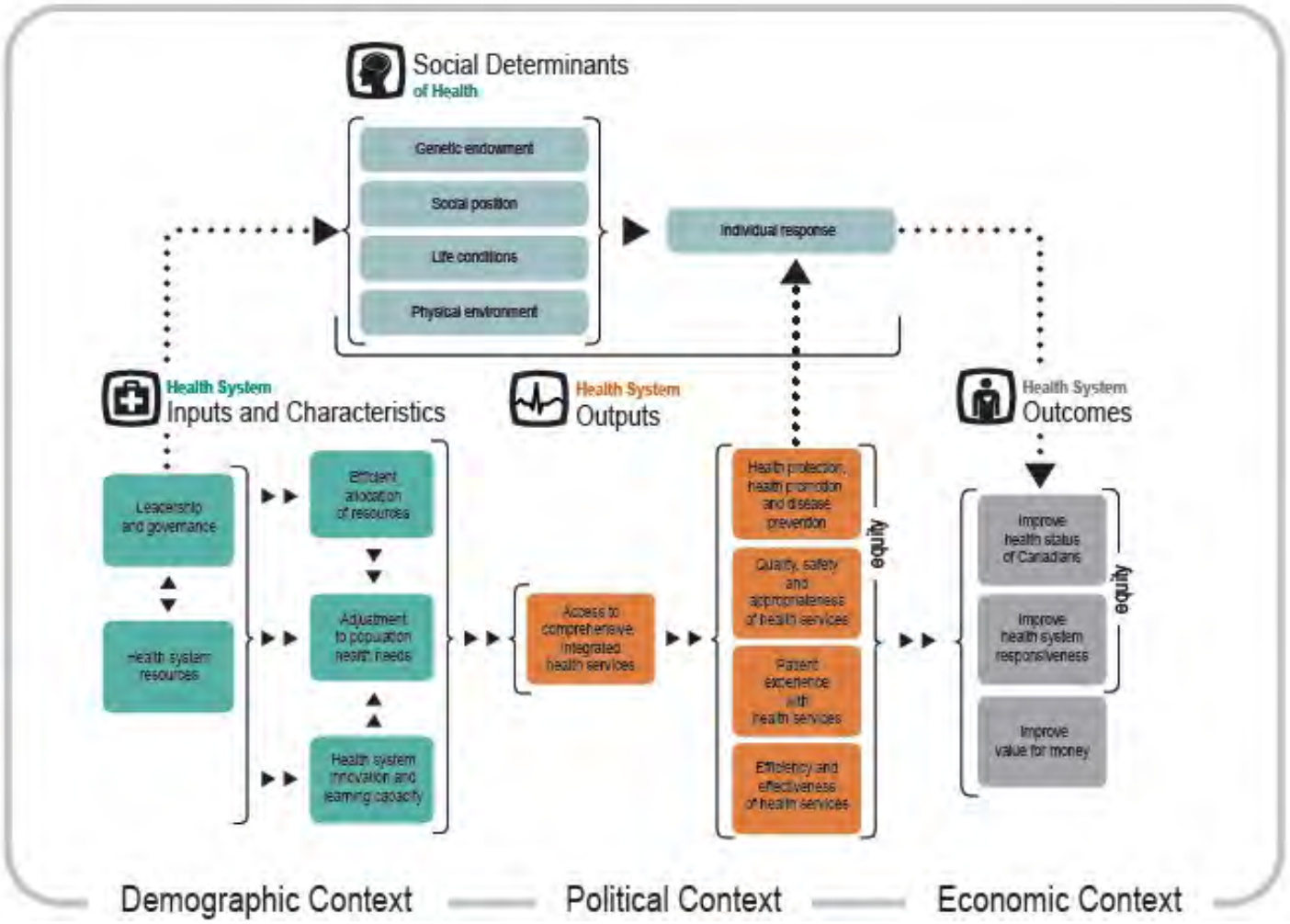
CIHI has developed a new framework for measuring health system performance (Figure 4). The framework builds on the previous framework developed by CIHI and Stats Canada (Figure 3). The new framework has four main quadrants including health system inputs, health system outputs, social determinants of health and health system outcomes. The framework also shows the relationship between each quadrant.

Under this initiative, CIHI will also develop interactive websites that have a focused set of cascading metrics that are meaningful and to useful to different audiences (Figure 5). CIHI recognizes that different audiences are interested in different aspects of health system performance and requires different levels of information.

CIHI"s proposed performance measurement reporting details four level of audience: public; provincial policy makers; regional health authorities; and points of care (hospitals, long-term care and primary care facilities). However, for this project, the scope of work only included development of accountability and performance frameworks that would address public and territorial policy maker"s audience levels. Reporting at the two lower levels currently does and will continue to exist in NWT, with HSSAs continuing to monitor and report appropriate indicators at the HSSA and point of care levels.

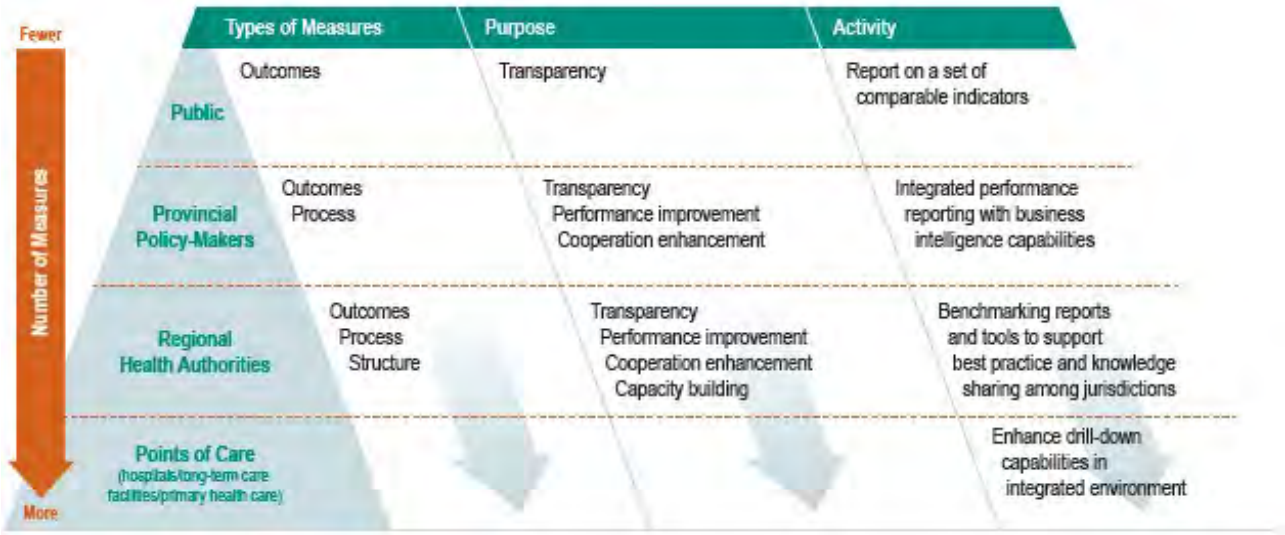
[13] Based on the document titled „Enhancing Pan-Canadian Health System Performance Reporting at CIHI". This document was provided to MNP by CIHI.

Figure 4: New CIHI Framework for Measuring Health System Performance[14]



[14] Based on the document titled „Enhancing Pan-Canadian Health System Performance Reporting at CIHI". This document was provided to MNP by CIHI.

Figure 5: CIHI Proposed Performance Measurement Reporting by Audience Type



5.1.2 Partners for Health Reform*plus*

Partners for Health Reformplus (PHRplus), was a five year project that ran from 2000 to 2005. The project was funded by the US Agency for International Development and focused on health policy and health system strengthening in developing and transitional countries. An article was published from the project titled „Accountability and Health Systems: Overview, Framework, and Strategies (Brinkerhoff 2003) that:

- Defines accountability;
- Provides an analytical framework for accountability and health service delivery systems;
- Describes the role of health sector actors in accountability; and
- Describes accountability-strengthening strategies.

The definitions of accountability from the article are included in Section 2.0 of this report. Accountability is defined as being answerable and having the obligation to answer questions regarding decisions and/or actions. Two aspects of accountability include:

- An informing aspect or transparency to report the activities and outputs of what was done; and
- A justification aspect to provide reasons to explain the why behind the activities and outputs. This aspect is linked to the World Health Organization‟s notion of stewardship and good governance.

The availability and application of sanctions for the overseeing actor to impose on the accountable actor for not meeting targets gives “teeth” to accountability. However, sanctions without enforcement diminish accountability.

There are three types of accountability identified for health systems including financial accountability, performance accountability and political/democratic accountability (Brinkerhoff 2003). The definition and description for each type of accountability is as follows:

- **Financial Accountability** - tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. The operational basis for financial accountability begins with internal agency financial systems that follow uniform accounting rules and standards.

- **Performance Accountability** - demonstrating and accounting for performance in light of agreed upon performance targets. Its focus is on the services, outputs, and results or outcomes of public agencies and programs. Performance accountability is linked to financial accountability in that the financial resources to be accounted for are intended to produce goods, services, and benefits for citizens, but it is distinct in that financial accountability‟s emphasis is on procedural compliance whereas performance accountability concentrates on results and in the case of a health and social services systems, health outcomes.
- **Political/Democratic Accountability** - has to do with the institutions, procedures, and mechanisms that seek to ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens‟ interests, and responds to ongoing and emerging societal needs and concerns. The political process and elections are the main avenues for this type of accountability.

5.1.3 United Kingdom Department of Health

The National Health Service (NHS) is responsible for providing a number of health services in England including emergency and urgent care, hospital services, general practitioner services, pharmacy services, dental services, eye care services, mental health services and social services[15]. The UK Department of Health developed NHS Outcomes Framework to set out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board accountable for the health outcomes achieved by the health system (Department of Health 2010). This framework was first published in 2011/2012 and then updated in 2013/2014 to include a total of 63 indicators including 14 overarching indicators and 49 improvement area indicators (Appendix C). The purpose of the NHS Outcomes Framework is to:

- Provide a national level overview of how well the NHS is performing;
- Provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spending of public money; and
- Act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

The indicators in the framework have been organized into five domains which identify the national outcomes that the NHS should be working on to improve (Department of Health 2012). Within each domain, there are overarching indicators and improvement area indicators that focus on improving health and reducing health inequalities. The five domains include:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

MNP identified the NHS framework as a best practice and recommended it be part of the informing body of knowledge for development of NWT‟s frameworks due to its focus on health outcomes. The five domains are all outcome related and focus on the „ultimate‟ goals of health and social services: positive outcomes for patients.

[15] http://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/NHSServices.aspx

5.2 Principles

The Department of Health and Social services committed to four principles that must guide the development of a new accountability framework. MNP used these principles to guide our work.

- **Clarity** – Roles, responsibilities and performance expectations are clearly defined and communicated.
- **Efficiency** – Performance expectations must be in balance with capacity to deliver results, and must reflect human, fiscal and capital resources.
- **Effectiveness** – Reporting between all relevant stakeholders is meaningful, credible and timely and allows for informed decision making.
- **Flexibility** – Performance plans must allow for adjustments to be made based on review and feedback, and consequent changes to strategic directions and resource allocations, along with any changes in system structure.

5.3 Critical Success Factors

Based on the best practices research, other jurisdiction research, stakeholder input and application of our own experiences, MNP developed the following critical success factors for NWT HSSs consideration:

- **Keep it Simple** – Start small with performance measurement and develop over time. This will improve the probability of success and the ability to build off that success. Start with high-level system wide performance measures.
- **Anchor with Standards and Guidelines** – Use peer reviewed standards and/or guidelines as an anchor or benchmark for performance measurement.
- **Focus on Health & Social Service Outcomes and System Performance** – Focus on health and social service system performance measurement and outcomes rather than system processes.
- **Use Relevant Performance Measures** – Report on a mix of measures that are relevant to and reflective of the health and social services system including hospital based, non-hospital based, and community measures.
- **Availability of Data** – The ability to collect data that will inform performance measures is the driving force behind the feasibility of what can and cannot be reported.
- **Consistent Data Collection and Analysis** – Consistent data collection and analysis improves the quality of the data used for reporting. It is important to have confidence in the data being reported. Some jurisdictions analyze and manage data at the department of ministry level to ensure consistency and quality.
- **Communication** – Communication with key stakeholders during the development and implementation of the accountability framework is important. Buy-in and utilization of the framework will improve if stakeholders are informed of the reasons for the framework during the development stage. Ongoing communication and reporting to stakeholders is also required after implementation of the framework to maintain buy-in and participation.

6.0 Gaps in Current Accountability Framework

By considering current state for the NWT HSS system (Section 3.0) and subsequently considering other jurisdictions (Section 4.0) and best practice research (Section 5.0) two distinct points representing where NWT is now and where it could be in regard to an accountability framework, can be established. With these two "goal posts" established, the gap between them can be readily determined. MNP has articulated a summarized list of the strengths and gaps with the current NWT HSS system Accountability Framework (Table 3) and a summarized list of the current strengths and gaps for measuring the performance of the NWT HSS system (Table 4). These gaps effectively define the elements that need to be developed during the next phase of work where the NWT HSSs accountability framework is defined.

Table 3: Strengths and Gaps of Current Accountability Framework

Dimension	Strength	Gap
Definition of accountability	✓	
Definitions of other key terms	✓	
Roles, responsibilities and accountabilities articulated	✓	
Roles, responsibilities and accountabilities defined		✓
Service level agreements/sanctions		✓
Domains/categories of performance measurement		✓
System performance measures included		✓
Performance targets based on established standards		✓
Reporting requirements documented		✓
Framework updated on regular basis		✓
Framework incorporates best practice		✓
Stakeholder awareness of framework		✓
Linked to current strategic plan		✓

Table 4: Strengths and Gaps of Current Performance Measurement

Dimension	Strength	Gap
Standard set of performance measures reported for HSS system		✓
Performance measures in strategic plan linked to annual report	✓	
Performance measures informed through consistent data collection and analysis		✓
Capacity exists to collect data for performance measures throughout the system		✓
Regular reporting of performance measures	✓	
Communication and awareness of performance measures/reporting		✓
Consistent organization and categorization of performance measures in all reports		✓
Stakeholder buy-in to system performance measurement		✓

7.0 Recommendations: Accountability Framework

7.1 Components of a New Accountability Framework

As defined in the scope of this project, the desired outcome is: C*lear and appropriate accountabilities and reporting functions within the NWT Health and Social Services System to ensure that credible and timely information on the ongoing relevance and performance of all HSS program spending is available and is used to support evidence-based decision-making with respect to policy development, expenditure management and program quality assurance.* Accordingly, MNP was engaged to assist with:

- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities.

Work completed by MNP in 2011 identified a number of components of accountability that are directly applicable and relevant to this project (Appendix D). Items discussed in this document include:

- Roles and responsibilities;
- Reporting accountabilities;
- Instruments or tools for accountability; and
- Accountability agreements.

In this section of the report we provide a visual representation of MNPs recommended accountability framework for the NWT Health and Social Service System, with more detail on possible components of a framework provided in Appendix D.

Section 8.0 of the report details MNPs recommended performance framework.

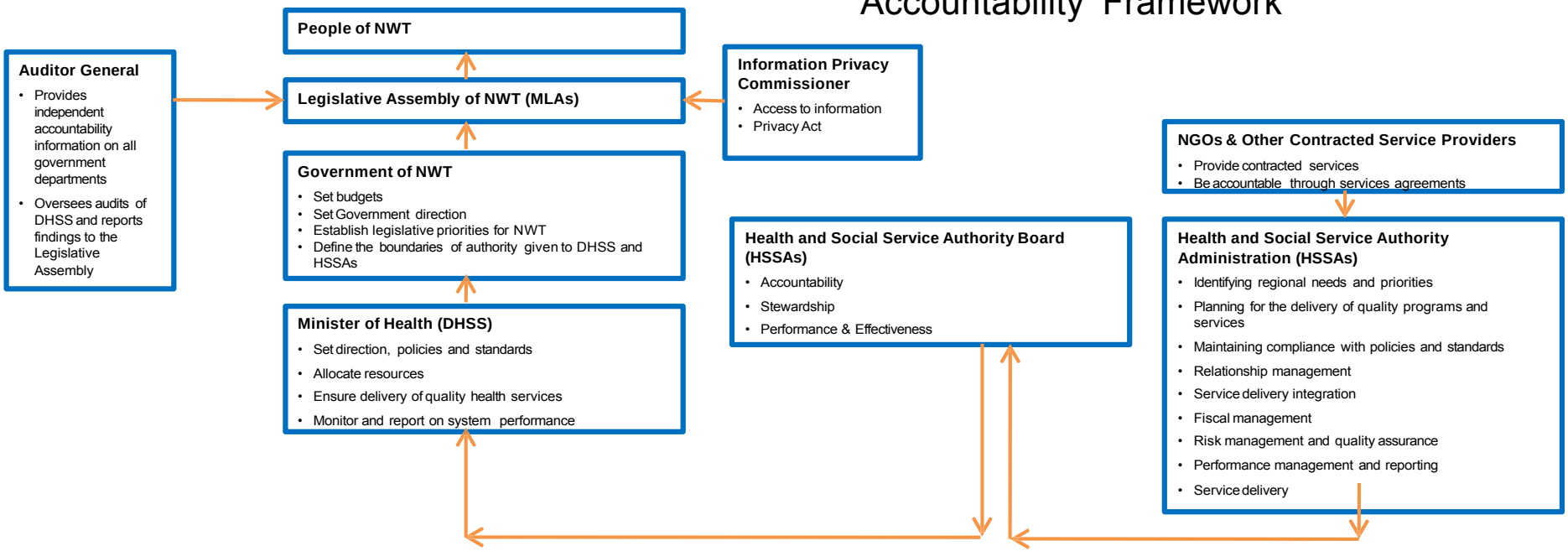
7.2 Recommended Accountability Framework

Using the accountability framework developed in the 2011 MNP report as a starting point (Appendix D), the other jurisdiction research completed (Appendix C) was then utilized to inform refinement of an accountability framework for NWTs Health and Social Services System.

Note that at the time of completion of this project there is active discussion within NWT to modify the current governance system for health and social services. As it is difficult to recommend a final accountability framework until such time as the governance model has been determined, MNP has provided a high-level accountability framework on the page that follows, but is recommending that a more detailed accountability framework be developed once the governance of NWT‟s health and social services system is finalized.

The high-level accountability framework presented details the accountability relationships and key responsibilities for the „players‟ in NWTs Health and Social Service System as it exists today. Detail regarding roles and responsibilities, reporting accountabilities, mechanism and tools that can be used to manage system accountability; including an outline for an accountability agreement can be found in Appendix D.

NWT Health and Social Service System Accountability Framework



8.0 Recommendations: Performance Framework

One specific recommendation made in the 2011 MNP report (Appendix C) was to develop system and program performance indicators. *"To understand HSSA and system performance, consistent system and program performance indicators must be developed. Data collection tools and resources will also be required to ensure indicators are measured and data is collected, analyzed and findings are presented in required reports. This will increase the system's ability to ensure compliance and control, quality assurance, and risk management."*

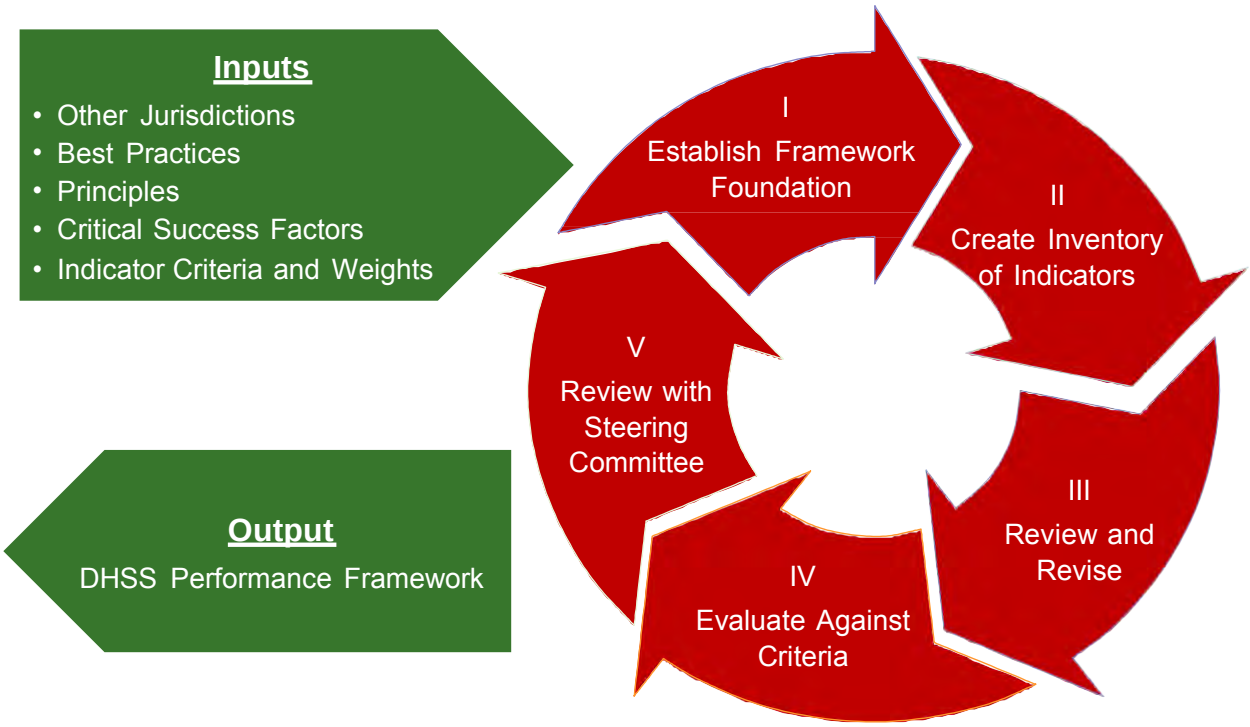
This section details recommendations for an NWT Health and Social Service performance framework including:

- The performance framework development approach;
- The performance measurement indicators;
- Frequency of reporting;
- Types of reporting;
- Formats of reports; and
- Report audiences.

8.1 Performance Framework Development Approach

The approach MNP used to develop the performance framework is summarized in the graphic below (Figure 6).

Figure 6: Performance Framework Development Approach



8.1.1 Inputs

8.1.1.1 Other Jurisdictions

- MNP examined the approach to health and social services system accountability in three other Canadian provinces including:
  - Alberta;
  - Saskatchewan; and
  - Nova Scotia
- Detailed documentation regarding these three jurisdictions practices for both health and social services are contained in Appendix C of this report
- Indicators that these jurisdictions use were part of the inventory that was considered for the NWT HSS system

8.1.1.2 Best Practices

- MNP reviewed numerous approaches to health system accountability and performance measurement
- MNP identified three approaches that can be considered best practice and are most relevant to the NWT HSS system
- These best practices provided significant insight into approaches that we used to guide development of the new accountability framework, and in particular the indicators
  - Canadian Institute for Health Information – Performance Measurement Framework
  - Partners for Health Reformplus (PHRplus) - „Accountability and Health Systems: Overview, Framework, and Strategies" (Brinkerhoff 2003)
  - The UK Department of Health - NHS Outcomes Framework (*sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board accountable for the results achieved by the health system*)

8.1.1.3 Framework Principles (DHSS)

- **Clarity** – Roles, responsibilities and performance expectations are clearly defined and communicated
- **Efficiency** – Performance expectations must be in balance with capacity to deliver results, and must reflect human, fiscal and capital resources
- **Effectiveness** – Reporting between all relevant stakeholders is meaningful, credible and timely and allows for informed decision making
- **Flexibility** – Performance plans must allow for adjustments to be made based on review and feedback, and consequent changes to strategic directions and resource allocations, along with any changes in system structure

8.1.1.4 Critical Success Factors (MNP)

- **Keep it Simple** – Start small with high-level system wide performance measures and develop over time
- **Anchor with Standards and Guidelines** – Use peer reviewed standards and/or guidelines as an anchor or benchmark for performance measurement
- **Focus on Health Outcomes** – Focus health system performance measurement on health outcomes rather than health system processes
- **Use Relevant Performance Measures** – Report on a mix of measures that are relevant to and reflective of the health system including some hospital based and non-hospital based measures

- **Availability of Data** – The ability to collect data that will inform performance measures is the driving force behind the feasibility of what can and cannot be reported
- **Consistent Data Collection and Analysis** – Consistent data collection and analysis improves the quality of the data used for reporting. It is important to have confidence in the data being reported
- **Communication** – Communication with key stakeholders during the development and implementation of the accountability framework is important. Buy-in and utilization of the framework will improve if stakeholders are informed of the reasons for the framework during the development stage

8.1.1.5 Indicator Criteria and Weights

- Nine criteria against which indicator options were measured were created, and then weighted by the Steering Committee
- These criteria are as follows:
    1. *Reliable and Valid Data Available* – Considers the reliability and validity of the data
    2. *Capacity to Collect Data Exists* – Considers the capacity requirements to collect and report on the measure
    3. *Allows for Target Creation* – Considers whether the measure allows targets to be set
    4. *Performance Measure is Meaningful to the Public* – Considers whether the measure will be meaningful to the public
    5. *Performance Measure is Meaningful to the NWT HSS System* – Considers whether the measure will be meaningful to the NWT HSS system
    6. *Anchored with Standards and Guidelines* – Considers whether the performance measure allows for comparison to peer reviewed standards and/or guidelines
    7. *Allows for Decision Making* – Considers the degree to which having the information will allow the NWT HSS system to make policy, strategic and/or operational decisions
    8. *Focuses on System Outcomes and Performance* – Considers the degree to which the measure focuses on health and social service system performance measurement and health outcomes rather than processes
    9. *Degree to Which the HSS System Can Impact Change* – Considers the degree to which the NWT HSS system has the ability to impact change
- To determine the weightings of the feasibility criteria, each criterion was compared against the other
- A score was assigned for each comparison between two criteria based on a scale (Figure 7)
- Scores were then be summed for each criterion and weighted against the total scores to arrive at the aggregate weighting (Figures 8, and 9).

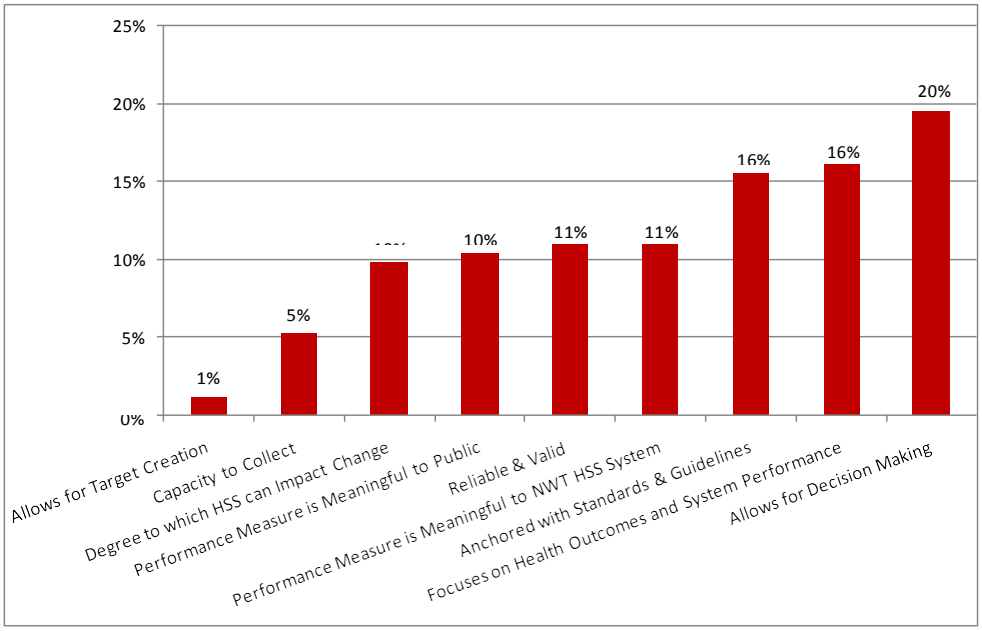
Figure 7: Weighting Legend

Description	Score
Criterion is **less important** than its comparison	0.2
Criterion is **equally important** as its comparison	1.0
Criterion is **more important** than is comparison	5.0

Figure 8: Indicator Criteria and Weights

	1) Reliable and Valid Data Available	2) Capacity to Collect Data	3) Allows for Target Creation	4) Performance Measure is Meaningful to Public	5) Performance Measure is Meaningful to NWT HSS	6) Anchored with Standards and Guidelines	7) Allows for Decision Making	8) Focuses on Health Outcomes and System Performance	9) Degree to which HSS can impact change	Total Value	Individual Weighting
1) Reliable and Valid Data Available		5.0	5.0	1.0	1.0	0.2	1.0	1.0	1.0	15.2	11%
2) Capacity to Collect Data	0.2		5.0	1.0	0.2	0.2	0.2	0.2	0.2	7.2	5%
3) Allows for Target Creation	0.2	0.2		0.2	0.2	0.2	0.2	0.2	0.2	1.6	1%
4) Performance Measure is Meaningful to Public	1.0	1.0	5.0		1.0	0.2	0.2	1.0	5.0	14.4	10%
5) Performance Measure is Meaningful to NWT HSS System	1.0	5.0	5.0	1.0		1.0	1.0	0.2	1.0	15.2	11%
6) Anchored with Standards and Guidelines	5.0	5.0	5.0	5.0	1.0		0.2	0.2	5.0	21.4	16%
7) Allows for Decision Making	1.0	5.0	5.0	5.0	1.0	5.0		5.0	5.0	27.0	20%
8) Focuses on Health Outcomes and System Performance	1.0	5.0	5.0	1.0	5.0	5.0	0.2		1.0	22.2	16%
9) Degree to which HSS can impact change	1.0	5.0	5.0	0.2	1.0	0.2	0.2	1.0		13.6	10%

Figure 9: Indicator Criteria and Weights

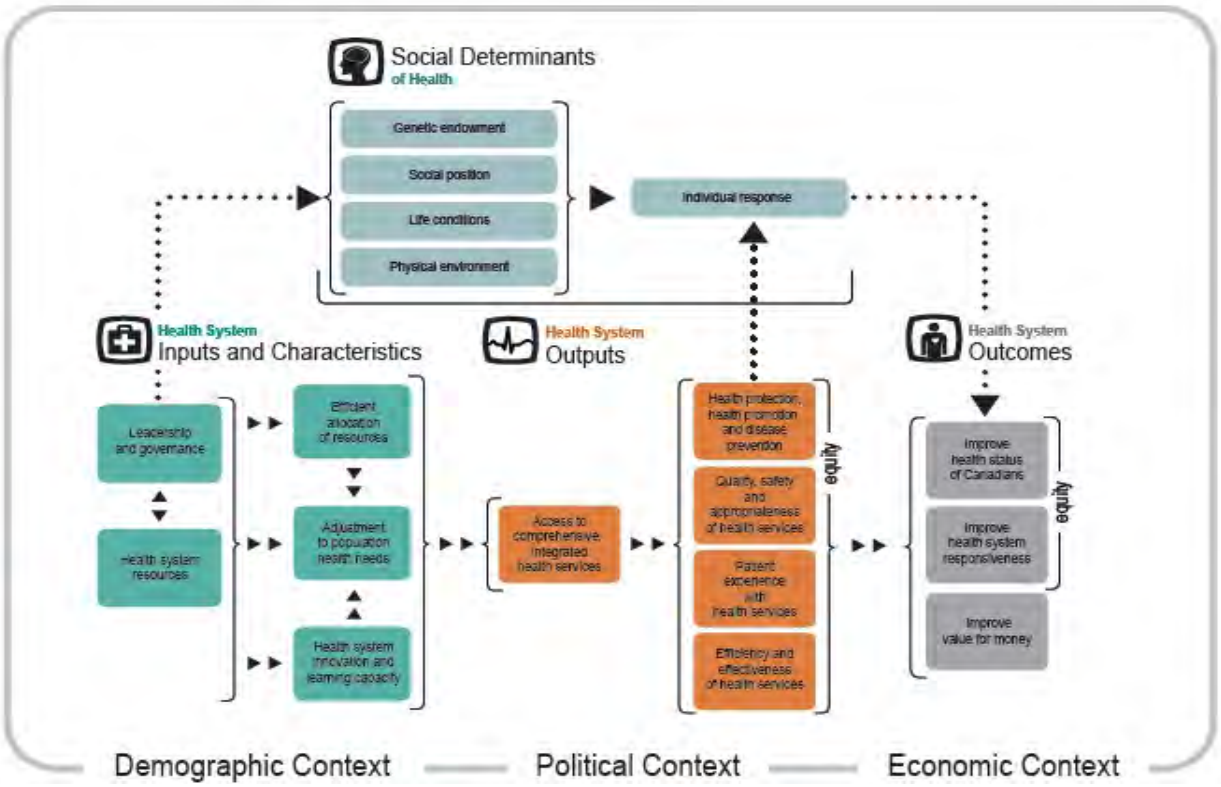


8.1.2 Establish Framework Foundation

- In reviewing other jurisdictions frameworks as well as leading practices in Canada, MNP recommended using the *Canadian Institute for Health Information – Performance Measurement Framework* as the foundation (Figure 10):
  - Can readily be adapted to incorporate both health and social services elements which is critical to the NWT HSS system framework.
    - Currently, there is a lack of a national framework for child welfare and social services and more work has been done in the health sector in this regard, leading to MNPs recommendation to utilize CIHIs framework as the basis for the NWT framework.
    - DHSS is encouraged to continue to follow the work of the National Child Welfare Outcomes Indicator Matrix and incorporate advancements in social service indicators as this work progresses nationally.
  - Is comprised of four equally important and interrelated quadrants that represents a system:
    - Health and Social System Inputs and Characteristics
    - Health and Social System Outputs
    - Health and Social System Outcomes
    - Social Determinants of Health
  - Was designed to allow system managers and policy makers to assess system performance
  - Based on recognized literature and research
  - Has potential to be a capacity saver for the Department of HSS

Note that as stated earlier in this report, CIHI"s proposed performance measurement reporting details four level of audience: public; provincial policy makers; regional health authorities; and points of care (hospitals, long-term care and primary care facilities). However, for this project, the scope of work only included development of accountability and performance frameworks that would address public and territorial policy maker"s audience levels. Reporting at the two lower levels currently does and will continue to exist in NWT, with HSSAs continuing to monitor and report appropriate indicators at the HSSA and point of care levels.

Figure 10: CIHI Framework



The quadrants and performance dimensions of the framework are defined below.

- **Health and social system inputs and characteristics** – refer to the relatively stable characteristics of the health and social services system, including:
  - Governance and leadership capacities in the system,
  - Resources available for use,
  - Distribution and allocation of those resources,
  - Capacity to adjust and adapt to meet population health needs, and
  - Innovation and learning capacities of the system
- **Health and social system outputs** – are the immediate results of activities undertaken by the health and social services system. Common outputs include the delivery of accessible, timely and effective health and social services
- **Health and social system outcomes –** correspond to the intrinsic goals of the health and social services system. These outcomes are:
  - Improvement of the level and distribution of health in the population,
  - Health and social services system"s responsiveness to the needs and demands of the people of NWT, and
  - Value for money to ensure system sustainability
- **Social determinants of health** – represent the factors outside the health and social services system that influence the health of a population. In the framework these include:
  - Genetic endowment,
  - Social position,
  - Life conditions, and

- Physical environment

More detail regarding each of the quadrants and dimensions definitions can be located in the Canadian Institute for Health Information 2012 publication, “A Performance Measurement Framework for the Canadian Health System”. https://secure.cihi.ca/free_products/HSP-Framework-ENweb.pdf.

8.1.3 Create Inventory of Indicators

- An inventory of 55 initial indicators was created using all the inputs to inform their development:
  - Other jurisdictions,
  - Best practices,
  - Principles,
  - Critical success factors, and
  - Indictor criteria

8.1.4 Review and Revise

- The indicators were circulated for comment and/or discussed with:
  - Version 1.0
    - Director, Corporate Planning, Reporting and Evaluation
  - Version 2.0
    - Director, Corporate Planning, Reporting and Evaluation
    - Senior Health Analyst, Corporate Planning, Evaluation and Analysis Unit
  - Version 3.0
    - Director, Corporate Planning, Reporting and Evaluation
    - Circulated to Steering Committee representatives
  - Version 4.0
    - Senior Health Analyst, Corporate Planning, Evaluation and Analysis Unit
  - Version 5.0
    - Steering Committee
- Indicators were removed, new ones added, and others were modified, resulting in the initial list of 55 indicators being reduced to 42.

8.1.5 Evaluate Against Criteria

- The 42 indicators were then evaluated using the nine weighted criteria and a three-point scale
- Each of the 42 indicators received a weighted score *(the higher the score the “better” the indicator met the criteria, implying the “better” the metric)*
- One of the criteria considered the capacity for collecting the needed data
- Despite this criteria receiving the second lowest weight, (5%), in completing the reviews it became apparent there was going to be a real issue with collecting data for many of the proposed indicators
- Accordingly it was recommended that any indicator receiving a score of 1 (poorly meets) be eliminated from further consideration
- This further reduced the number of indicators from 42 to 21
- This resulted in MNP recommending the inclusion of 21 indicators.

8.1.6 Review with Steering Committee

- The recommended 21 indicators were reviewed with the Steering Committee for final inclusion decision.
- Through this discussion some indicators were removed and new ones added resulting in a total of 25 indicators being selected (Appendix E)
- A total of 18 indicators were not selected (Appendix F). There were a number of non-selected indicators that were identified as priorities for DHSS to pursue in the future and these have been highlighted in Appendix F.

8.2 Performance Measurement Indicators

The 25 selected performance measurement indicators are summarized (Table 5) and detailed in Appendix G. Note that some of the indicators proposed may eventually be reported in ways that vary from the manner recommended (e.g. more or less detail, in rate vs. number format etc) following implementation.

Table 5: Selected Performance Indicators

Selected Performance Indicators
Inputs and Characteristics
1. The quarterly proportion of actual HSSA expense under or over projected expenses (variance reporting)
2. The proportion of HSSAs with published, current operating (health and social service) plan and annual report
3. The rate of critical incidents per 1,000 employee days worked
4. Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)
5. Average wait times by type of surgery (time of booking to surgery)*
6. Average wait time for offer of placement in a long-term care facility
7. Rate of adoption of newly established clinical standards of care
Outputs
8. Utilization rate of tele-health technology for patient care activities
9. Number (%) of children receiving child welfare care in their home community: by age group and demographic (Aboriginal)
10. The number of patients and the number of escorts using the medical travel program per fiscal year
11. Proportion of the population receiving: full immunization coverage by the age of two years
12. Incidence **rate** of sexually transmitted infection in NWT
13. Average number of critical incidents reported: a) per 1,000 inpatient bed days, and b) per 1,000 outpatient visits
14. Average number of placements per year per child: Aboriginal and non-Aboriginal
15. Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year (e.g. Hospital year 1, LTC year 2, Primary Health year 3)
16. Percentage of no-shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA

Selected Performance Indicators
Outcomes
17. Incidence rate of cancer by type
18. Incidence rate of diabetes
19. Self-reported health status of NWT residents
20. Average length of time between specialist referral and specialist appointment
Social Determinants of Health
21. The proportion of children who are developing well at school entry
22. Percentage of NWT population who smoke
23. Percentage of NWT population with reported substance abuse issues
24. Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child
25. Percentage of NWT population who are obese

*This indicator is located in two dimensions of the performance framework (Efficient Allocation of Resources, and Improve Health and Social Service System Responsiveness)

8.3 Reporting Frequency

The recommended frequency of reporting for all indicators is annual. The DHSS may choose to internally report on select indicators with greater or lesser frequency however, annual reporting to the public and the GNWT legislature is recommended. Given the data collection challenges detailed in Section 3.4.1 of the report, one of the filters used to assess the selected indicators was the capacity of the GNWT to collect the data (Figure 8). The GNWT will have to remain cognizant of its capacity for collecting the required data for the twenty-five selected indicators. Changes to the recommended reporting frequency and/or the number of indicators reported on may need to be made as the GNWT implements the recommendations and some of the indicators may not be reported on in initial reports due to unforeseeable challenges and times constraints involved in establishing data capture and reporting systems.

8.4 Reporting Formats

Selecting a reporting format that is appealing to and easily understood by the audiences is important. Historically, the DHSS has utilized a number of formats and significant effort has been applied to developing reports that will be useful and appealing to their audience.

- Internally, a “Performance Measures” report was developed and implemented in the spring of 2012 to report quarterly on a set of indicators.
- Externally, the 2011/2012 NWT Health and Social Services Annual Report: Measuring Success and Focusing on Results was published in October 2012 to report on progress against the priorities and action articulated in the DHSS Strategic Plan.

MNP believes these reports are sound and that redevelopment is not required or recommended. Utilizing graphical representation of results is likely the most impactful for a reader, however supplementing the

graphical representation with narrative explanation is required to provide robust information. MNP is recommending that information on each reported indicator be structured under five headings as follows:

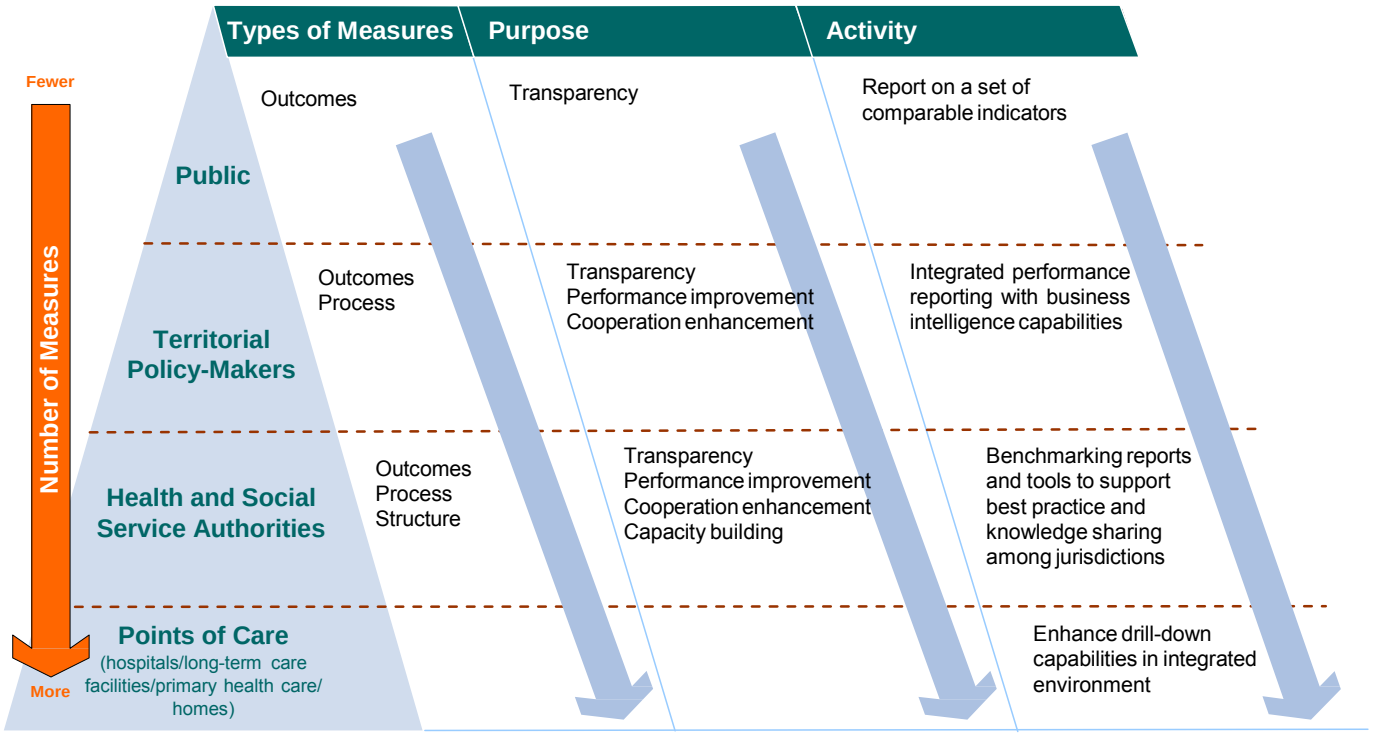
- Indicator Title;
- What is Being Measured;
- Why is This of Interest;
- What does this tell us; and
- How Are We Doing.

MNP has developed narrative for each of the selected indicators under each of these headings that are detailed in Appendix G.

8.5 Audiences

Guiding the development of the performance indicators was the understanding that they were meant to be at the "system" level rather than the HSSA level and to be utilized to report primarily to two groups: the public; and the GNWT decision –makers. Accordingly, the types of measures required and their purpose will be different than would be required to report to different groups such as health and social service authorities or points of care (Figure 11). A HSSA would require more detailed reporting in order to have information available that allows for operational decision making, whereas at the territorial policy maker level higher level, trending information will be more valuable to understand which parts of the system are working well and which are not. This is not suggesting that more detailed performance reporting should not be completed by HSSAs, but rather the focus of this project was to develop system level reporting.

Figure 11: Reporting Audiences



*Adapted from Canadian Institute of Health Information – Performance Measurement Framework

8.6 Updates to Framework

It is recommended that the framework is formally reviewed on an annual basis. Further, it is recommended that as the indicators are reported on, feedback should be sought from both the public and GNWT decision makers re: their value and usefulness that in turn, may drive the need to modify the indicators. While the intent of the framework is to ensure that it reflects the DHSSs core business and this is not likely to change dramatically over time, there may be instances when changes are required as a result of emerging strategic priorities and/or as new sources of information become operational (e.g. electronic medical records) allowing for the development of more effective performance measurements. The DHSS is cautioned to carefully consider changes before making them, ensuring that the same criteria and process used to select the original indicators is utilized to assess potential new additions. In particular, due attention should be provided to balance the desire to enhance the indicators with the capacity requirements. In other words maintaining the simplicity of the indicators and framework is felt to be critical to the ongoing ability of the DHSS to report in a timely and effective manner. One way to ensure the purpose of the framework is understood will be communications regarding

Connecting and linking the performance framework to the DHSS strategic plan will be a process that can be anticipated to unfold in the future. When DHSS embarks on the development of a new strategic plan, using the performance framework as input into its development and vice-versa is recommended. As the strategic plan evolves so too will the need to evolve the performance framework, in order ensure as much alignment as possible.

References

Alberta Health (2012). *Annual Report 2011 – 2012.* Retrieved from http://www.health.alberta.ca/documents/Annual-Report-12.pdf

Alberta Health Services (2012). *Q2 performance report 2012/13*. Retrieved from http://www.albertahealthservices.ca/Publications/ahs-pub-pr-2012-12-performance-report.pdf

Alberta Human Services (2012). *Annual Report 2011 – 2012.* Retrieved from http://humanservices.alberta.ca/documents/2011-12-Human-Services-Annual-Report.pdf

Brinkerhoff, D. (2003). *Accountability and health systems: Overview, framework, and strategies.* Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Canadian Institute for Health Information and Statistics Canada (2012). *Health Indicators 2012.* Retrieved from https://secure.cihi.ca/free_products/health_indicators_2012_en.pdf

Canadian Institute for Health Information (2012). A Performance Measurement Framework for the Canadian Health System.

Department of Health (2010). *The NHS outcomes framework 2011/2012.* Retrieved from http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123138.pdf

Department of Health (2012). *The NHS outcomes framework 2013/2014.* Retrieved from https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf

Health Council of Canada (2012). *Measuring and reporting on health system performance in Canada: Opportunities for improvement.* Retrieved from http://www.healthcouncilcanada.ca/tree/HCC_Health_Indicators_WP_EN_WEB.PDF

Northwest Territories Health and Social Services (2011). *Building on our foundation 2011-2016: A Strategic Plan for the NWT Health and Social Services System.* Retrieved from http://www.hss.gov.nt.ca/sites/default/files/building_on_our_foundation.pdf

Northwest Territories Health and Social Services (2011). *Northwest Territories Health Status Report.* Retrieved from http://www.hss.gov.nt.ca/sites/default/files/nwt_health_status_report.pdf

Northwest Territories Health and Social Services (2012). *Measuring success and focusing on results: NWT Health and Social Services System 2011/2012 Annual Report.* Retrieved from http://www.hss.gov.nt.ca/sites/default/files/measuring_success_and_focusing_on_results.pdf

Nova Scotia Department of Community Services (2012). *Annual Accountability Report for the Fiscal Year 2011-2012.* Retrieved from http://novascotia.ca/coms/department/documents/Accountability_Report_2011-2012.pdf

Nova Scotia Department of Health and Wellness (2012). *Annual Accountability Report for the Fiscal Year 2011-2012.* Retrieved from http://novascotia.ca/DHW/reports/Accountibility-Report-2011-2012-DHW.pdf

Saskatchewan Ministry of Health (2012). *2011-12 Annual Report.* Retrieved from http://www.health.gov.sk.ca/health-annual-report-2011-12

Saskatchewan Ministry of Social Services (2012). *2011-12 Annual Report.* Retrieved from http://www.socialservices.gov.sk.ca/2010-11MSS-AnnualReport.pdf

Appendix A: DHSS Reporting

Reporting Obligations Questionnaire

As part of the Current State Assessment review of the Data Warehouse Preliminary Analysis project the reporting obligations of each division need to be identified. Any related information already identified as part of the Information Needs interview process conducted during the past March and April are shown under the appropriate tables that follow. Please verify this information and augment as necessary.
In particular, the information fields requested are:

Division & Division Group:	The name of your Division and if applicable, the name of your group (e.g. Division: Territorial/Integrated Services. Division Group: Continuing Care)
Contributor Name:	Your name. Contributing on behalf of your group
Reporting Obligations:	Identify the name of each report that your group requires to produce for internal DH&SS groups or external entities.
Notes	Any notes that help describe the particular report in addition to its name
Data Sources:	Identify the source systems used to contribute the required information. If you are not sure of the systems involved then please identify who generates the report for you
Recipient:	Identify the intended recipient of the report
Frequency:	Identify the how often you need to produce the report (e.g. monthly, annually etc)
Turn Around Time:	Identify the period of time that you have available to produce the report (i.e.: from the point of time the source data is available (e.g. HMIS data received) to the point that the report is generated)
Issues:	Identify issues affecting the generation of the report (particular emphasis on issues that are not identified as part of the interview process)
Priority:	High/ Medium/ Low

Division	Division Group	Contributor Name
Policy, Legislation and Communication		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Annual Canada Health Act (NWT portion).	The P.A.R. division provides the data and Policy division provides the narrative and submits the document to the Federal Government		Health Canada	Annual		
Professional Registry reports		Severed photocopies of applications	CIHI	Annual	1 yr.	Very labour intensive to manually prepare information
FMBS: Variance Reports		FIS		Quarterly		

Division	Division Group	Contributor Name
Financial Management		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
N/A	The Board shall provide the Department with financial statements and reports as required in Schedule C in accordance with part IX of the *Financial Administration Act*					Is this referring to the Core Funding Contribution Agreement? See below.
HSSA Business Plan	Authorities shall submit a business plan to the Minister on an annual basis		Minister	Annual		Authorities not required to submit annual business plans
HSSA Budget	Shall Submit a budget to the Minister on an annual basis		Minister	Annual		In the past couple of years, we have received deficit budgets from Authorities that could not be approved.
DH&SS Funds Expended	Shall account to the Department for the funds expended in the Contribution Agreement		Minister	Annual		Is this referring to the Core Funding Contribution Agreement? Authorities are funded under annual Core Funding Contribution Agreements. Schedule C of those agreements lay out annual reporting requirements.
Expenditures by Community	In order to fulfill this obligation, we require the information from the Authorities.		Financial Management Board	Quarterly Reports are due three weeks after each quarter		We don"t require this reporting of the Authorities. Perhaps this is referencing GNWT Geographic Tracking exercise of former years. No longer required to report on this.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Annual Hospital Survey	The completion of Annual reports are a federally legislated requirement The Department performs a coordination function in gathering and compiling this information within the territory. HSSA"s submit to Department end of September to ensure time to compile and send to CIHI by Oct 31 deadline.		CIHI	Annual Due October 31 of each year		Authorities and Dept have been getting better at submitting data and meeting deadlines. Our score by CIHI on the data can be improved however, as Authorities are currently not reporting statistical data at the minimum reporting requirements. Department has not yet pushed for more statistical data reporting in this format. Focus for past couple of years has been improving the reporting of financial data.
Expenditure Management Report (Variance)	The Department is required to submit a monthly report to the Department of Finance explaining the year-to-date expenditures as well as the year end projected expenditures.	Program managers and SAM	Department of Finance Department of Finance provides summary information to FMB.	Monthly - Due 15 days after each month end. Annual - due during Year end reporting schedule		We have had issues of getting program manager feedback in a timely manner to complete the variance by deadline. This has recently been improving. Typically one week late in submission. Projections can be suspect – often program managers overestimating what year end expenses will be. Critical that this information be as accurate as possible as it affects decisions to move forward with requests for Supplementary Funding.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Information Item: Authority Variances		Authority Variance Submissions	Department of Finance / FMB	Due 45 days after the end of each financial quarter.		Directed by FMB to provide an Info Item on the status of Authority projected variances. Meeting deadline dependent upon the timeliness and quality of information provided by the Authorities. Information provided in the Info Item can impact the Departments ability to access Supplementary Funding.
HSSA Audited Financial Statements			Minister Department of Finance also receives copies. Government Accounting for Consolidation purposes Budgeting and Evaluation for assessment purposes.	Annual Audited financial statements are due by June 30		Continue to work to ensure the reports are per the required format in the annual Instructions to Auditors. Need to ensure information is at a level of detail appropriate for consolidation purposes of the GNWT. Working towards having the AFS tie directly to the approved Chart of Accounts.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Contracts > 5K List	Government Accountability	• SAM • Contracts Registry and Reporting System	Department of ITI Public	Regular data entry and Annual reconciliation		Some contracts are out of scope for the registry Ability to keep staff in the Authorities trained is sometimes a struggle – with turnover and the responsibility for training with ITI.

Division	Division Group	Contributor Name
Population Health		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Communicable disease occurrence information reported within 24 hours and 7days according to the schedules under the Communicable Disease Regulations under PHA		Laboratories & Clinicians Frontline doctors and nurses report to health protection unit via phone or fax	Chief Medical Health Officer and the Registrar of Disease Registries Health Canada	Monthly Based on Occurrence Monthly	24 hours or less	
TB Annual Report		Lab, clinicians &IPHIS	Regional Report Yearly International circumpolar Surveillance PHAC	Yearly		
STI Audits & Reports		Lab, Clinical	Individual communities clinics/RHSS & CPHO	Quarterly		
Enhance Pneumococcal, meningococcal, Heamophilus B Reporting		Lab, clinicians	CPHO, International circumpolar Surveillance committee & PHAC	Monthly		
Immunizations		Frontline health practitioners submit data to the GNWT by email or fax	DH&SS, Health Authorities, Public Health Nurses Public Health Agency Canada	Monthly Yearly	Depends on the request	The GNWT currently lacks a surveillance system that can produce timely immunization reports. In 2012, the immunization registry was established, but this is still populated by direct entry from written and

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
						excel data submissions
Notifiable diseases: Influenza		Reports from lab samples sent directly to GNWT; Sentinel sites reporting ILI through PHAC	Canadian Public Health Agency	Weekly		
Notifiable diseases: all others		iPHIS system	Public Health Agency Canada	Annual		
Notifiable diseases: Selected		ICS reporting sheets filled out based on hospitalization reports sent to GNWT by fax	International Circumpolar Surveillance	Monthly, Annual review	About one to two months, depending on how long individual is in hospital	
Diabetes Prevalence and Incidence		CIHI DAD, physician billing data, nurse submission of paper CHMIS forms	DH&SS, Health Authorities, National Diabetes	every year	Two to three years	
Cancer Incidence		Canadian Cancer Registry - NWT	DH&SS, Health Authorities	Yearly National Report	Three years	
Cancer - Incidence		CIHI DAD, pathology reports, radiology reports, autopsy reports, physician records	Canadian Cancer Registry	Yearly	Three years	
Cancer Incidence Trends		Canadian Cancer Registry - NWT	DH&SS, Health Authorities	Every 5-10 years	?	

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Cancer Screening Tests		Lab reports	Chief Medical Health Officer , Health Authorities	Quarterly	Several months to one year	
Injury Tracking		CIHI DAD, physician billing records	DH&SS, Health Authorities	Every 5-10 years		
CHMIS (Community Health Management Information System)		Community nursing staff	DH&SS, Health Authorities	Quarterly	Delayed at present. Last year available 2006	Data entry has significant backlog
FMBS: Variance Reports		FIS		Quarterly		
GNWT Report on Drinking Water	Produced jointly by HSS, MACA, ENR, and PWS. Provides detailed water quality and community water system information as well as updates on various projects and activities.	NWT Drinking Water Quality Database	Public, Cabinet, Health Canada and FPT Committee on Drinking Water	Annual	Previous year	

Division	Division Group	Contributor Name
Corporate Planning, Reporting and Evaluation		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Building on Our Foundation – A Strategic Plan for the NWT HSS System 2011-2016	The H&SS Strategic Plan for 2011-2016	Varied Review the business plan for more details. Located on I drive.	DHSS	Every 5 years	Varies	• constant changing and evolving indicators • this plan is developed in conjunction with the Department
The Northwest Territories Health and Social Services System Annual Report	The HSS Annual Report is used to: • Report on system-wide performance indicators; • Provide an update on innovative programs and initiatives in H&SS Authorities; • Satisfy a legislated requirement to report on cost of medical care plan; • Present the financial position of the Department and H&SS Authorities			Annually		
NWT Health Status Report	Profiles of the health status of NWT residents	• DAD • Vital Stats • CCHS • Tobacco Addictions • Immunization • Cancer	DHSS Public	Every 5 Years • NWT Health Status Report 2010 • NWT Health Status Report 2004		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
		• Communicable Diseases • Chronic Disease • Community Services • Census • NWT Surveys				
Performance Measures Report	Tracks indicators that are both relevant to the strategic priorities of HSS and also can provide a signal to problems that may need attention			Quarterly		
NWT Addictions Report	Profiles and provides information about the use of alcohol, tobacco, drugs, as well as gambling of NWT residents	Bureau of Statistics	Public	Every 2-3 years • NWT Addictions Report 2009 • NWT Addictions report 2006		
NWT Youth Smoking Report	Profiles the use of tobacco by NWT youth in grades 5 to 9	Bureau of Statistics	Public	Every 5 years • Youth smoking in the NWT (2009) • NWT Youth Smoking Survey (2002)		
Utilization Reports	Physician Services Report: Profiles utilization of physician services by reason (condition requiring treatment), ranked by an estimation of costs (separate??) Form part of the HSS			Every 5 years		Physicians are the second largest cost area for the H&SS system. A significant portion of physician costs go to treat patients with conditions that are preventable.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
	accountability reporting to the Legislative Assembly and the public. These reports provide information on some of our most vital and costly services (physician services, hospital services and information on access to health centers).					
Ongoing Satisfaction Surveys	Satisfaction surveys are conducted regularly as part of the H&SS system wide evaluation and reporting system			Every 2nd year • Satisfaction with Health Care Services in the NWT • NWT Hospital Satisfaction Report – Stanton and Inuvik (2010) • Community Health Services Satisfaction Report (2009) • Hospital Satisfaction Report (2008, 2006, 2004)		
Ad Hoc reports in support of the other DH&SS divisions and Ministerial request	Example reports; Homecare, Seniors Profile, Nutrition etc.		Support other divisions as required • part of physician negotiations • special supplemental health	Ad hoc		• timing of information • reliability and consistency of the information • CFIS- to put this information into a data mart • incomplete data (missing third party claims/events)

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Health Service Reports		Community Health Data	Public Recipients	5 Years		• missing third party events • increased value with inter-jurisdictional comparable information
Issues brought forward not specifically focused to any report	1. Hospital occupancy rates in hospitals often vary by the number of open beds 2. Completeness of reports can be hindered by the lack of third party information 3. It would be to the benefit of the analysts if no show cases could show on reports 4. It is apparent that the gathering of NGO information for our data bases would be beneficial to our analysts as much of mental health is outside our reporting jurisdiction 5. Reporting of non-insured services such as the mental health clinic and mental health and community wellness workers would significantly increase the data value if it were included in the EMR scope 6. It would be extremely useful to have the true vacancy rates of Health Workers to effectively develop a human resource Community Needs Assessment 7. It will be beneficial to gain access to the CIHI Portal for comparability to other jurisdictions					

Division	Division Group	Contributor Name
Information Services		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
OCIO/IPC: capital project status reports included						
PM: YTD exp. Commitments						
FMBS: Variance Reports		FIS		Quarterly		

Division	Division Group	Contributor Name
Health Services Administration		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Fiscal Accountability/ Program Management			Finance Division	Monthly/quarterly		
Vital Statistics		Photocopies of Registration Forms	Stats Canada Population Health Elections Canada Elections NWT Government of Nunavut Aboriginal Affairs and Northern Development Canada Human Resource Canada	Monthly		Legislated
Variance Reports		SAM	Finance Division	Quarterly		
Migration Reports		HMIS	Provinces/Territories	Monthly		
Health Care Card Issuance		HMIS	Contractor	Weekly		

Division	Division Group	Contributor Name
Medical Travel Services (Stanton)		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Utilization reporting	Comparison of utilization information for similar periods over different years			Annual		
Travel costs by Community				Annual		
Travel costs by type of service	Extensively used for evaluation of services considered to be brought into NWT – comparing to current costs and travel requests (e.g.: reviewing the need for a new CT scanner)			Ad hoc – legislative requests		
Variance Reports		FIS	Finance/FMBS	Quarterly		

Division	Division Group	Contributor Name
Community Wellness and Social Services		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Report of the Director, Child and Family Services	This report is a legislated requirement	Child and Family Services Information System	Legislative Assembly	Annual	Up to 18 years	CFIS no longer supported by the Vendor and must be replaced
NORTH Report	Forms part of the Health Portfolio Contribution Agreement with Health Canada	FNIHB contribution funding recipients	First Nations and Inuit Health Branch, Health Canada	Annual	Up to 5 years	Recipient capacity to collect and submit the required information
Status Reports – Mental Health and Addictions action plan		Program records	Minister	Sessional and as requested	Up to 3 years	
Status Reports – Implementation of Rxs from the Standing Committee Review of the C&FS Act		Program records	Minister	Sessional and as requested	Up to 3 years	
Early Childhood Development Report	Should be in Child and Family Services			2/3 Years		

Division	Division Group	Contributor Name
Territorial Health Services	Territorial Health Services	Donna Allen

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
N/A	Information requests come from different health authorities, Nursing associations, the Maternal Prenatal Committee etc			Ad hoc		
Home Care status report	Report based on program obligations from Federal and NWT requirements	Community Health Management Information System/Authority Narrative Reports	Federal Government	Annual		
Southern placement report	Indicating associated expenditures by southern facility	Through variance reporting process	Deputy Minister	Quarterly		
Southern placement usage requests.	Receiving multiple requests regarding southern program level information covering the combination of both placement facility information and associated travel costs	Coordinator, Southern Placements - Finance		Ad hoc		
Facilities utilization information		CIHI Data	DH&SS – Senior Management	Monthly		
TeleHealth Activity Report	Activity report over a time period		Deputy Minister/ Legislative Assembly	Annual		
Home Care	Essential for funding	Health Suite	Federal Government	Semi-Annual		Defined by Federal and NT Health Care Group
Telecare		Clinadata	DM	Quarterly		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
		Contract service provider	Regional Advisory Committee	Monthly		
FMBS: Variance Reports		FIS		Quarterly		

Appendix B: HSSA Reporting

Background

MNP has been contracted by the NWT Department of Health and Social Services to assist with:

- The development of an inventory of existing performance monitoring and reporting within the system, and working with primary stakeholders to identify system-wide performance and reporting requirements; and
- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities, and creation of an action plan to implement the accountability framework and performance measurement system.

Your help is needed to determine the information collected on a regular basis to inform overall performance, decision making and the reporting obligations of the Health and Social Services Authorities (HSSA) in the NWT.

In Section 1.1 below, please list and describe:

- What information **you regularly collect** and feel is critical to managing performance and informing decision making for your HSSA.
- What information **you believe should be collected, but is not**, and is critical to managing performance and informing decision making for your HSSA.

In Section 1.2 below, please provide a listing of all of the reports that you are obligated to provide to:

- Territorial and/or Federal Government Departments/ Agencies; and
- All other recipients including other organizations, agencies, or the public.

For each report that you are obligated to provide, indicate the following:

- **Name:** The name of each report that you produce/receive.
- **Description & Purpose:** A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation process, etc.)?
- **Performance Indicators:** If there is performance indicators included in the report please specify what they are?
- **Frequency:** How often the report needs to be provided (monthly, annually, etc)
- **Data Source:** Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.
- **Age of Data:** How old is the data that is being used to produce the report?
- **Roll Up for Territorial Level Reporting:** Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?

- **Issues:** Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?

In Section 1.3 below please identify those questions that you are being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific

An MNP representative will be following up with each of you by telephone to discuss further.

Critical Information for Managing Performance

The following information is critical for managing performance and informing decision making for your HSSA.

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
MEDICAL TRAVEL	
Medical travel trip statistics	High level stats such as reasons for medical travel based on acuity.
Financial statistics	The MT system tracks per patient trip, not necessarily vendor trips. i.e. for one charter trip you may have 6 different patients. While we may be aware 6 people travelled we are not aware they were all on one flight. The same would be true for ground transport. We track this manually through excel for medevacs
Medevac spreadsheet – crucial so the medical director can follow up on instances of inappropriate medevacs and create report for all Authorities so they are aware of problems.	Need better information to manage contracts and performance against requirements. Was patient outcome improved?
	Proper approvals for all instances of medical travel. Proper approvals for all escorts
PHARMACY	
Inventory	Pharmacist Workload – To measure clinical impact on patient care. Collect data to justify future increase in FTEs.
Night Cupboard Usage	
Narcotic Discrepancy Reports	
Daily Controlled Med Report	
Month End Billing	
Medications not Loaded	
Outdated Narcotics	
Loading and Unloading (Narcotics)	
Refill Pick and Delivery	
Weekend Narc Refill	
Weekend Narc Load	
Nicotine Usage Report	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
Do Not Use Abbreviations Indicator Report	
Vaccines Purchased	
BIOMED	
Preventative Maintenance Completion Rate – High Risk	
Preventative Maintenance Completion Rate – Non-High Risk	
DIAGNOSTIC IMAGING	
Wait Times	
Quantifying DI Exams	
Utilization of Units, Transfusion	
No Shows	
Turnaround times	
LIST OF REHABILITATION SERVICES INDICATORS **Volume/Quantitative indicators** **MONTHLY REPORTS:** • Waiting times • No show rate • Inpatient attendances – o Nunavut vs. NWT o Adult vs. peds • Outpatient attendances o Nunavut vs. NWT o Adult vs. peds ▪ Preschool vs. school age o Yellowknife vs. Other NWT vs. Kitikmeot (by community) o Telehealth attendances o Homecare, TDF, Avens • Workload Measurement o Direct patient care time o Indirect patient care time o Non-patient care time	Monitor program delivery and impact on client outcomes.

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
• Track in-services given and attended. **Following each Travel Clinic:** • attendances by community o Adult vs. peds • # of service days to each community (includes travel time) • Amount of time spent delivering community service in YK i.e. prep and reports • Amount of overtime accrued during travel. • Actual cost of travel service – transportation, accommodation + per diem. **ANNUAL REPORTS:** <u>Program specific – Outpatients</u> • # of referrals received o urgent vs. routine • # of WCB referrals • # of new patients • # of carry over attendances <u>Program specific– SLP School – indicators for each school</u> • # students referred • # screened/assessed • # requiring follow-up • # discharged • # seen for language • # seen for articulation/phonology • # seen for voice • # seen for fluency • # seen for augmentative <u>Program specific – OT School – indicators for each school</u> • # students referred • # screened/assessed • # requiring follow-up	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
• # discharged Program specific – Infant Hearing Program (also reported to QM committee) • # of infants screened o # screened in Stage 1 – Nursery o # screened in Stage 2 – Audio clinic o # assessed in Stage 3 – full Audio assessment • # of infants passed • # of infants referred • # of infants identified with hearing loss • # of infants identified with risk factors **Clinical Outcomes/Qualitative indicators: (all clinical outcomes reported to QM committee)** Physiotherapy - Outpatients • Lower Extremity Functional Scale (LEFS) • Upper Extremity Functional Scale (UEFS) • Neck Disability Index (NDI) • Oswestry Low Back Pain Disability Occupational Therapy • Functional Independence Measure – Homecare • Goal Attainment Scaling – Preschool • Peabody Developmental Motor Scale – Aboriginal Head Start + Four Plus • Satisfaction Questionnaire – Travel + CDT Speech Language Pathology • Goal Attainment Scaling – Aboriginal Head Start, Four Plus + Schools	
Hospital Wide	
Security Patient Watches	To determine cost effectiveness of current model of service delivery
Patient Watch Uses	As above

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
ER Triage Wait Times	CTAS requirement
ER Left Without Being Seen/Against Medical Advise	High risk issue
Medication Reconciliation Upon Admission	Required Organizational Practice as per Accreditation Standards (ROP)
Mandatory Certifications	
Falls Risk Assessment Upon Admission	ROP
Client Satisfaction	Standard of Care
Surgical Site Infections	ROP
Hospital Acquired MRSA Infections	ROP
Hospital Acquired VRE Infections	ROP
Hospital Acquired C. difficile Infections	ROP
Hospital Acquired Urinary Tract Infections	Identified as above CIHI benchmark.
Maternal/Child Services (Pediatrics/OBS)	
VBAC Rate	All are standards of care
Workplace Hazards	
Breastfeeding Initiation Rates	
Cesarean Section Rates	
Induction of Labour Rates	
Rates of Trauma to the Perineum	
Psychiatry	
Patient Satisfaction Survey	
Suicide Risk Assessment	ROP
30 Day Readmission Rate	
Average Length of Stay	
Workplace Hazards	
Official Languages	
French Language Services	
Aboriginal Wellness Services	
Medicine	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
Patient Satisfaction	
Pressure Ulcers	ROP
Registration	
Declaration Audit sheet	
HMIS Extract	
Daily Census Summary	
Extended Care Unit	
Average of Pressure Ulcers	ROP
Workplace Hazards	
Surgical Services	
Surgical Checklist	ROP
OR No Shows	Measure effective utilization
Health Records	
Incomplete Charts	
Missing Discharge Summaries	
Staff Development & Education	
SafeStart Attendance	
Orientation to Hospital Attendance	
Nursing Orientation Attendance	
CPR, NCI, IV & Cardiac Rhyth	
Certification Exams	
Journal Usage	
	Medipatient does not retain the “date of referral” information once an appointment is booked, therefore making it difficult to track wait time from the date of referral.

Reporting Obligations

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Medevac Report	Track medevacs – for senior management and cabinet. Information can be used to see the financial impacts of not having certain procedures or resources available in the NWT.	Dispatch times and whether the contractor meets the standard of 45 from initial call to wheels up.	Monthly	Data comes from the medical travel system as well as an excel spreadsheet	Can be used for several years	It"s in excel so maybe?	Data integrity and if an error is made in the system it will also appear as such.
Annual medical travel statistics	Used in the STHA annual report and for the Department of Health to show how many NWT residents are transported	Not really, just shows the number of trips year over year.	Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and available as far back as the system began	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Quarterly medical travel statistics	Used by the Department on a quarterly basis to determine where core funding is being allocated. Also accompanies the variance report		Quarterly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system"s introduction	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Annual reports for THSSI funding	Report tracks medical travel utilization over the year. The report is used by the Department to		Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be	Data is constantly evolving and is available from	It"s in excel so maybe?	Data integrity issues. Limited reporting software makes reports

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	offset financial loses to the MT program.			generated	the system‟s introduction		much longer and tedious to generate
FMBS Supplemental funding report	High level reports which need to explain why the MT program is in a deficit situation. This assists the program in obtaining supplemental funding. The reports contain explanations and show stats on why costs have increased or revenues have decreased.		Yearly as required	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system‟s introduction	It‟s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Ad hoc reports for various third parties			Ad Hoc	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system‟s introduction	It‟s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate
Reports for funding entities such as Health Canada (NIHB)	These reports track medical travel statistics and financial costs for this clientele. These reports are required per the contribution agreement between		Yearly	Data comes from the medical travel system and is manipulated in excel so these reports can be generated	Data is constantly evolving and is available from the system‟s introduction	It‟s in excel so maybe?	Data integrity issues. Limited reporting software makes reports much longer and tedious to generate

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
	Health Canada and the GNWT.						
Medical Daycare Unit- daily stats	All of the above	Specifically the numbers and trends	As required	Manual collection into a excel data sheet	Collected daily	no	As it is all manual, the quality of data may not be accurate if staff has not updated the data source.
Endoscopy	Wait list/ Follow up lists	Specifically the numbers and trends	quarterly	From Medi-patient	current	Currently working with the Territorial Endoscopy working group	There are several layers in the wait list so challenging to ensure that when the data is given that the information is correctly understood.
Endoscopy	No show/cancellation	Specifically the numbers and trends	As required	Manual collection into a excel data sheet	Collected daily	?	
Endoscopy	indicators	Currently working with the Territorial Endoscopy working group to determine what should be collected					As it will be a manual collection, it is difficult to determine exactly what should be collected and what will be done with the data.

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Cardiac diagnostics	Wait list/ Follow up lists	Specifically the numbers and trends	quarterly	From Medi-patient	current		
Staff certifications	indicator	% of staff with the appropriate hospital certifications.	quarterly	Report from staff development	Up to 3 mo	?	Cumbersome data collection and manual calculations. Requires staff time.
Medication reconciliation completion	Indicator	% of med reqs completed appropriately	Weekly for quarterly report	Manual by patient chart review	< 2 weeks	?	Cumbersome data collection and manual calculations. Requires staff time!
Endoscopy chart audit	Indicator	% of chart completed appropriately	Weekly for quarterly report	Manual by patient chart review	< 2 weeks	?	Cumbersome data collection and manual calculations. Requires staff time!
Dialysis	Quality indicators						Not currently being done due to cumbersome data collection and manual

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							calculations. Requires staff time!
ER Volumes	Historical numbers of visits to the ER – Required for Contribution Agreement		quarterly	Medipatient – electronically	< 4 weeks	?	
Clinic No-Sows	Historical data pertaining to patient appointments and # of no shows – required for contribution agreement		Quarterly	Manually, review of day sheets	< 4 weeks	?`	Day sheets sometimes arrive late. Report is due the end of the month immediately following the end of the quarter. This means there could be data missing
Medical Travel	Historical Data pertaining to volume of med travel trips and number of escorts – required for contribution agreement reporting		Quarterly	Manually	<4 weeks	?	Because of limitations within the Medical Travel info system, some degree of estimation is required. Not all trips are entered (i.e. if Med Travel does not book the trip)

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OR No Shows	Historical number of scheduled surgeries and the number of times and reasons patients do not show		Quarterly	Manually	<4 weeks	?	Manual system, with no consistency in definitions. Requires manual counting
Workload units for Diagnostic Imaging	Used to determine complement staff, instrumentation and other resource needs – feeds into CIHI	Yes for Stanton	Quarterly for STHA and annually for CIHI	Electronic retrieval from Medipatient	12 months	CIHI data is processed by Finance	
Workload units for Laboratory	Used to determine complement staff, instrumentation and other resource needs – feeds into CIHI		Annually	Electronic from Laboratory Information System – for Stanton	12 months	CIHI data is processed by Finance	
Fecal Occult Blood Tests	Reported to Office of Chief Public Health Officer (OCPHO) – regulated reporting		Monthly	Electronic from Laboratory Information System – for NWT	1 month	To OCPHO	
Blood Product Utilization	National Reporting for Canadian Blood Services (CBS)– monitoring of transfusion practices for each NWT laboratory	Planned for this fiscal Reactivating the STHA Blood Utilization Committee	Monthly	Electronically form LIS	Monthly	CBS format - Excel	
Transfusion /Transmitted	National monitoring of blood product utilization		annually	Part electronic and Manual	12 months	To Public Health Agency of Canada	

Name The name of each report that you produce/receive	Description & Purpose A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation, etc)	Performance Indicators If there is performance indicators included in the report please specify what they are?	Frequency How often the report needs to be provided (monthly, annually, etc)	Data Source (source, manual/electronic, ability to modify) Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.	Age of Data How old is the data that is being used to produce the report?	Roll Up for Territorial Reporting (yes/no) Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?	Issues Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?
Injuries Surveillance System (TTISS) Database						(PHAC)	
Canadian Partnership Against Cancer	National reporting of cancer screening for provinces and territories	Targeted age group screening Yield (outcomes) of screens	Annually	Information is collected in Picture Archiving System and manual data entry of reports This data is collected by the NWT Breast Screening Program	12 months	Data is collected in Excel format and the non-nominal data is also shared with OCPHO	
NWT Breast Screening Program	Data is collected, analyzed and reported by Breast Screening Coordinator	Turn-around-time between exam and report Turnaround time for investigation completion of abnormal exams % of targeted population screened and outcomes	Annually	Information is collected in Picture Archiving System and manual data entry of reports	12	Data is collected in Excel format and the non-nominal data is also shared with OCPHO	

Board Member and/or Community Member Questions

What questions are you being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific
Samples of questions from MLAs in Legislative Assembly and Standing Committees that often require a large amount of manual research and quick turnaround time. Some expectations are unrealistic given the limits for the current systems Series 1 • Please provide the total number of emergency hospital visits for the fiscal year 2011-2012 and the current fiscal year. • Please provide the total number of visits to health centres for fiscal year 2011- 2012 and the current fiscal year. • Of the total number of emergency hospital and health centre visits during fiscal year 2011-2012 and the current fiscal year, how many were alcohol and/or drug related? • Of the total number of alcohol and/or drug related emergency hospital and health centre visits, how many were classified as mental health disorders with self-harming or suicidal indications? • Of the total number of alcohol and/or drug-related emergency hospital and health centre visits, how many individuals were released from care and how many were sent to institutions specifically for alcohol and/or drug treatment? Series 2 • Numbers of SLPs in your HSSA • SLP vacancies – how many and how long • SLP Caseload – how many peds on caseload, what portion of your caseload is peds, what portion is preschool • SLP waiting list – how many and how long is SLP wait list? Does your waitlist for children differ from general SLP waitlist? • Utilization of telehealth - challenges and successes with Telehealth • Any other issues around SLP services to support ECD – e.g. lack of preschool children being identified Series 3 1. (a) Under Section 6(a) and (b) of the NWT Mental Health Act, how many voluntary patients have there been throughout the Northwest Territories hospitals and health centres from the 2009-2010 fiscal year to the present? (b) Of those voluntary patients, how many were admitted into the hospital and how many were denied admittance during the same time period? (c)) Of those voluntary patients denied admittance, how many were reasoned due to lack of beds and/or space during the same time period? 2. (a) Under Section 8(1), what are the specific numbers in which a medical practitioner has had to make an order for detention for a psychiatric assessment from the 2009-2010 fiscal year to the present? (b) Under Section 8(3), how many reports has the Minister's office received since the 2009-2010 fiscal year to the present? 3. (a) Under Section 15(1),what are the specific numbers in which a medical practitioner had to apply to admit an involuntary patient from the 2009-2010 fiscal year to present? (b) Under Section 16(1) and (2), how many applications has the Minister examined, and how many applications were approved, and how many were refused during the same time period?

What questions are you being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific
Series 4 • Exactly how are Medevacs organized for Colville Lake? Where do they originate from (which medevac base services Colville Lake)? • Is it possible to determine how many Medevacs are provided to Colville Lake each year? • Is there any data on response times for trips to Colville Lake? Expected response time? • Any other information that might assist the Minister in responding to Medevac related concerns in Colville Lake?
1. Any requests that involve information based on ICD coding for inpatient statistics is at least 3 months behind due to the fact that once documents for coding are received, it is sent out of the organization for coding. So in order to get statistics for 4th quarter of 2012/2013, we will need to wait until August or September 2013.
2.
3.
4.
5.
6.

Appendix C: Other Jurisdiction Insights

Alberta

Accountabilities: Alberta Health

The Alberta Department of Health has a combined focus in its planning, policy, and funding on health and wellness, including responsibility for certain programs for seniors. The department is also responsible for financial and reporting functions and internal controls with the intentions of:

- Offering reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded;
- Safeguarding the assets and properties of the Province under Ministry administration;
- Providing Executive Council, the President of Treasury Board and Minister of Finance and the Minister of Health information needed to fulfill their responsibilities; and
- Facilitating preparation of Ministry business plans and annual reports as required by the *Government Accountability Act.*

Further, the department sets the strategic policy, standards and regulations, as well as ensuring accountability and the fostering of innovations in health service delivery. The organizational structure of the Alberta Health system is provided in Figure 3.

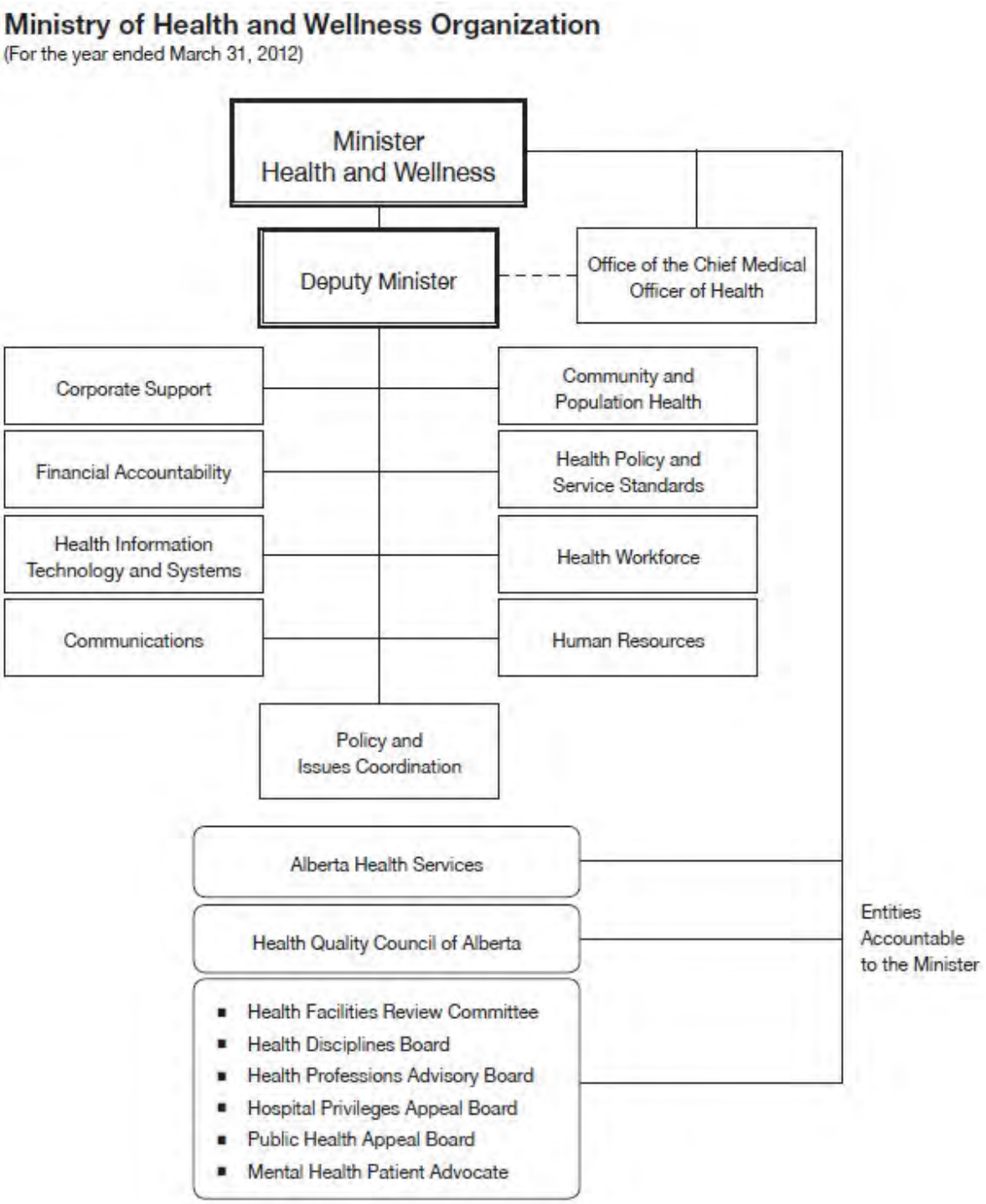
The Minister of Health is held ultimately responsible for the overall quality of health services in Alberta and is responsible for reporting to the Legislative Assembly. The Deputy Minister of the department supports the Minister and coordinates with the CEO of Alberta Health Services to provide direction, communicate government expectations and outline the strategic goals, guidelines and directions of the Provincial government. The Deputy Minister is accountable to the Minister and may exercise all of the powers, duties and functions of the Minister except making of regulations as defined in the Regulation Act.

A number of divisions exist within the Department of Health which are responsible for carrying out key activities for the health system and are accountable to the Deputy Minister.

Alberta Health has delegated the responsibility for the delivery of health services to one provincial authority: Alberta Health Services. Alberta Health Services is governed by a Board and is accountable to the Minister of Health for the delivery and operation of the public health system in Alberta[16]. The Government of Alberta has a five-year funding agreement with Alberta Health Services that expires at the end of fiscal 2014–2015. Alberta Health Services prepares and submits a health plan to the Minister which outlines the performance measures and targets for the organization in accordance with the Regional Health Authorities Act and the direction provided by the Minister of Health[17].

[16] http://www.albertahealthservices.ca/Publications/ahs-pub-2011-2015-health-plan.pdf.
[17] http://www.albertahealthservices.ca/3238.asp.

Figure 7: Organizational Structure of Alberta Health[18]



[18] Alberta Health and Wellness 2011-2012 Annual Report.

Alberta Health Services is responsible for the following legislated mandate:

- Promote and protect the health of the population in Alberta and work toward the prevention of disease and injury;
- Assess on an ongoing basis the health needs of Alberta;
- Determine priorities in the provision of health services in Alberta and allocate resources accordingly;
- Ensure that reasonable access to quality health services is provided in and through Alberta; and
- Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta.

Alberta Health Services has six wholly owned subsidiaries which assist with the delivery of health services in the province.

The Chief Medical Officer of Health (CMOH) is appointed by the Minister under the Public Health Act to monitor the activities of the government, Alberta Health Services, medical officers of health and executive offices on behalf of Albertans to protect and promote public health and prevent disease and injury. The CMOH is accountable to the Minister.

The Health Quality Council of Alberta is responsible to measure, monitor and assess patient safety and health service quality at the request of the Minister or the Alberta Health Services and is accountable to the Minister.

There are number of other entities that are also accountable to the Minister in the Alberta Health System as shown in Figure 3 above.

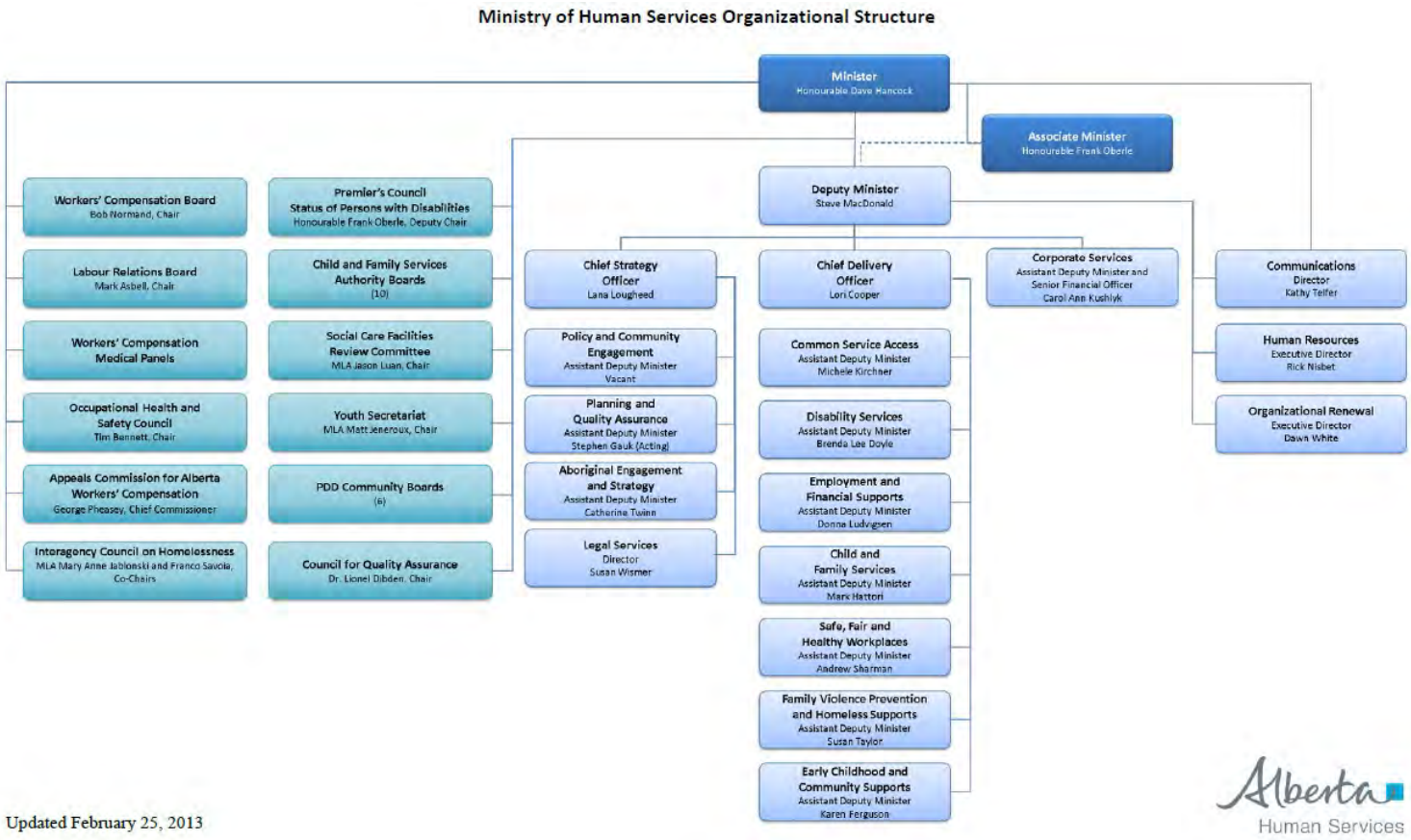
Accountabilities: Alberta Human Services

Alberta Human Services‟ mission is to assist Albertans in creating the conditions for safe and supportive homes, communities and workplaces so they have opportunities to realize potential. Its core business is to work collaboratively with community partners to deliver citizen-centered programs and services that improve quality of life for Albertans[19]. The recently merged Ministry of Human Services includes (Figure 4):

- The Department of Human Services
- Alberta Labour Relations Board
- Appeals Commission for Alberta Workers‟ Compensation
- Child and Family Services Authority Boards
- Occupational Health and Safety Council
- Secretariat for Action on Homelessness
- Social Care Facilities Review Committee
- Workers‟ Compensation Medical Panels
- Workers‟ Compensation Board
- Youth Secretariat

[19] http://humanservices.alberta.ca/department.html.

Figure 8: Organizational Structure for Alberta Human Services[20]



Despite this merger, the executives of the individual entities within the Ministry have retained their primary responsibility and are accountable to the Minister. Collectively, the executives ensure the Ministry complies with all relevant legislation, regulations and policies.

Reporting": Alberta Health

Alberta Health publishes an annual business plan and an annual report which contain 19 performance measures for the Alberta health system (Figure 5). The performance measures are organized into four categories including effective health system accountability, strengthened public health and healthy living, appropriate health workforce utilization, and excellence in health care.

[20] http://humanservices.alberta.ca/documents/organizational-chart.pdf.

Figure 9: Alberta Health Performance Measures[21]

Performance Measures Summary Table

Goals/Performance Measure(s)	Prior Years' Results				Target	Current Actual
Core Business : Leadership and governance						
1. Effective health system accountability						
1.a* Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year	58% 2005/2006	60% 2007/2008	61% 2009/2010	67% 2010/2011	65%	62% 2011/2012
2. Strengthened public health and healthy living						
2.a Smoking: Prevalence of smoking **						
• Alberta youth aged 12 to 19 years	11% 2005	10% 2007	12% 2008	12% 2009	9%	13% 2010
• Young adults aged 20 to 24 years	33% 2005	30% 2007	26% 2008	25% 2009	24%	30% 2010
2.b Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization***						
• Seniors aged 65 years and over	60% 2007/2008	58% 2008/2009	56% 2009/2010	59% 2010/2011	75%	61% 2011/2012
• Children aged 6 to 23 months	64% 2007/2008	43% 2008/2009	16% 2009/2010	25% 2010/2011	75%	29% 2011/2012
• Residents of long term care facilities	94% 2007/2008	95% 2008/2009	91% 2009/2010	90% 2010/2011	95%	91% 2011/2012
2.c Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)***						
• Chlamydia	329 2007	344.7 2008	379.3 2009	356.1 2010	330	371.2 2011
• Gonorrhea	64 2007	60.8 2008	43.8 2009	32.5 2010	50	39.6 2011
• Syphilis	7.3 2007	7.0 2008	7.7 2009	4.7 2010	6.5	2.4 2011
3. Appropriate health workforce utilization						
3.a Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network**	—	—	55% 2008/2009	60% 2009/2010	68%	67% 2010/2011
4. Excellence in health care						
4.a* Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13% 2005/2006	10% 2007/2008	9% 2009/2010	12% 2010/2011	9%	11% 2011/2012

[21] 2011-2012 Health and Wellness Annual Report.

Goals/Performance Measure(s)		Prior Years' Results				Target	Current Actual
4.b	Continuing care:						
	Number of persons waiting in an acute care hospital bed for continuing care	645 2007/2008	754 2008/2009	707 2009/2010	471 2010/2011	375	467 2011/2012
	Number of persons waiting in the community for continuing care	–	1,065 2008/2009	1,039 2009/2010	1,110 2010/2011	900	1,002 2011/2012
4.c	Wait time for hip replacement surgery: 90th percentile wait time in weeks	36 2007/2008	36 2008/2009	35 2009/2010	39 2010/2011	27	40 2011/2012
4.d	Wait time for knee replacement surgery: 90th percentile wait time in weeks	49 2007/2008	46 2008/2009	49 2009/2010	49 2010/2011	35	48 2011/2012
4.e	Wait time for cataract surgery: 90th percentile wait time in weeks	28 2007/2008	30 2008/2009	42 2009/2010	47 2010/2011	30	35 2011/2012
4.f	Alberta Netcare: Number of care providers accessing Alberta Netcare**	29,110 2007/2008	34,200 2008/2009	39,866 2009/2010	– 2010/2011	45,229	– 2011/2012
4.g	Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45% 2007/2008	46% 2008/2009	46% 2009//2010	53% 2010/2011	60%	57% 2011/2012
4.h	Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	29.3% 2007	32.8% 2008	35.1% 2009	38.8% 2010	38%	41.9% 2011

*** Indicates Performance Measures that have been reviewed by the Office of the Auditor General**
The performance measures indicated with an asterisk were selected for review by ministry management based on the following criteria established by government:

- Enduring measures that best represent the goal and mandated initiatives.
- Measures for which new data is available.
- Measures that have well established methodology.

The performance measures for Alberta Health were developed based on the following criteria:

- **Reliability** – information used in applying performance measure methodologies agrees with underlying source data for the current and prior years" results.
- **Understandability** – the performance measure methodologies and results are presented clearly.
- **Comparability** – the methodologies for performance measure preparation are applied consistently for the current and prior years" results.
- **Completeness** – goals, performance measures and related targets match those included in the provincial budget.

In addition to the performance measures published by Alberta Health, Alberta Health Services publishes a quarterly report with 60 performance indicators. This includes 50 that are from the provincial action plan and approved by the Government of Alberta and 10 that are directly related to Alberta Health Services" priority areas. The dashboard from the December 13, 2012 performance report is provided in Appendix F. Alberta Health Services also updates its performance targets every three years within a five-year rolling cycle.

Next Steps for Alberta Health System Indicators

The Government of Alberta relies on a comprehensive set of indicators drawing from the tracking of health care delivery across the province, and focusing on a subset of those indicators at a strategic level. As observed by provincial government staff, the previous focus of indicators was on areas for attention and/or high risks. However, the reporting and progress with such a broad portfolio of metrics can be slow and/or not reflective of the overall achievements of the health sector.

The multitude of measures includes a number of input and/or output focused metrics, as proxies for the intended outcomes of health sector programs and services. The measures will stay in place for internal reference and operational management and there is a current interest in developing a smaller set (around 15) of balanced measures at a high level for provincial reporting. These measures are intended to represent health system outcomes, at the intervention level with a 1-5 year perspective, and include considerations of the social determinants of health. The reporting would be on a longer cycle (annual instead of quarterly); and, the focus will also be on appropriate time frames for the outcomes. For example, patient experience has a shorter term, while health status outcomes have a longer time to demonstrate results.

While the government and associated health services cannot be fully responsible for health outcomes, the future focus may be on building a strong community primary care foundation, health and wellness of the population and health system sustainability. In keeping with the strategic focus of these proposed measures, target setting will shift to the outcome level to encourage innovative problem solving.

Reporting: Alberta Human Services

Alberta Human Services are publishes an annual report and an annual business plan which contain 24 performance measures (Figure 6). The performance measures are categorized by goal. Additional performance measures related to specific populations and programs are reported at a greater level of detail, focusing on program delivery and impacts around:

- Abuse and Bullying
- Adoption
- Disability Services
- Family and Community supports
- Financial Supports
- Foster and Kinship Care
- Guardianship and Trusteeship
- Homelessness
- Newcomer Services
- Working in Alberta

Areas with specific plans and reporting include Homelessness, and Child and Family Services.

In addition to the reporting conducted by Alberta Human Services, the Government of Alberta publishes a report titled „Measuring Up" that reports on progress towards the goals of the government. Goal three in this report is “Strong Communities: Promote strong and vibrant communicates and reduce crime so Albertans feel safe”. The performance measures for this goal include a number of aspects associated with social services at the highest level.

Figure 10: Alberta Human Services Performance Measures[22]

Performance Measures Summary Table

Goals/Performance Measures	Prior Years' Results				2011-12 Target	Current Actual
Goal 1: Vulnerable children, individuals and families are protected and supported in times of need.						
Percentage of children who suffer injury that results in hospitalization or death while receiving protective services	0.1% 2007-08	0.1% 2008-09	0.1% 2009-10	0.15% 2010-11	0%	0.14% 2011-12
Percentage of expenditures in the children/youth/families project and service category of Family and Community Support Services[1]	49.3% 2007-08	48.7% 2008-09	45.8% 2009-10	42.1% 2010-11	50%	46.0% 2011-12
Percentage of Albertans who have information to better help in situations of family violence or bullying:* • Family violence • Bullying	 66%[2] 65% 2007-08	 N/A N/A 2008-09	 73% 65% 2009-10	 N/A N/A 2010-11	 73% 67%	 71% 74% 2011-12
Percentage of adults staying at government-funded women's emergency shelters who report that they are better able to keep themselves and the children under their care safer from abuse	96.1% 2007-08	96.7% 2008-09	96.8% 2009-10	96.8% 2010-11	95%	94.1% 2011-12
The number of children in the permanent care of the Director for whom Adoption or Private Guardianship Orders are granted	509 2007-08	550 2008-09	579 2009-10	551 2010-11	597	531 2011-12
Percentage of children and youth who received child intervention (family enhancement or protective services) and did not require protective services within 12 months of file closure	87% 2007-08	86% 2008-09	90% 2009-10	89% 2010-11	87%	88% 2011-12
Percentage of Aboriginal children in foster care/kinship care who are placed with Aboriginal families	38.5% 2007-08	38.7% 2008-09	39.9% 2009-10	40.7% 2010-11	50%	42.7% 2011-12
Percentage of participants employed after leaving Income Support	61% 2007-08	64% 2008-09	52% 2009-10	63% 2010-11	70%	64% 2011-12
Goal 2: Alberta has a fair, safe, healthy and inclusive workplace and a skilled labour force that contributes to economic prosperity.						
Percentage of clients reporting they are either employed or in further education or training after leaving a skills training program*	73% 2007-08	75% 2008-09	68% 2009-10	72% 2010-11	75%	77% 2011-12

[22] Alberta Human Services 2011-2012 Annual Report.

Goals/Performance Measures	Prior Years' Results				2011-12 Target	Current Actual
Inter-provincial rank of Alberta's labour force participation rate (#1 is the highest)	#1 74.2% 2007	#1 74.7% 2008	#1 74.3% 2009	#1 72.9% 2010	#1	#1 73.7% 2011
Inter-provincial rank of Alberta's First Nations, Métis and Inuit off-reserve labour force participation rate (#1 is the highest)	#1 72.3% 2007	#1 71.5% 2008	#3 69.9% 2009	#1 70.6% 2010	#1	#1 67.7% 2011
Lost-Time Claim Rate: number of lost-time claims per 100 person-years worked	1.98 2007	1.73 2008	1.53 2009	1.41 2010	1.55	1.49 2011
Number of new immigrants to Canada who choose Alberta as their destination	20,860[2] 2007	24,200 2008	27,017 2009	32,650[2] 2010	27,000	30,941[3] 2011
Percentage of employers whose employment practices resulted in no complaints being registered with Employment Standards	98% 2007-08	97% 2008-09	98% 2009-10	97% 2010-11	98%	97% 2011-12
Percentage of collective bargaining agreements settled without a work stoppage (strike or lockout)	98.5%[2] 2007-08	98.9%[2] 2008-09	98.0%[2] 2009-10	99.7%[2] 2010-11	98%	99.0% 2011-12
Percentage of applications, with Board involvement, settled before reaching a formal hearing	56% 2007-08	67% 2008-09	58% 2009-10	55% 2010-11	57%	73% 2011-12
Percentage of decisions rendered within 90 calendar days from the completion of the hearing(s)	96% 2007-08	88% 2008-09	62% 2009-10	81% 2010-11	85%	80% 2011-12
Average number of days from when an appeal is received to when it is finalized: • Standard Appeals	144	172	153	154	135	141
• Complex Appeals	182 2007-08	212 2008-09	180 2009-10	176 2010-11	165	170 2011-12
Percentage of decisions not challenged or overturned	95.9% 2007-08	98.1% 2008-09	97.2% 2009-10	97.8% 2010-11	98%	99.2% 2011-12
Goal 3: In collaboration with communities and stakeholders, the conditions and opportunities are created for Albertans to succeed.						
Percentage of families accessing the Family Support for Children with Disabilities program that indicate the services provided had a positive impact on their child	N/A 2007-08	86.1% 2008-09	N/A 2009-10	89.5% 2010-11	N/A	N/A 2011-12
Percentage of youth receiving Advancing Futures Bursaries who successfully completed their planned studies during the fiscal year	N/A 2007-08	78% 2008-09	79% 2009-10	79% 2010-11	81%	83% 2011-12
Percentage of licensed day care centres and contracted family day home agencies that are accredited and participating in accreditation*	N/A 2007-08	N/A 2008-09	N/A 2009-10	96.3% 2010-11	94%	96.5% 2011-12

Figure 11: Performance Measures for Goal 3 in Measuring Up Report[23]

Goal 3 – Strong Communities – Promote strong and vibrant communities and reduce crime so Albertans feel safe.

Goal Three Performance Measures (audited)	Targets 2011-12	Previous Results	Current Results	Trend → 3 - 5 Years (unaudited)
Public Perception of Safety in the Neighbourhood (see note 9) Percentage of Albertans who feel reasonably safe to very safe walking alone in their area after dark.	82%	82% (2010-11)	82% (2011-12)	
Participation in the Arts (see note 10) Percentage of adult Albertans who participated in arts activities or events.	91.0%	89.5% (2010-11)	86.0% (2011-12)	
Affordable Housing Units (see note 11) Number of affordable housing units approved for development.	667	2,005r (2010-11)	1,212 (2011-12)	
Albertans' Satisfaction with their Local Governments (see note 12) Percentage somewhat satisfied to very satisfied.	80%	72% (2010-11)	77% (2011-12)	
Goal Three Performance Measures (unaudited)				
Support for Albertans with Developmental Disabilities (see note 13) Satisfaction of families/guardians of adults with developmental disabilities with Persons with Developmental Disabilities-funded services.	n/a*	85.3% (2010-11)	n/a*	
Social and Emotional Development (see note 14) Percentage of Alberta children demonstrating:				
Healthy social development	Maintain or improve Alberta's result relative to the national average	Alberta 84.5% Canada 82.6% (2008-09)	**	Alberta
Healthy emotional development		Alberta 83.2% Canada 83.8% (2008-09)	**	Alberta
Violent Crime Rate (see note 15) Rate of violent crime per 100,000 population.	1 per cent annual decrease	-2% 1,513 (2009)	-3% 1,476 (2010)	
Property Crime Rate (see note 16) Rate of property crime per 100,000 population.	3 per cent annual decrease	-7% 5,336 (2009)	-8% 4,908 (2010)	
Volunteerism (see note 17) Percentage of adult Albertans who volunteered in their community.	83.0%	72.3% (2010-11)	80.4% (2011-12)	
Support for Albertans with Low Incomes Who Need Temporary Help (see note 18) Percentage of participants employed after leaving income support.	70%	63% (2010-11)	64% 2011-12	

r – revised

* not applicable (biennial survey)

** The National Longitudinal Survey of Children and Youth was discontinued in 2010. The last results are for 2008-09.

Notes:

Calendar years are presented, for example, as 2011; fiscal years are presented, for example, as 2011-12.

The numbered note references in the tables refer to the Sources and Notes section on pages 57 to 63 which summarizes the methodologies and data sources for each of the performance measures.

For full methodology, refer to Supplementary Information Measuring Up – unaudited, online at www.alberta.ca.

[23] Measuring Up: Progress Report on the Government of Alberta Strategic Plan. 2011-2012 Annual Report.

Next Steps for Alberta Human Services Indicators

There is a current initiative to further combine the multiple processes and points of data collection into a single client tracking system, called Moibus, however, this will take significant amounts of time and resourcing to accomplish. Programs currently collect and report data through internal templates, sharepoint systems, as well as larger client management systems.

Additional work continues through the Social Policy Framework, which is not currently associated with particular indicators or measures but contributes to the qualitative discussion around social policy values and interests, and is intended to inform provincial social policy changes in moving forward.
The Government of Alberta will continue to seek improvements around the foundational indicators of social services, including:

- Child and family services – in Alberta more detailed information is tracked by the Child and Family Services Authority, especially those related to children in care
- Income supports and the related effectiveness and impacts, including the case loads, and comparisons to unemployment/reemployment rates
- Low income cut offs and analysis of poverty rates – this allows for contextual understanding of economic prosperity across all members of the community
- Homelessness and associated vulnerable populations and programs
- First Nations interaction with the system – understanding that First Nations communities have different needs and complexity, to better understand and provide effective programs and services, as well as move towards improving social outcomes in those communities.

Saskatchewan

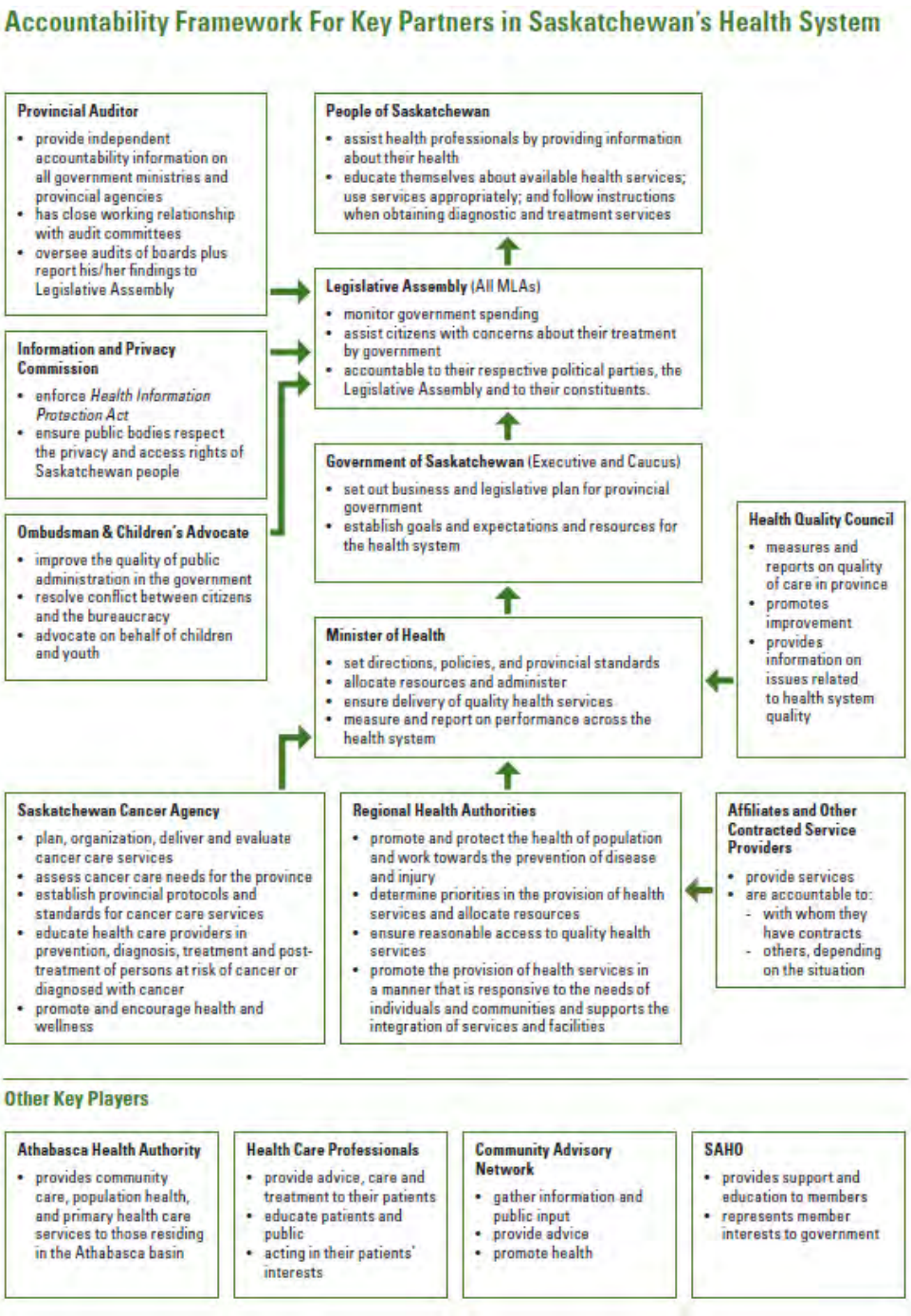
Accountabilities: Saskatchewan Ministry of Health

The most recent version of the Accountability Framework for the Saskatchewan Health system is published in the “Guide to Corporate Governance” developed by the Ministry of Health (Figure 8). Within the framework:

- Members of the Legislative Assembly are accountable to their electorate
- The Government of Saskatchewan, the Minister of Health, the Provincial Auditor and the Information and Privacy Commissioner and the Office of the Ombudsman & Children‟s Advocate are accountable to the Legislative Assembly
- Regional health authorities, the Cancer Agency and health care organizations are accountable to the Minister of Health; and health care organizations and contracted service providers are accountable to the regional health authorities with which they have funding and service agreements.

Each year the Saskatchewan Ministry of Health issues a health-region-specific “Accountability Document”, which sets out the Ministry‟s expectations of regions for the funding that is provided. It contains both high-level organizational (governance and directional) expectations and program-specific expectations for the regions. These expectations are complementary to those articulated in legislation, regulation, policy, and directives. Information in the Accountability Document is intended to clarify the ways that the Ministry of Health will evaluate compliance with expectations.

Figure 12: Saskatchewan Health System Accountability Framework[24]



[24] Guide to Corporate Governance. Saskatchewan Ministry of Health.

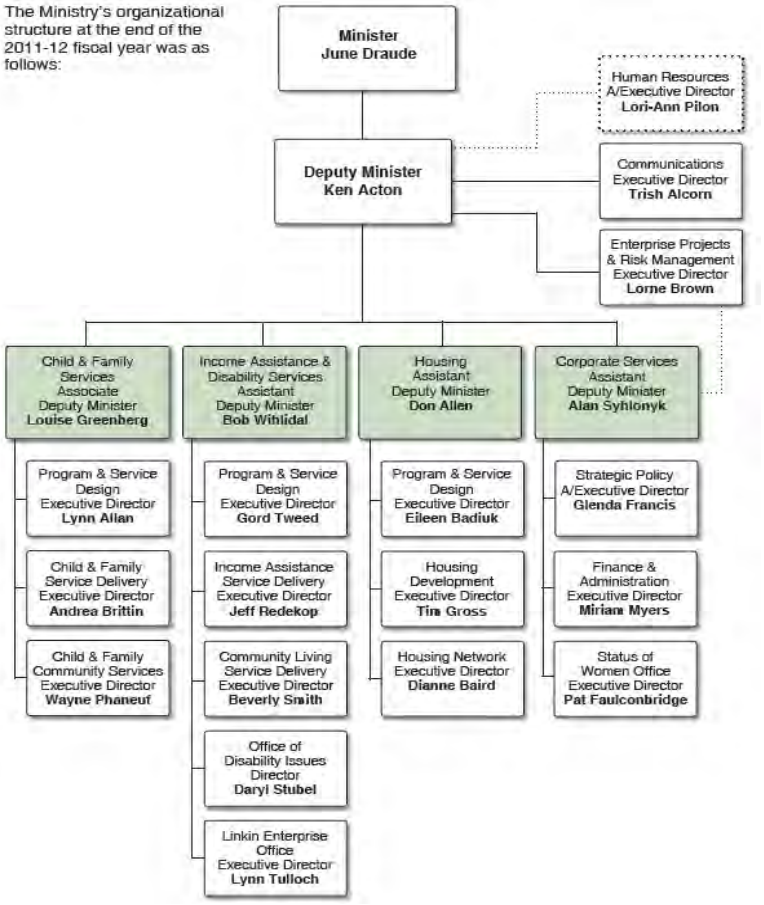
Changes to Health System Accountability

The Saskatchewan Health System has recently changed its approach to strategic planning, which will impact the Accountability Framework documented in Figure 6. However, the nature of these changes is unknown at this time. The new approach to strategic planning is based on Hoshin Kanri. Under this new approach, a provincial health leadership team has been established composed of representatives from Saskatchewan Health, health authority CEOs, Saskatchewan Cancer Agency and other partner organizations. The health leadership team will develop the strategic plan for the Saskatchewan Health system which includes health system performance metrics. Due to this new approach to planning, Saskatchewan Health is reviewing and considering eliminating the Accountability Document with the health authorities. The first Saskatchewan Health System Plan is expected for the 2013/2014 fiscal year.

Accountabilities: Saskatchewan Ministry of Social Services

The Saskatchewan Ministry of Social Services provides child welfare services, income support programs for low-income families, seniors and people with disabilities, social assistance programs for people out of work, housing programs and services to support families and people with disabilities. The Ministry delivers most of its programs through 20 service offices (as well as a number of day offices) in communities across the province. The organizational chart for the Ministry is provided in Figure 9.

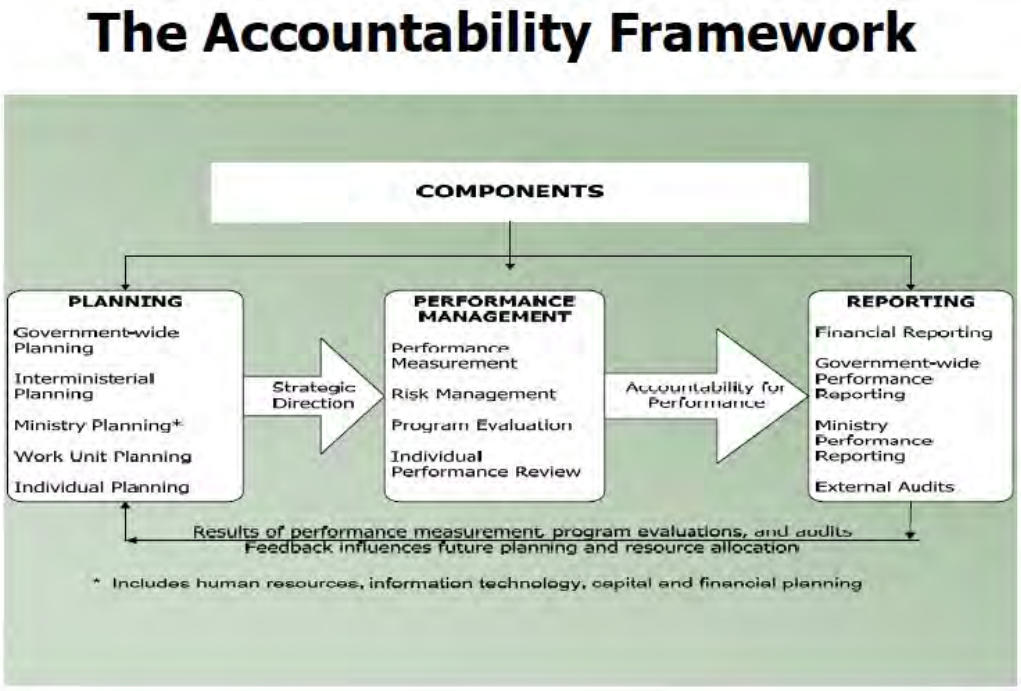
Figure 13: Organizational Chart for Ministry of Social Services[25]



[25] Based on the Ministry of Social Services 2011-2012 Annual Report.

The Government of Saskatchewan has developed an accountability framework that the Ministry of Social Services uses as a basis for developing their planning and performance measurement (Figure 10). There is also a growth plan for the Government of Saskatchewan that has growth targets for the province to the year 2020 that cascade down to the ministries.

Figure 14: Government of Saskatchewan Accountability Framework[26]



Reporting: Saskatchewan Ministry of Health

The Ministry of Health publishes performance measures in its annual reports and annual Ministry plans. The performance measures in the most recent 2011-2012 annual report are not exactly the same as the performance measures in the 2012-2013 Ministry plan. The performance measures in the newly developed 2013/2014 Saskatchewan Health System Plan may also be different, given the new approach to planning that was taken.

The following nine performance measures were published by the Ministry of Health in its 2011/2012 annual report. Included for each measure is a description of the significance of the measure and an analysis of the results. The data sources for each indicator vary depending on the indicator.

- Percentage of patients rating the hospital where they received their care as the "best possible hospital" (10 out of 10) (measures the patient experience and quality of care, tracked by the Health Quality Council)
- Surgery wait time indicators (quality of care indicators, Saskatchewan surgical registry)
    - Number of cases at March 31 that had already waited greater than 12 months for surgery
    - Number of cases at March 31 that had already waited greater than 18 months for surgery

[26] http://www.finance.gov.sk.ca/PlanningAndReporting/AccountabilityFrameworkDiagram.pdf

- Provincial hospital standardized mortality ratio (HSMR) for all Saskatchewan hospitals (quality of care). HSMR is calculated as the ratio of actual (observed) deaths to expected deaths, multiplied by 100 (based on CIHI calculation)
- Attendance Support Indicators. These are tracked and reported because studies suggest that healthy workplace environments in health care tend to contribute to higher quality services and positive work experiences for providers
    - Number of Sick Time Hours per Paid FTE in RHAs/SCA
    - Number of Loss Time Workers Compensation Claims per 100 FTEs* in RHAs/SCA
    - Number of Wage-driven Premium Hours per Paid FTE in RHAs/SCA
- University of Saskatchewan medical graduates establishing practices in Saskatchewan. The retention rate is defined as graduates who, six months after graduation, have been registered by the College of Physicians and Surgeons of Saskatchewan and are practicing in the province
- Financial performance against budget including an explanation for variances

The following seven performance measures were included in the 2012/2013 plan for the Ministry of Health. For each measure, a description is provided along with historical results.

- Better Health
    - Age Standardized Hospitalization Rate for Ambulatory Care Sensitive Conditions (rate per 100,000 population)
    - Tuberculosis (TB) Incidence Rate (rate per 100,000 population)
    - Rate of newly reported HIV cases (rate per 100,000 population)
- Better Care
    - Number of Patients Waiting for Surgery Longer than 6 months and 12 months
    - % Patients rating their hospital experience as 10 out of 10
- Better Value
    - % Health Care Budget Growth
- Financial Summary with projected budget for the upcoming year

In addition to the broad provincial system performance measures noted above, the Ministry of Health also has available on its website annual reports with statistics and specific indicators for the following:

- Medical Services Branch
- Drug Plan and Extended Benefits Branch
- HIV-AIDS Report (Public Health Branch)
- eHealth Saskatchewan

Other Health System Reporting

Reporting on the performance of the Saskatchewan Health system is also available on the „Quality Insight Online‟ website (http://www.qualityinsight.ca/indicators). This website contains over 100 indicators on health system performance and provides the ability to drill down into more detail. This website was developed and is maintained by Saskatchewan‟s Health Quality Council.

Each Health Authority and the Saskatchewan Cancer Agency publish an annual report with performance measures specific for their region.

Data Collection

Currently, data collection within the Saskatchewan Health system involves a number of different databases and systems operated by different partner organizations. A lot of the data that inform the health system performance measures are supplied by the health regions and are consolidated and rolled up by the Ministry of Health. The Ministry also has some databases of collected data. The Saskatchewan Health system is working on a system-wide medical record that will help standardize data collection.

The Saskatchewan Health Quality Council has their own databases and also has contacts in the regions that collect data for them. The organization also administers the patient experience surveys in the province. The Health Quality Council is responsible for managing and collating the data it reports on.

eHealth Saskatchewan is developing a new data warehouse that will be accessible to the Ministry of Health and the Health Quality Council. All three parties are involved in the development of the warehouse.

A lot of the data for quality improvement at specific sites comes from the lean management initiatives. A lot of this is real-time data that can inform where and when improvements are required.

Next Steps for Performance Measurement

The performance measures and targets in the new health system plan are expected to change. The new health system plan may also eliminate the need to have Accountability Documents with the health authorities.

Reporting: Ministry of Social Services

The Ministry of Social Services publishes performance measures in its annual reports and annual Ministry plans. The performance measures included in the 2012/2013 Ministry Plan are aligned with the performance measures included in the 2011/2012 annual report.

The following ten performance measures were published in the Ministry of Social Services 2011/2012 annual report. For each measure, a description of the background of the measure as well as an analysis of the results is provided.

- Housing supply indicators
    - Housing market starts in Saskatchewan urban communities (i.e. population of 10,000 or greater)
    - Saskatchewan Housing Corporation completed units
- Number of families receiving the Saskatchewan Employment Supplement (monthly average)
- Proportion of children in out-of-home care who are placed with extended family members or other persons who have sufficient interest in the child (PSIs). Being placed with extended family, or other caregivers with whom they have an existing and significant relationship, is less emotionally difficult for a child than placement with a foster family whom the child may not know
- Number of families receiving child protection services from the Ministry
- Number of children living in foster homes with more than four placements
- Number of Saskatchewan Assured Income for Disabilities (SAID) beneficiaries (monthly average)

- Number of people with intellectual disabilities living in their own residences through Ministry-funded supported independent living programs
- Percentage of the Saskatchewan population 0-64 years of age who receive social assistance
- Ministry of Social Services Annual WCB Claims

The following six performance measures were included in the 2012/2013 plan for the Ministry of Social Services. For each measure, a description is provided along with historical results.

- Percentage of the Saskatchewan population 0-64 years of age who receive social assistance
- Number of children in out-of-home care
- Proportion of children in out-of-home care who are non-wards
- Housing market starts in Saskatchewan urban communities (i.e. population of 10,000 or greater)
- Saskatchewan Housing Corporation completed units
- Financial Summary with projected budget for the upcoming year

In addition to the provincial system measures noted above, the Saskatchewan Housing Corporation also publishes an annual report which is available on the Ministry of Social Services website. The report provides a discussion on performance measures specific to the Saskatchewan Housing Corporation as well as financial performance.

To inform performance measurement, the Ministry requires quality data in a timely fashion. Currently, most of the data is housed by the divisions in the Ministry which has created some challenges in getting data in a timely fashion[27].

Next Steps for Performance Measurement[28]

The Ministry of Social Services is currently working on improving and strengthening performance measurement by developing a balanced scorecard and focusing more on system outcomes. The Ministry is currently working on this at the strategic level and will cascade down to the divisions over time. The Ministry has worked on identifying its strategic directions and will link performance measures and targets to the strategic plan. There will be a focus on key measures that need to be influenced in the system. The Ministry will report on a small number of performance measures to the public at the strategic level and a larger number of measures internally for operational purposes.

As part of its strategic planning, the Ministry of Social Services has included a risk-management component. The Ministry has identified the key risks to achieving its strategic plan, assessed and prioritized them and assigned risk owners to those which need to be monitored and managed.

The Ministry is working on improving data collection and management through the development of a data warehouse. The data warehouse will allow the Ministry to pull together and manage data from different sources and should improve the quality and timeliness of data for reporting performance using the balanced scorecard.

[27] Based on discussions with representatives from the Ministry of Social Services
[28] Based on discussions with representatives from the Ministry of Social Services

Nova Scotia

Accountabilities: Department of Health and Wellness[29]

The Department of Health and Wellness is responsible for setting strategic direction and provincial policy to ensure services are accessible and timely: developing standards; monitoring, measuring and evaluating quality; conducting financial and human resources planning; administering the allocation of resources; and establishing requirements for information systems. The Department is also responsible for mental health and addiction services, physician services, pharmaceutical programs, primary health care services, emergency health services, continuing care services, public health, physical activity, sport, and recreation.

The Department provides funding to the District Health Authorities (DHAs) and the Izaak Walton Killam (IWK) Health Centre which are responsible for service delivery and resource management of the health and wellness system.

MNP was unable to find a documented accountability framework or organizational structure for the Department of Health and Wellness.

Accountabilities: Department of Community Services[30]

The primary responsibility of the Department of Community Services is to ensure the basic needs of individuals and families are met by providing financial support to persons in need and by protecting children and adults at risk. The department provides funding directly to clients and to service providers who provide prevention, residential, vocational, child care, housing, protection and other social services on behalf of the department.

The department has three core business areas including Housing, Employment Support and Income Assistance, and Family and Community Supports. MNP was unable to find a documented accountability framework or organizational structure for the Department of Community Services.

Reporting: Department of Health and Wellness

The Department publishes performance measures in an Annual Accountability Report and an Annual Statement of Mandate. All of the performance measures in the 2011/2012 Accountability Report and Statement of Mandate were the same. However, there were some differences in the performance measures included in the 2011/2012 Accountability Report and the 2012/2013 Statement of Mandate.

There were a total of 37 performance measures included in the 2011/2012 Accountability Report. For each performance indicator, a description is provided for what the indicator measures, what the current value of the measure is, and future targets. The data contained in the report comes from various sources that have different reporting time periods[31]. The performance measures include:

- Percent of Patients with Total Length of Stay from Triage to Emergency Department Departure within Emergency Care Standards indicators
    - Percent of Canadian Emergency Department Triage and Acuity Scale (CTAS) 1- 3 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 8 Hours

[29] Nova Scotia Department of Health and Wellness 2012-2013 Statement of Mandate.
[30] Nova Scotia Department of Community Services 2012-2013 Statement of Mandate.
[31] Nova Scotia Department of Health and Wellness 2011-2012 Accountability Report.

    - Percent of CTAS 4 – 5 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 4 Hours
- Percent of CTAS 4 – 5 Patients Being Seen in Emergency Departments
- Percent of Time that Paramedics Can Pass Responsibility of Care to Hospital Staff Within 20 Minutes of Arrival to the Emergency Department
- Percent of Patients Receiving Hip and Knee Replacement within National Benchmark. The national benchmark for each of these procedures was set to 26 weeks (or 6 months)
- Percent of Patients Beginning Radiation Therapy (RT) Within 8 Weeks and 4 Weeks
- Number of Facilities with Operating Rooms that Implement a Safe Surgical Checklist
- Health Care Services Offered in French and Number of Health and Wellness Documents Published in French
- Number of Clients Receiving Home Care Services
- Percent of Individuals Waiting for Long Term Care who are Receiving Home Care
- Number of Health Care Providers Using Electronic Medical Record (EMR)
- Retention Rate of New Nurse Graduates
- Percent of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard
- Number of Recommendations in the Auditor General‟s Special Report on Pandemic Preparedness to which the Department of Health and Wellness has Responded
- Number of Recommendations from the H1N1 Lessons Learned Report To Which the Department of Health and Wellness has Responded
- Electronic Health Record (EHR) Initiative – Number of Clinical Users of SHARE (Secure Health Access Record)
- Number of Serviced Patient Calls received by HealthLink 811
- Number of Primary Health Care Providers Who Have Undergone Advanced Self Management Support Training
- Number of Primary Health Care Teams in Nova Scotia
- Number of Chronic Disease Self-Management Program Sessions
- Number of Primary Health Care Teams Offering Advanced Access – Same Day or Next Day Access
- Participation Rates in the Colon Cancer Prevention Program (CCPP)
- Percent of Applicable Response Time Standards Met or Exceeded
- Percent of Service Inquiries Investigated and Closed Within 20 Days
- Number of Cultural Competency Guidelines Implemented
- Breastfeeding Initiation Rate: Percentage of Infants Receiving Breast milk and/or Who Had Early Breast Contact
- Percent of Nova Scotia Population (12 yrs +) Who Report Eating at Least 5-10 Servings of Fruit/Vegetables Per Day
- Percent of Food Insecure Households
- Smoking indicators
    - Percentage of Young Adults Aged 20 to 24 Who Smoke
    - Percentage of Population Aged 25 and Over Who Smoke
- Injury-related Mortality Rate (rate per 100,000)
- Percent of adults (20 years of age and older) Active Enough for Health Benefits

- Percent of Junior High Girls Active Enough for Health Benefits
- Percent of Adults with a Gambling Problem
- Percent of the Nova Scotia Population Aged 15 years and Older and Currently Experiencing Harms from their Drinking
- Human Papillomavirus (HPV) Vaccine Coverage Rate for School-Based Female Population
- Financial results with an explanation of significant variances are also provided in the report.

The 2012/2013 Statement of Mandate for the Department of Health and Wellness includes the following 21 performance measures:

- Percent of Patients with Total Length of Stay from Triage to Emergency Department Departure within Emergency Care Standards indicators
    - Percent of Canadian Emergency Department Triage and Acuity Scale (CTAS) 1- 3 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 8 Hours
    - Percent of CTAS 4 – 5 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 4 Hours
- Percent of CTAS 4 – 5 Patients Being Seen in Emergency Departments
- Number of hours that Collaborative Emergency Centres (CECs) are closed
- Percent change in number of long waiting (1+ years) patients waiting for surgery
- Percent of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard
- Number of new health care providers implementing EMR in their daily practice
- Electronic Health Record (EHR) Initiative – Number of Clinical Users of SHARE (Secure Health Access Record)
- Percent of Nova Scotia Population (12 yrs +) Who Report Eating at Least 5-10 Servings of Fruit/Vegetables Per Day
- Percent of Food Insecure Households
- Percent of Junior High Girls Active Enough for Health Benefits
- Prevalence of 18 years and older who are at risk for or have gambling problems and seek treatment services
- Breastfeeding Initiation Rate: Percentage of Infants Receiving Breast milk and/or Who Had Early Breast Contact
- Percent of women who exclusively breastfeed for at least 6 months
- Prevalence of adolescents aged 13-18 years who engage in organized forms of gambling
- Percent of the Nova Scotia Population Aged 15 years and Older and Currently Experiencing Harms from their Drinking
- Smoking indicators
    - Percentage of Young Adults Aged 15 to 19 Who Smoke
    - Percentage of Young Adults Aged 20 to 24 Who Smoke
    - Percentage of Population Aged 25 and Over Who Smoke
- Retention Rate of New Nurse Graduates
- Projected budget for upcoming year

In addition to the system wide indicators listed above, the Department of Health and Wellness also provides access to the Annual Accountability Report on Emergency Departments which provides statistics and measures specific Emergency Departments in Nova Scotia.

The reporting requirements of the district health authorities in Nova Scotia are mandated in the Health Authorities Act. Each health district publishes an annual report which provides measures specific to each district.

Reporting: Department of Community Services

The Department of Community Services publishes performance measures in its annual Accountability Report and Statement of Mandate. All 17 performance measures listed in the 2011/2012 Accountability Report were the same as the performance measures included in the 2012/2013 Statement of Mandate. For each performance indicator, a description is provided for what the indicator measures, what the current value of the measure is, and future targets. The 17 performance measures include:

- Number and Percent of Nova Scotians Living in Poverty based on the after-tax low-income cut-off (After-Tax LICO)
- Number and Percentage of Children Living in Poverty based on the after-tax low-income cut-off (After-Tax LICO)
- Average Monthly Beneficiaries as a Percentage of the Population based on the average number of people on the department‟s income assistance caseload each fiscal year as a percentage of Nova Scotia‟s population
- Percentage of Income Assistance Recipients with Wage Income
- Youth Assisted to Enhance Employability
- The number and percentage of households unable to access acceptable housing
- Co-operative housing ranking based on the % of co-operative organizations “in difficulty”
- Households Assisted with Health and Safety Repairs
- Public Housing Vacancy Rate
- Number of Children in Care Placed for Adoption
- Number of Child Care Spaces
- Child Care Subsidies based on the percentage of subsidized spaces
- Participation in the Direct Family Support for Children program
- Number of Clients Served by Adult Service Centres
- Number of Services for Persons with Disabilities (SPD) Licensed Facilities with Escalated Non-Compliance
- Licensing Turnaround Time based on the % of the department‟s licenses that meet the 10 day service standard
- Financial results with an explanation of significant variances are also provided in the report.

In addition to the measures listed above, the department also provides access to the Nova Scotia Housing Development Corporation Annual Accountability Report and Business Plan on its website. The 2011/2012 Accountability Report and 2012/2013 Business Plan for the Housing Development Corporation include performance measures specific to the organization.

United Kingdom - NHS

NHS Outcomes Framework 2011/12

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
- I One- and II five-year survival from colorectal cancer
- III One- and IV five-year survival from breast cancer
- V One- and VI five-year survival from lung cancer

Reducing premature death in people with serious mental illness
1.5 *Under 75 mortality rate in people with serious mental illness**

Reducing deaths in babies and young children
1.6.I Infant mortality*
1.6.II Perinatal mortality (including stillbirths)

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition***

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions
2.3.I Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.II Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator needs to be developed.*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at I **30 days** and II **120 days*****

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to inpatients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to I GP services and II dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator needs to be developed based on the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator needs to be developed.*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare-associated infection (HCAI)
- I MRSA
- II *C difficile*

5.3 Incidence of newly acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Ten overarching indicators
covering the broad aims of each domain
Thirty-one improvement areas
looking in more detail at key areas within each domain
Fifty-one indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2011/12 at a glance

**Shared responsibility with Public Health England*

***EQ-5D™ is a trademark of the EuroQol Group. Further details can be found at www.euroqol.org*

****Indicator also included in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator

NHS Outcomes Framework 2013/14

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
i Adults ii *Children and young people*
1b Life expectancy at 75
i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7)
1.3 Under 75 mortality rate from liver disease* (PHOF 4.8)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
i *One- and* ii *Five-year survival from all cancers*
iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
ii Neonatal mortality and stillbirths
iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** * (ASCOF 1E, PHOF 1.8)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **** (ASCOF 1F & PHOF 1.8)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life****** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
ii Proportion offered rehabilitation following discharge from acute or community hospital

NHS Outcomes Framework 2013/14
at a glance

Alignment across the Health and Social Care System

* Indicator shared with Public Health Outcomes Framework (PHOF)
** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
*** Indicator shared with Adult Social Care Outcomes Framework
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Indicators in italics are placeholders, pending development or identification

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out of Hours services
iii NHS Dental Services
4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator is under development*

Improving people's experience of integrated care
4.9 *An indicator is under development* *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Appendix D: Excerpt from Business Process Design Report

Included in the appendix below are excerpted sections from the 2011 Business Process Design Report completed by MNP for the Department of Health and Social Services. These excerpted sections provide detail on accountability concepts that MNP recommends be considered as elements of the accountability framework proposed in Section 8.0.

Key Roles and Responsibilities

Key roles and responsibilities for system participants need to be clearly defined, communicated and understood to ensure a viable and sustainable system. The table below outlines the key roles and responsibilities of the GNWT, Department of HSS, a Governance Board and HSSAs. Mechanisms used to define roles and responsibilities are further defined in subsequent tables: Accountability Mechanisms; and Governance Mechanisms.

Key Roles and Responsibilities

Role	Responsibility	Mechanisms
Government of NWT		
Define the boundaries of authority given to DHSS and HSSAs		- Legislation: acts and regulation
Approve budget and provide sufficient funds		– Finance Board – Main Estimates
Establish legislative priorities for NWT		- Cabinet and Standing Committee
Deliver some back office consolidation functions through departments		- Service agreements
Department of Health and Social Services		
Provide System Direction	Ensure NWT adheres to principles of accessibility, universality, portability, comprehensiveness and public administration	- Canada Health Act
	Understand, measure and report the health status of NWT residents	- Health Status Report
	Set Health and Social System direction and territorial priorities for health and social services	- System Strategic Plan
	Recommend budget to Financial Management Board	- Funding Model
	Establish appropriate funding model and ensure fiscal accountability	- Funding Model
	Establish, maintain and communicate Health and Social Services regulations, acts, standards, policies and directives	– Program Standards – Department Policies – Ministerial Directives

Support and Compliance	Define the programs, services, infrastructure, access, quality and relevance of health and social services	– DHSS Business Plan and Action Plan – ISDM
	Provide services regarding vital statistics, registration of health care, insured services, extended health benefits, and non-insured health benefits.	– Health Services Administration
	Establish expectations of HSSAs • Define limits and boundaries to authority and responsibility assigned to the HSSAs • Define service delivery requirements – insured services and benefits • Define performance requirements, indicators and reporting requirements	– Accountability Agreement
	Ensure compliance with authority and associated responsibilities through reporting process	– Annual DHSS performance and variance reports – Audited DHSS financial statements
System Collaboration	Maintain and build intergovernmental linkages	– Committees – Task Forces
	Communicate to and engage with system stakeholders	– Community level forums – Community Health Services Satisfaction Reports
	Support and collaborate with the NWT HSSA	– JSMC, JLC
	Redirect issues or complaints	– Patient concerns resolution process
Health and Social Service Authority Board		
Accountability	Promote ethical and responsible decision making by establishing a code of conduct and defining organizational values	– Board Charter and by-laws
	Safeguard integrity in financial reporting by having the capacity to understand financial information, hiring reputable external auditors and establishing an audit committee function	– Financial Administrations Act – Governance Terms of Reference and Policies – Audited financial reports
	Ensure timely and balanced disclosures by having a relevant communication structure as defined by any regulatory requirements with a balance between good news and bad	– Board Charter – Quarterly and annual performance and variance reports
	Understand and respect the rights and needs of stakeholders by establishing communication policies, publishing annual reports and other communications to stakeholders	– Community Level Forums – Quarterly and annual performance and

		variance reports
Stewardship	Establish responsibilities of board and management by establishing governance policies, defining CEO, Chair and board member job descriptions, and defining committee structures and mandates	– Board Charter – Position descriptions – Terms of Reference – Policies and By-laws
	Ensure CEO competence, performance and succession	– Position Description – Policies and By-laws
	Understand risk and risk management by identifying the risks, understanding potential risks, and understanding management‟s risk identification and mitigation plans	– Risk Management Plan – Terms of Reference
	Relationship management with CEO, Minister and Stakeholders	– JLC and JSMC – Community level forums
Performance and Effectiveness	Ensure an effective and transparent appointment process that ensures: • Regional and cultural representation • Health and social service sector experts • Functional experts (strategy, operations, finance, communication, HR)	– Board Charter – Policies and By-laws
	Add value through an effective board chair who ensures positive dynamics at the board table	– Position Description – Policies and By-laws
	Add value by measuring individual board members, board as a whole and board chair	– Position Description – Policies and By-laws
	Add value by ensuring a positive board and organization culture • Board orientation, development and training • Board assessment • Recommendation to Government regarding succession of board members	– Board Charter – Terms of Reference – Policies and By-laws
Health and Social Service Authority		
Overall direction and planning	Gather public and other stakeholder input	– Community level forums
	Assess health status and health needs of population	– Community level forums – Health status monitoring
	Define, implement and review organizational policies and by-laws	– HSSA Policies and By-laws
	Comply with acts, regulations, territorial policies and ministerial directives	– DHSS Strategic Plan
Relationship management	Between Board and Minister of Health and Social Services	– Joint Leadership Committee
	Between Department (DM, ADM and department directors) and HSSA (CEO and management)	– JSMC, committees, task forces

	With regions, communities and NWT residents Community relations function Approach will be different within each region or even community depending on context	– Community level forums o Print and Radio, etc – Patient concerns resolution process
	With other stakeholders (professional associations, NGOs, special interest groups)	– Working Groups – Committees
Service delivery integration	ISDM implementation through Regional Delivery Centres	– HSSA Policies – HSSA Business Plan / Action Plans – Task Force
	Medical Officer of Health, hospital privileges, medical staff bylaws	– Policies and By-laws – Committee
	Define, implement and review clinical service delivery standards	– Policies and By-laws – Task Force
	Contractual arrangements with NGOs for service delivery	– Service agreements
	Medical travel coordination and administration	– HSSA Policies – Committee
Fiscal management	Establish fiscal policies and internal controls	– Financial policies and by-laws
	Budget, allocate and report financial resources for service delivery	– Budgets/projections
	Review fiscal performance and variance reports quarterly and take required action	– Quarterly and annual HSSA performance and variance reports – Audited annual HSSA financial statements
Risk management and Quality Assurance	Define, implement and support a risk management process	– Identify, mitigate, manage and report risk
	Address concerns from NWT residents or through Department	– Patient concern resolution process
Performance management	Monitor, evaluate and report delivery of quality health and social services	– Quarterly and annual performance and variance reports o Performance indicators o Measurement tools
	Respond to compliance and performance concerns	– Quarterly and annual performance and variance reports

The previous table provides a detailed summary of the roles, responsibilities and mechanisms for accountability. The table below further defines the authority relative to each system participant and provides a summary of responsibility and methods for communication.

Summary of Roles, Authority, Responsibilities and the Methods for Communication.

Role	*Authority*	*Responsibility*	*Methods*
GNWT Provide overall direction & support	Within limits, decides on and delivers: • Policies, strategic priorities and goals Within limits, delegates authority to DHSS • Health and social services	• Define policies, strategic priorities and goals • Define delegated authority • Provide sufficient resources to DHSS to fulfill authority and responsibilities • Deliver some back office consolidation	• Acts and Regulations
DHSS Provide direction & implementation support	Within limits, decides and delivers: • Strategic priorities and service delivery standards Within limits, decides and delegates responsibility to deliver: • Services and programs Within limits, delegates authority for: • Back office consolidation • Clinical collaboration	• Define strategic priorities for health system • Define core services and programs standards, performance indicators, and ensure compliance • Define delegated authority and responsibilities • Provide sufficient resources to divisions of DHSS and NWT HSSA to fulfill delegated authority and responsibilities • Coordinate efforts with other GNWT departments	• Special Ministerial Task Forces • Strategic Plan • Accountability Agreement with NWT HSSA • Joint Senior Management Committee • Joint Leadership Committee
HSSA Implementation	Within limits, decides and delivers: • Services and programs • Clinical standards Within limits, decides and delegates responsibility to deliver: • Back office consolidation • Clinical collaboration	• Define vision, mission and values for HSSA • Define decisions made • Define and deliver system integration • Deliver defined tertiary services to residents of territory • Deliver assigned secondary services to residents of region and territory • Deliver assigned primary services to residents of region • Deliver assigned clinical coordination, back office consolidation, or clinical support consolidation • Gather input and feedback from communities	• Board committees • Strategic and Business plans with financial forecasts/budgets • Accountability/Contribution/ Service agreements with GNWT and NGOs as required • Business and action plans with financial forecasts/budgets • Hospital accreditation process • Community level forums

Accountability Mechanisms

Accountability mechanisms outlined in the table below will help to ensure successful implementation of the recommended system structure. To more clearly communicate accountability to HSSAs we are recommending the development of an annual accountability agreement. This is discussed in more detail in a subsequent section.

Accountability Mechanisms

Role	Mechanism	Description
Communicate Roles, Responsibilities and Expectations		
Department of H&SS	Ministerial Directives	Provides direction to DHSS and HSSAs regarding performance expectations on special events or emerging issues. Should a special event or an emerging issue become a permanent situation then policies or standards will need to be developed or updated
	Program Standards	Provides direction to DHSS and HSSAs regarding program performance expectations on permanent programs
	Clinical Standards	Provides direction and guidance to DHSS, HSSAs, and clinicians regarding clinical standards of care and expectations
	Department Policies	Provides direction to DHSS and HSSAs regarding general performance expectations on a specific situation
	System Strategic Plan	Based on Budget Address, Legislation and Main Estimates – outlines current state, vision, mission, values and system strategic priorities
	System Business Plan	Based on System Strategic Plan – outlines department structure, services, communication strategy, operational requirements and associated departmental projections
	System Action Plan	Based on System Business Plans - details projects and required actions with associated outcomes, responsibilities, timelines and required resources
	Accountability Agreement with HSSA	An agreement between the DHSS and the HSSA outlining authority, roles, responsibilities, performance expectations, accountability and funding
	Contribution Agreements	Provides direction to NGOs and other governments regarding contracted service delivery, roles, responsibilities, performance expectations, accountability and funding
H&SS Authority	HSSA Business Plan with budgets or projections	Provides direction to HSSA regarding structure, services, communications, operations, resource requirements (people, financial and infrastructure) and associated performance indicators
	Contribution Agreements	Provides direction to NGOs and other governments regarding contracted service delivery, roles, responsibilities, performance expectations, accountability and funding
Communicate Performance and Variance to Expectations		
Government	Public Accounts	Consolidated financial statements for all departments within

Role	Mechanism	Description
of NWT		the GNWT
Department of H&SS	NWT Health Status Reports	Published every five years, it provides a measure of NWT population‟s health and well being
	Annual Report	Published annually to provide a snapshot of the health and social services system performance against goals including summary of expenditures
	Performance Measures Report	An annual report on progress against the defined system performance measures (can be combined with the annual report)
	Patient/Client engagement summary	Report most recently published in 2009 based on satisfaction questionnaires distributed during 2008
	Patient Concern Resolution Process	Defined process in collaboration with the HSSA to examine and address patient concerns
H&SS Authority	Quarterly and Annual HSSA Performance and Variance Reports	A report of HSSA performance against expectations detailed in the accountability agreement
	Annual Audited HSSA Financial Statements	Provides a measure of system financial performance and how it compares to expectations detailed in the annual accountability agreement

Challenges in Current Framework (2011)

In our opinion, the current health system framework does not ensure sufficient accountability and has inadequate controls. This is due to a number of factors:

- The DHSS has not specifically defined or communicated consistent program standards and associated performance indicators to measure outputs or outcomes of funded programs and services. This is required to communicate consistent system and program performance expectations, measures and indicators within an Accountability Agreement. This will ensure HSSA reports provide the data and information required to communicate HSSA performance and as a result system performance.
- The DHSS does not have adequate capacity to provide feedback to, or follow up with, eight HSSAs regarding the required content or timeliness of HSSA annual reports or financial reports. This is required to understand HSSA and system performance and ensure compliance.
- The HSSAs have limited capacity (human resources and information systems) to measure and report on program and service delivery performance indicators. This is required to understand system performance.

This section provides direction to address challenges that have been identified in the framework.

Service Delivery Expectations

Service delivery expectations need to be developed and documented for the system. In particular, access points should be defined for all primary, secondary and territorial services along with the required infrastructure and resources. This is required to support a funding model and define service and program delivery expectations for each HSSA.

Program Standards

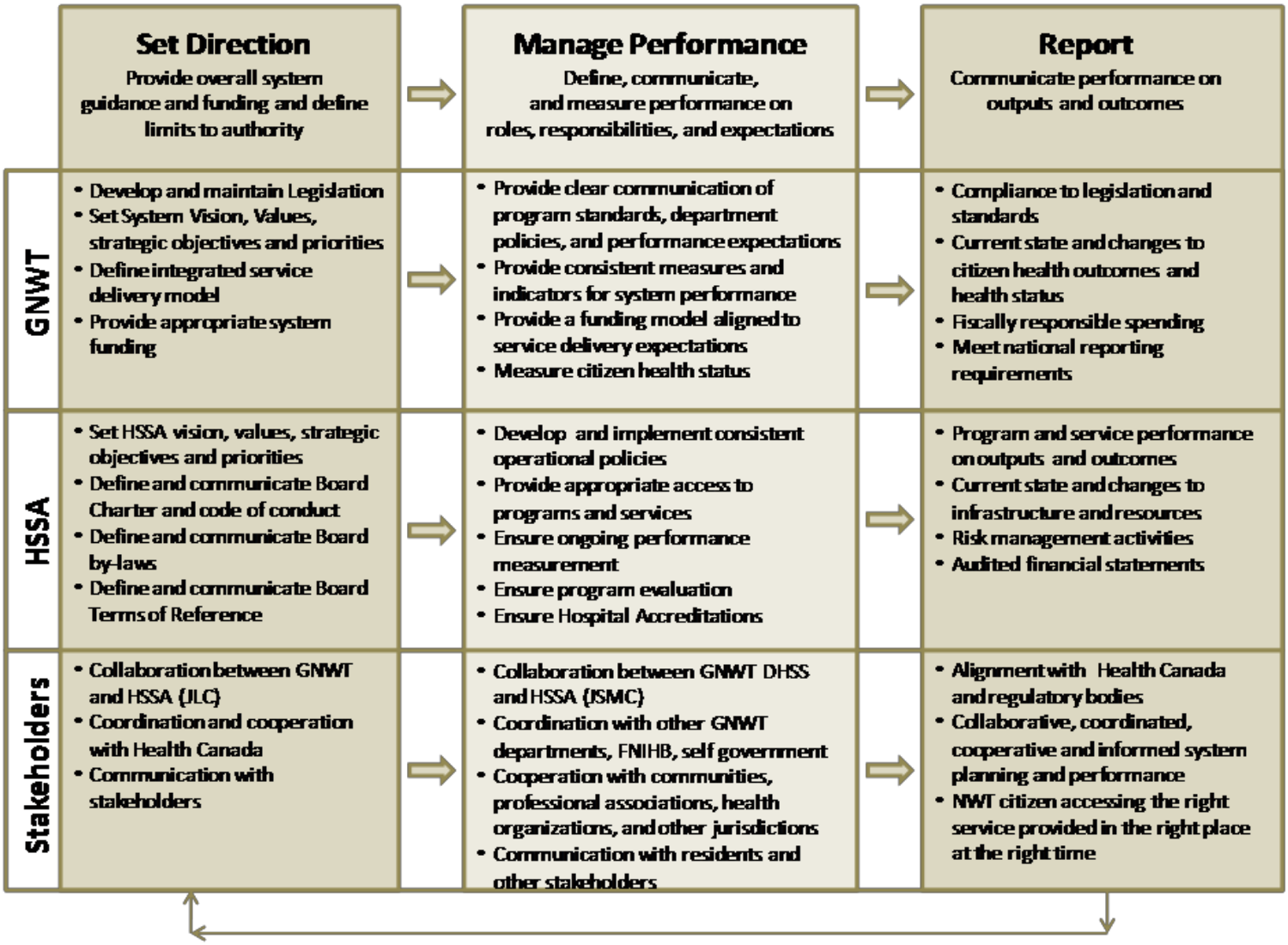
Program Standards have not been consistently defined for all HSS programs. In addition, some that have been defined are not always relevant for NWT delivery. Program standards are required to communicate performance expectations and associated performance indicators to HSSAs.

System and Program Performance Indicators

To understand HSSA and system performance, consistent system and program performance indicators must be developed. Data collection tools and resources will also be required to ensure indicators are measured and data is collected, analyzed and findings are presented in required reports. This will increase the system‟s ability to ensure compliance and control, quality assurance, and risk management.

Recommended Accountability Framework (2011)

An accountability framework provides a visual representation of health and social service system management roles, responsibilities, performance expectations, and reporting measures. A recommended framework was developed during the Business Process review completed in 2011 and is presented below. This accountability framework served as the starting point for development of the framework presented in Section 8.0.



Accountability Agreement

As identified in the section on accountability instruments, to more clearly communicate accountability to HSSAs we are recommending the development of an Accountability Agreement. The purpose of this agreement is to ensure mutual understanding of roles, responsibilities, associated performance expectations, required resources, and reporting requirements to ensure accountability. To reinforce the accountability framework proposed, the current Contribution Agreement will need to be modified. The outline presented in the table below is an initial recommendation that should be reviewed and modified by the DHSS as required.

Accountability Agreement

Agreement Section/Schedule	Description	Current State
Sections 1 through 12		
Section 1.0 Purpose of Agreement	Refers to relevant Legislation and Acts (compliance). Defines overall Mission: To promote, protect and provide for the health and wellbeing of the people of the NWT. Wellness, Accessibility and Sustainability. Defines purpose of agreement: To communicate roles, responsibilities, performance expectations, reporting requirements and associated funding allocations to the HSSAs.	Does not exist currently
Section 2.0 Definitions	Provide definitions for key terms used in the Agreement.	Currently exists as Section 1.0 Will need to be updated with additional terms used within new Schedules
Section 3.0 Term	Timeline of agreement. For example: April 1, 2011 to March 31, 2012.	Currently exists as Section 2.0
Section 4.0 Financial Contribution and Related Provisions	Define the total amount to be paid and payment installment amounts and dates. Will refer to relevant schedules: • Schedule 6 – Financial Administration • Schedule 7 – Compliance • Schedule 8 – Budget	Currently exists as Section 3.0 and Schedule 2 Will need to be updated to refer to appropriate Schedules
Section 5.0 Accountability	Defines Accountability and refers to relevant schedules: • Schedule 2 – System Integration and Planning • Schedule 3 – Performance Requirements • Schedule 4 – Special Projects • Schedule 5 – eHealth • Schedule 7 – Compliance	Replaces current Section 4.0 on Reporting and Evaluation Will need to be developed

Agreement Section/Schedule	Description	Current State
Section 6.0 Audits and Inspections	Defines expectations and process for GNWT audit or inspection.	Currently exists as Section 5.0 Will need to determine if information is still valid.
Section 7.0 Confidentiality	Defines expectations regarding confidentiality. Refers to relevant Legislation.	Currently exists as Section 6.0
Section 8.0 Liability and Indemnity	Defines responsibility of GNWT and HSSA regarding liability and indemnity.	Currently exists as Section 7.0
Section 9.0 Insurance	Defines expectations regarding insurance. Refers to Schedule 9.	Currently exists as Section 8.0
Section 10.0 Termination	Defines rights of GNWT regarding termination.	Currently exists as Section 9.0
Section 11.0 Dispute Resolution	Defines protocol for dispute resolution between GNWT and HSSA.	Currently exists as Section 10.0
Section 12.0 General	Defines protocol for amendments, notifications, and other general statements. Contact information for both GNWT and HSSA.	Currently exists as Section 11.0
Schedules 1 through 9		
Schedule 1 General	Provides a description of the schedules‟ purpose, current state and future development. This section will also identify the Schedules that are currently under development and therefore require updating on an annual basis.	Does not currently exist
Schedule 2 System Integration and Planning	Outlines the limits of authority (scope of decision making), roles and responsibilities, and accountability. Provides detail regarding the expectations and required protocol for community engagement, system planning, and system integration.	Does not currently exist
Schedule 3 Performance Requirements	Provides detail regarding system performance expectations for clearly defined core services that align to the ISDM. This section will also identify any program standards that need to be followed along with performance indicators, associated measures and variance resolution.	Does not currently exist
Schedule 4 Special Projects	Defines any special projects or programs that are not core-funded and identify associated agreements and funding allocations.	Does not currently exist

Agreement Section/Schedule	Description	Current State
Schedule 5 eHealth	Identifies performance requirements for the collection, storage and use of data and information for health system management and defines expectations regarding eHealth.	Does not currently exist
Schedule 6 Financial Policies and Protocol	Identifies performance requirements for effective financial management and administration. This would include reference to applicable Legislation, policies, and protocol. Please refer to Table 6 Financial Instruments and Table 7 Financial Protocols for more information	Some information can currently be found in Section 3.0 Will need to be supplemented by additional information on financial policies and protocol
Schedule 7 Compliance	Outlines compliance protocols. For example reporting format, content and timing requirements, rewards for successful performance, and consequences or required interventions for poor performance. This section should include a summary table of all required reporting and timelines to monitor compliance.	Currently exists as Schedule 3. Will need to be supplemented by detail regarding reporting format and content.
Schedule 8 Budget	Defines the budget. Ensure the budget is aligned with performance expectations of service delivery and administration responsibilities as defined in legislation, accountability agreement, policies and program standards.	Currently exists as Schedule 1 and Schedule 1.1. Will need to be revised categories in funding model
Schedule 9 Insurance Requirements	Detail regarding HSSA and GNWT responsibilities regarding insurance.	Currently exists as Schedule 4.

Appendix E: Selected Indicators

Quadrant	Dimension	Indicator #	Indicator (s)	Frequency of Reporting	Recommended Data Source	Notes
Inputs & Characteristics						
	Leadership and Governance	**1**	The quarterly proportion of actual HSSA expense under or over projected expenses (variance reporting).	Quarterly - internal Annually - external	DHSS (Finance)	
		2	The proportion of HSSAs with published, current operating (health and social service) plan and annual report	Annually	DHSS	An annual manual count
	Health and Social Service System Resources	**3**	The rate of critical incidents per 1,000 employee days worked	Annually	DHSS	
		4	Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)	Annually	DHSS (Human Resources)	Currently reporting
	Efficient Allocation of Resources	**5**	Average wait times by type of surgery (time of booking to surgery)	Annually	Stanton HSSA	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.
		6	Average wait time for offer of placement in a long-term care facility	Annually	DHSS (TAC)	Information should be readily available. May require template creation
	Adjustment to Population Health Needs					
	Health and Social Service System Innovation & Learning Capacity	**7**	Rate of adoption of newly established clinical standards of care	Annually	Committee to develop	This indicator on the rate of adoption of newly established clinical standards of care provides information that is important from a compliance perspective, and also in the context of the receipt of $500,000 in new funding to support the related work of a committee on developing these standards. Note that this committee could play a role in further specifying the reporting on this indicator.
Outputs						
	Access to Comprehensive Integrated Health and Social Services	**8**	Utilization rate of tele-health technology for patient care activities	Annually	DHSS	Tele-health technology represents a strategic priority for the GNWT, and there have been substantial investments put toward its use.
		9	Number (%) of children receiving child welfare care in their home community: by age group and demographic (Aboriginal)	Annually	DHSS	Will require template creation
		10	The number of patients and the number of escorts using the medical travel program per fiscal year	Annually	DHSS	
	Health Protection, Health Promotion, and Disease Prevention	**11**	Proportion of the population receiving: full immunization coverage by the age of two years	Annually	Population Health	This is an important measure for the health and social services system, however currently challenges will be faced collecting this data. Felt to be important enough to remain.
		12	Incidence **rate** of sexually transmitted infection in NWT	Annually	Population Health, NWT Bureau of Statistics and Public Health Agency of Canada	
	Quality, Safety and Appropriateness of Health and Social Service Services	**13**	Average number of critical incidents reported: a) per 1,000 inpatient bed days, and b) per 1,000 outpatient visits	Annually	DHSS	Will require template creation. There is a patient safety framework under development by the department and that has linkages to this indicator.
		14	Average number of placements per year per child: Aboriginal and non-Aboriginal	Annually	DHSS	Will require template creation
	Patient Experience with Health and Social Service Services	**15**	Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year (e.g. Hospital year 1, LTC year 2, Primary Health year 3)	Annually	DHSS Survey	Would report different sites each year (eg. Hospital, LTC, Primary Health, Outpatient). As noted earlier, there is a need to report on the quality of experience for those utilizing mental health and substance use services. Satisfaction of experiences with medical travel is another category, although this might ultimately become a separate questionnaire that is administered by phone, as contact information is available. This indicator should draw on the work of the Institute for Citizen Centered Service (http://www.iccs-isac.org/cmt/about-the-cmt/) including the use of scaled questions on the importance of, and satisfaction with, aspects of experience such as the ease of access (location, physical access, hours of service, use of alternative means including online, etc), timely provision of the service, being treated with respect and empathy, protection of privacy, receiving the service that was needed, and access to needed, understandable information. Currently, this type of surveying occurs within facilities and is carried out by administrative staff, on a given month in a calendar year. There are inconsistencies in the administration of these surveys across the regions and
	Efficiency and Effectiveness of Health and Social Services	**16**	Percentage of no-shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA	Annually	DHSS	This indicator provides for an understanding of "lost access" for other participants in the health and social services system. The collection of related data is now more consistent and covers a range of health and social services.
Outcomes						
	Improve Health Status of NWT Citizens	**17**	Incidence rate of cancer by type	Annually	DHSS	Report on types on rotating basis (e.g. Breast year 1, colorectal year 2, lung year 3 then repeat)
		18	Incidence rate of diabetes	Annually	DHSS	
		19	Self-reported health status of NWT residents	Annually	Stats Canada Survey	Annually may show little variation, but very relevant to the public
	Improve Health and Social Service System Responsiveness	**Repeat of # 5**	Average wait times by type of surgery (time of booking to surgery)	Annually	Stanton HSSA	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.
		20	Average length of time between specialist referral and specialist appointment	Annually	DHSS	It will be important in defining this indicator to consider the points in time that are being captured. For example, the time of physician referral to the specialist confirmation of an appointment, and then from the time of specialist confirmation to the actual appointment. Note that the data associated with this indicator pertains to specialist appointments that take place within the Northwest Territories (i.e., referrals to specialists in jurisdictions such as Alberta are excluded).
	Improve Value for Money					
Social Determinants of Health						
	Genetic Endowment	**21**	The proportion of children who are developing well at school entry	Annually	Education Culture and Employment	Wil need to work closely with ECE to develop tracking mechanism
	Social Position					
	Life Conditions	**22**	Percentage of NWT population who smoke	Annually	Cdn Community Health Survey	
		23	Percentage of NWT population with reported substance abuse issues	Annually	Stats Canada & DHSS	Annually binge drinking reported via Stats Canada & every 3 years detailed DHSS survey
		24	Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child	Annually	DHSS	Requires determination of whether Social Services can track.
		25	Percentage of NWT population who are obese	Annually	Cdn Community Health Survey	
	Physical Environment					

Appendix F: Non - Selected Indicators

Quadrant	Dimension	Indicator #	Indicator (s)	Notes
Inputs & Characteristics				
	Leadership and Governance			
	Health and Social Service System Resources	**26**	Number of WCSS claims	Not identified as a priority
	Efficient Allocation of Resources	**27**	Physician utilization (#) of electronic medical records by community with EMR	There is an expectation that 100% of physicians will utilize so no need to measure
		28	Average wait time for placement in a long-term care facility	Average wait times for the offer of placement was deemed more important than this indicator, and actual placement is influenced by personal decisions regarding the location of the facility. As continuum of care strategy evolves may want to reconsider including this indicator
	Adjustment to Population Health Needs			
	Health and Social Service System Innovation & Learning Capacity	**29**	Utilization rate of tele-health technology for learning activities	Not deemed a priority at this time
Outputs				
	Access to Comprehensive Integrated Health and Social Services	**30**	Average percentage of individuals with mental illness who are satisfied with the access to, and quality of care	Merged into indicator # 14 (satisfaction questionnaire). Although there have been difficulties in the past in terms of rate and level of response, it is important to have an indicator on the quality of experience with mental health and substance use services.
	Health Protection, Health Promotion, and Disease Prevention	**31**	Percentage of mothers with new borns who participated in a pre-natal care program (by community)	Identified as a key priority for the future
		32	Average readmission rate for mental health diagnoses	Difficult to collect reliable data
	Quality, Safety and Appropriateness of Health and Social Service Services	**33**	Average number of child placement changes per year	Indicator # 13 determined to be more suitable
		34	Incidence rate of facility (Hospital, LTC) acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) in NWT	Originally on the short list, but DHSS advised to drop. Currently being reported
		35	Average percentage of biomedical equipment replaced based on life cycle schedules	Not deemed relevant to intended audiences
		36	Proportion of children who are investigated as a result of a new allegation of abuse or neglect within one year following closure of their child welfare file	Identified as a key priority for the future
	Patient Experience with Health and Social Service Services	**37**	Percentage of NWT residents reporting unexpected harm to self or an immediate family member while receiving care	Not feasible at this time
	Efficiency and Effectiveness of Health and Social Services	**38**	Average rate (proportion) of emergency room visitation by level of urgency	Not deemed a priority
Outcomes				
	Improve Health Status of NWT Citizens			
	Improve Health and Social Service System Responsiveness	**39**	Percentage of individuals with a designated GP or NP	Turnover and locums make the reliability of this indicator questionable. Keep on the radar as most other jurisdictions in Canada have this as a key indicator
		40	Average Emergency Department wait time (Cdn ED Triage and Acuity Scale (CTAS))	Identified as a key priority for the future
	Improve Value for Money			
Social Determinants of Health				
	Genetic Endowment	**42**	Incidence rate of select genetic conditions	Not deemed relevant to intended audiences
		42	Incidence rate of FASD	Identified as a key priority for the future
	Social Position	**43**	Income disparity between highest 10% and the lowest 10%	DHSS made decision to drop this indicator. It will be accounted for by the government wide anti-poverty strategy

Appendix G: Selected Indicators: Detail

Indicator # 1	
HSSA quarterly variation of projected expenses to actual expenses	
What is being measured?	The proportion of actual HSSA expense under or over projected expense.
Why is this of interest?	HSSAs are provided with an annual budget to adminster and deliver health and social services in their respective regions, and financial variance reporting is a means to ensure accountability in the system .
What does this tell us?	The number of HSSAs whose expenses are greater or less than budgetted for particular line items. This will provide insight to the DHSS regarding aa potential need for budget adjustment, and/or that a particular HSSA requires assistance re: budget mandgement.
How are we doing?	TBD
Frequency of reporting	Internal – quarterly External - annual
Data Source	DHSS (Finance)
Notes	N/A

Indicator # 2	
Number of HSSAs with published, current operating (health and social service) plans and annual reports	
What is being measured?	The proportion of HSSAs that have a: A) Health and Social Service Plan B) Annual Report
Why is this of interest?	Annual health and social service plans and reports are a means by which a HSSA can be held accountable to those that they serve. These plans and reports provide a tangible means for a HSSA to articulate its plans and results.
What does this tell us?	Whether individual HSSAs have articulated plans for service delivery, and the degree of consistency or variation between them.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Individual HSSAs
Notes	Will be an annual manual count

Indicator # 3	
Proportion of total critical incidents that impact the safety of health and social services staff	
What is being measured?	The rate of critical incidents per 1,000 empoloyee days worked.
Why is this of interest?	The safety of staff in the health and social services system is a priority for the DHSS. All staff members should enjoy a safe work environment and understanding trends in regard to incidents that impact staff safety in a negative manner is crucial to understanding what the circumstances are that may create these situations.
What does this tell us?	Could indicate safety issues in particular facilities, programs or staffing categories that will highlight a need for further investigation to understand the reasons and develop solutions.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	DHSS
Notes	Will be an extract from critical incident reporting

Indicator # 4	
Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)	
What is being measured?	The vacancy rates for family practitioners, specialist practitioners, occupational and physiotherapits, nurses and social workers, by occupation sub-type.
Why is this of interest?	These professions are key components of the health and social services system and vacancies in these positions significantly impacts the capacity of the health and social services system.
What does this tell us?	Will provide an ability to forecast staffing shortages that will in turn allow for the development of strategies to mitigate these shortages. Will highlight where recruting efforts are most specifically needed.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	DHSS (Human Resources)
Notes	Currently reporting

Indicator # 5	
Average wait times by type of surgery (time of booking to surgery)	
What is being measured?	The average time a clients waits for NWT based surgeries from the date the surgery is booked to the actual date of the surgery.
Why is this of interest?	Providing timely and efficient access to services is a priority for the DHSS and Stanton HSSA. Waiting for surgery can be a particularly stressful time for patients and their family members and regularly tracking and reporting on the average wait time can provide useful information to health and social service system administrators that can be used to find ways to minimize these waiting periods.
What does this tell us?	Could indicate increases/decreases in demand for surgery and/or identify service gaps that require attention.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Stanton HSSA
Notes	Dr. Corkal advises that this is manually kept currently. Requires template creation. When reporting on this indicator, consideration will need to be given to comparing results to national benchmarks.

Indicator # 6	
Average wait time for offer of placement in a long-term care facility	
What is being measured?	The average time a patient waits to receive an offer of placement in a long term care facility as measured by the time between the date a determination that an individual requires placement in a LTC faciltiy to the date they are offered placement.
Why is this of interest?	Providing timely access to services is a priority for DHSS and the HSSAs.
What does this tell us?	Could indicate increases/decreases in demand for long-term care placements and/or identify service gaps that require attention.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS Territorial Admissions Committee (TAC)
Notes	N/A

Indicator # 7	
Rate of adoption of newly established clinical standards of care	
What is being measured?	The rate at which newly established standards of care are adopted by the system as a whole. For example, if a new clincal standard is developed that is appliable in long term care facilities, this will measure the rate at which all long term care facilties adopt the new standard.
Why is this of interest?	Establishing clinical standards are an identified priority for NWTs health and social service system.
What does this tell us?	Could be an indicator of inadequate training or communication of standards.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	To be developed by committee
Notes	This indicator provides information that is important from a compliance perspective, and also in the context of the receipt of $500,000 in new funding to support the related work of a committee on developing these standards. Note that this committee could play a role in further specifying the reporting on this indicator.

Indicator # 8	
Utilization rate of tele-health technology for patient care activities	
What is being measured?	The number of telehealth sessions that were specifically for patient care activities.
Why is this of interest?	Tele-health technology presents a signficant opportunity to improve access to servcies for all residents of NWT and allows for potential cost savings to be realized by using technology to minimize other health and social service costs. Telehealth helps reduce medical and staff travel by providing remote access to clinical advice for patients and professionals.
What does this tell us?	The degree to which the technology is being used for one of its stated purposes.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Tele-health technology represents a strategic priority for the GNWT, and there have been substantial investments put toward its use.

Indicator # 9	
Number (%) of children receiving child welfare care in their home community: by age group and demographic (Aboriginal)	
What is being measured?	By age group, the percentage of children receiving child welfare care who receive that care in their home community.
Why is this of interest?	Receiving care as close to home as possible is a priority for NWTs health and social service system. The degree to which the removal of children from their home community can be prevented is seen as an important objective.
What does this tell us?	The availability of child welfare placements in communities across NWT.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation

Indicator # 10	
The number of patients and the number of escorts using the medical travel program per fiscal year	
What is being measured?	The number of patients and the number of escorts using the medical travel program per fiscal year
Why is this of interest?	Medical travel represents a significant percetage of the DHSS budget every year, and monitoring its use will provide the DHSS with data and information that can help inform improvements to the medical travel program.
What does this tell us?	Will idenitfy trends regarding patients and escort travel.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	N/A

Indicator # 11	
Proportion of the population receiving: full immunization coverage by the age of two years	
What is being measured?	The proportion of the total population who have received full immunization coverage by the age of two years.
Why is this of interest?	Early childhood development is a priority for the health and social services system and immunization has been shown to be one of the most cost effective public health interventions available. Maintaining high vaccine coverage is necessary for preventing the spread of vaccine preventable diseases and outbreaks within a community.
What does this tell us?	The success of NWTs immunization program.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS (Population Health)
Notes	This is an important measure for the health and social services system, however currently challenges will be faced collecting this data. Felt to be important enough to remain.

Indicator # 12	
Incidence rate of sexually transmitted infection in NWT	
What is being measured?	The incidence of sexually transmitted infection in NWT.
Why is this of interest?	The incidence of STIs in the NWT is much higher than in the rest of Canada. STIs are spread through practicing unsafe sex, and can cause infertility, ectopic pregnancies, premature births and damage to unborn children.
What does this tell us?	STI rate can provide a proxy of the degree to which unsafe sex is being practiced.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS (Population Health), NWT Bureau of Statistics, and the Public Health Agency of Canada
Notes	N/A

Indicator # 13	
Average number of critical incidents reported: a) per inpatient patient day, b) among children in foster care, and c) per outpatient visit	
What is being measured?	The rate of critical incidents reported annually: a) Per 1,000 inpatient bed days b) Per 1,000 outpatient visits
Why is this of interest?	Critical incidents are a good indicator of safety and quality of care. Ensuring care is provided in a safe environment is critical to the overall effectiveness of the health and social services system.
What does this tell us?	If there are particular sectors of the health and social services system where an issue needs to be addressed and/or where other sectors could look to for improvement opportunities.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation. There is a patient safety framework under development by the department and that has linkages to this indicator.

Indicator # 14	
Average number of placements per year per child: Aboriginal and non-Aboriginal	
What is being measured?	The average number of placements an individual child has per year.
Why is this of interest?	Providing stable placement environments is a priority for the health and social services system and provides for a less disruptive experience for the child
What does this tell us?	Trends in child placement.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will require template creation

Indicator # 15	
Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year	
What is being measured?	The percentage of NWT residents who report that they were satisfied or very satisfied with the health and/or social service care received in NWT in the past year.
Why is this of interest?	Resident satisfaction with the care they have received can provide a means for the health and social services system to improve the delivery of services.
What does this tell us?	Could identify particular geographies where care is felt to be better or worse than others, potentially identifying areas for DHSS or HSSAs to investigate.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS Survey
Notes	Would report different sites each year (e.g. Hospital, LTC, Primary Health, Outpatient). There is a need to report on the quality of experience for those utilizing mental health and substance use services. Satisfaction of experiences with medical travel is another category, although this might ultimately become a separate questionnaire that is administered by phone, as contact information is available. This indicator should draw on the work of the Institute for Citizen Centered Service (http://www.iccs-isac.org/cmt/about-the-cmt/) including the use of scaled questions on the importance of, and satisfaction with, aspects of experience such as the ease of access (location, physical access, hours of service, use of alternative means including online, etc), timely provision of the service, being treated with respect and empathy, protection of privacy, receiving the service that was needed, and access to needed, understandable information. Currently, this type of surveying occurs within facilities and is carried out by administrative staff, on a given month in a calendar year. There are inconsistencies in the administration of these surveys across the regions and health authorities. Hence, there is a need to build into future contribution agreements a requirement for such surveying.

Indicator # 16	
Percentage of no-shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA	
What is being measured?	The proportion of scheduled patient appointments by HSSA for: a) Family physician or nurse practitioner; and b) Specialist physicians where the patient does not show up.
Why is this of interest?	No shows at appointments with these professionals represent a significant waste and negatively impacts health resource utilization. These appointments can result in lost appointment slots that cannot be readily filled. To maintain the sustainability of the health and social serivces system, waste in the system must be minimized.
What does this tell us?	Identifies possible areas of waste in the system.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	This indicator provides for an understanding of “lost access” for other participants in the health and social services system. The collection of related data is now more consistent and covers a range of health and social services.

Indicator # 17	
Incidence rate of cancer by type	
What is being measured?	The incidence rate of cancers by specified type.
Why is this of interest?	Cancer remains one of the most significant health challenges faced by Canadians and the incidence of cancers is projected to increase in NWT.
What does this tell us?	Monitoring incidence rates is important for cancer care planners providers and policy makers as it provides them with an indication of where serivces and programming should be focused.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Report on types on rotating basis (e.g. Breast year 1, colorectal year 2, lung year 3 then repeat)

Indicator # 18	
Incidence rate of diabetes	
What is being measured?	The incidence rate of diabetes in NWT.
Why is this of interest?	The NWT has the second highest proportion of Aboriginal population in Canada and diabetes prevalence rates among Aboriginal populations are at least 3 times higher than the general population.
What does this tell us?	Understanding the incidence of this disease is critical for health and social system planners to inform decision making regarding service provision.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	N/A

Indicator # 19	
Self-reported health status of NWT residents	
What is being measured?	Self-reported health status of NWT residents
Why is this of interest?	Self reported health status is one of the most common measures used in public health surveys in Canada and peer countries. How people feel about their own health is seen as a good indication of the burden of disease
What does this tell us?	How the citizens of NWT assess their own health status.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Statistics Canada Survey
Notes	N/A

Indicator # 20	
Average length of time between specialist referral and specialist appointment	
What is being measured?	The average length of time between the date a specialist referral is initiated and the date of the specialist appointment.
Why is this of interest?	Providing timely access to services is a priority for DHSS and the HSSAs.
What does this tell us?	Identifies potential areas of waste in the system and allows for standard setting and benchmark measurement.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Note that the data associated with this indicator pertains to specialist appointments that take place within the Northwest Territories (i.e., referrals to specialists in jurisdictions such as Alberta are excluded).

Indicator # 21	
The proportion of children who are developing well at school entry	
What is being measured?	The proportion of children who are developing well at school entry
Why is this of interest?	There is an overall initiative in NWT to develop a strategic and comprehensive territory-wide plan to improve the overall education system in NWT, with specific consideration as to how to enhance and strengthen student success and early childhood development. Understanding childrens needs is critical to the development of an effective strategy.
What does this tell us?	Will provide evidence to inform allocation of funding and services in the educational system.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Will need to work closely with ECE to develop tracking mechanism.

Indicator # 22	
Percentage of NWT population who smoke	
What is being measured?	The percentage of NWT population who self report smoking
Why is this of interest?	In Canada, it is estimated that smoking is responsible for 30% of all cancer deaths and is related to more than 85% of lung cancer cases. Lung cancer is the most preventable of all cancers, however, it remains to be the leading cause of cancer death for both men and women.
What does this tell us?	Smoking trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Canadian Community Health Survey
Notes	N/A

Indicator # 23	
Percentage of NWT population with reported substance abuse issues	
What is being measured?	The proportion of NWT population reporting drinking five or more drinks at least once per month.
Why is this of interest?	NWT has one of the highest self reported substance abuse rates in Canada. NWT youth are over 5 times as likely to particiapte in heavy frequent drinking than the national average (2009 Canadian Alcohol & Drug Use Monitoring Survey). Focusing on reducing substance abuse issues, particularly in youth, is a priority for the DHSS and HSSAs.
What does this tell us?	Substance abuse trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	Statistics Canada and DHSS
Notes	Annually binge drinking reported via Stats Canada & every 3 years detailed DHSS survey.

Indicator # 24	
Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child	
What is being measured?	The proportion of all children placed in homes where at least one caregiver is from the same culture as the child
Why is this of interest?	When children must be removed from their biological families, there is always an attempt to place them as much as possible within their community: this includes extended family, indifiduals emotionally connected to the child, or a family of a similar religious or ethno-cultural background. The degree to which placement in this manner can be achieved is important to the DHSS.
What does this tell us?	The degree to which NWTs services are meeting this national best practice.
How are we doing?	TBD
Frequency of reporting	Annually
Data Source	DHSS
Notes	Requires development of process to track.

Indicator # 25	
Percentage of NWT population who are obese	
What is being measured?	The percentage of NWT population who self report obesity.
Why is this of interest?	According to the World Health Organization the dramatic increase in overweight and obese Canadians constitutes and epidemic. The impact of obesitiy on non-communicable diseases such as cardiovascular disease, Type 2 diabetes, and cancer is significant, making the need for prevention and control clear.
What does this tell us?	Obesity trend in the NWT.
How are we doing?	TBD
Frequency of reporting	Annual
Data Source	Canadian Community Health Survey
Notes	N/A