Province of Nova Scotia
Department of Community Services
Department of Health

Management Audit Report
Volume One

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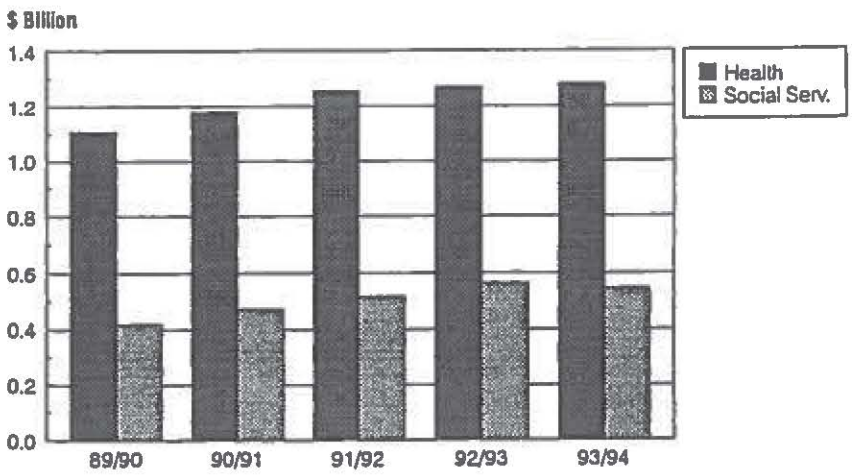
1.0 Introduction

1.1 Background

Expenditures on health and social services in Nova Scotia in the 1993/94 fiscal year are estimated to be $1.8 billion, or 40% of the Province's total ordinary expenditures. Health services expenditures will be approximately $1.28 billion (28% of total spending) while social services expenditures will be $544.5 million (12%).

The growth in Provincial spending on health and social services functions between 1989/90 and 1993/94 is illustrated below:

Ordinary Expenditures on Health and Social Services



Source: 1993/94 Budget Address

In the five years from 1989/90 to 1993/94, spending on health services has grown by 16%, from $1.11 billion to $1.28 billion. During the same period, staff resources devoted to the delivery of health services have declined by 7%. The increase in social services spending is even more dramatic, at 30%, growing from $0.42 billion in 1989/90 to $0.54 billion in 1993/94. Staff resources delivering social services grew by less than 4% in the same period. This growth in spending has taken place during a period when total Provincial programs spending has only increased by approximately 11%.

The increase in demand for both health and social services in Nova Scotia is symptomatic of a number of economic, technological and social trends. These trends include: an aging population; advances in medical technology; changing social patterns and behaviours; and, high unemployment rates and poor economic growth.

A similar pattern of large and growing expenditures for these services is common in all provinces, leading provincial governments across Canada to undertake fundamental reviews of the design and delivery of health and social services. The challenge facing provincial governments is one of reducing expenditures on health and social services while rationalizing, and in some cases improving, the nature and delivery of these services.

The Province of Nova Scotia has initiated a management audit of the Departments of Health and Community Services as part of the process of review and reform of the delivery of health and social services. The management audit is one of several which have been commissioned for all major Provincial departments in an effort to ensure that the Provincial public sector is operating as efficiently and effectively as possible.

1.2 The Management Audit

The Terms of Reference for this review included a number of issues typically covered in a management audit, such as the appropriateness of organizational structures and the adequacy of management practices and procedures. The Terms of Reference also included a number of broader management issues related to the mandate, design and delivery of health and social services in Nova Scotia.

We have pursued a comprehensive work program in addressing these audit issues. Audit activities have included: in-depth personal interviews with key Departmental management and staff; visioning sessions and focus groups with senior management; discussions with representatives of other provincial jurisdictions; and a comprehensive review of relevant Departmental documentation, reports and files.

In the following chapters of this report, we outline our approach to the management audit, the focus of our analyses, and the key findings and recommendation which have emerged. As noted in the Foreword, the requirements identified in the Terms of Reference have been addressed in three broad categories:

- Chapter 2.0 - Service Delivery
- Chapter 3.0 - Organization
- Chapter 4.0 - Management Practices

2.0 Service Delivery

We have addressed the following audit requirements from the Terms of Reference under the broad category of Service Delivery:

- To determine if there are any programs and services provided by the Departments that do not conform with the Departments' fundamental mandates.

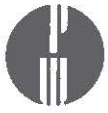
- To identify methods to streamline an individual's access to health and community services.

- To define the concept of continuum of care in such a manner as to provide for the integration of complementary community-based health and community services programs and services.

- To identify redundancies and deficiencies in health and social services that presently occur in support of the education system and to report on the potential net savings or net costs of implementing such changes.

The starting point for our review of service delivery issues was the definition and development of the concept of continuum of care and its application to the various programs and services of the Departments. A number of distinct continua were identified (i.e. income support and employment; child protection and care; adult protection and care; long term care, mental health; and, acute care). Programs and services of both Departments were then reviewed to determine whether or not they fit within Departments' mandates and warranted inclusion in one of the continua of care.

Entry and access to services was examined for each of the programs in each continuum, and methods to streamline access were identified. Examination of the continua of care also surfaced issues regarding the extent of complementary programs and ways of integrating them in the most cost-effective manner. The current problem of support for the educational system was examined as a stand-alone issue.



2.1 Fit of Programs with Departmental Mandates

The mandates for the Departments of Health and Community Services are broad. The Department of Community Services is mandated to provide:

- financial assistance to individuals and/or families whose income is insufficient to meet basic needs; and

- social services to individuals and/or families who, because of personal and/or family problems, are unable to cope on their own.

The Department of Health is mandated to provide hospital, homes for special care, medical, community-based health and drug dependency programs to the residents of Nova Scotia.

In view of the broad nature of these mandates, we found there were no major programs or services in either Department which were in conflict. Two programs (Young Offenders and Family Court) were, however, identified for examination in terms of the appropriateness of their current location in the Department of Community Services, versus the Department of Justice.

The Department of Community Services is currently responsible for the administration of Young Offender programs, including probation, residential placement, custody and assessment services, and operation of the Shelburne Youth Centre. The Department deals only with young offenders from 12 to 15 years of age. Offenders aged 16 or 17 years are dealt with through the Provincial Court system and associated support programs provided by the Department of Justice. The current approach to Young Offenders administration results in the duplication of some support functions and facilities between Community Services and Justice. Separated responsibilities also makes it more difficult for the departments to coordinate and harmonize their approaches to dealing with young offenders.

The Department of Community Services is also responsible for Family Court services, including intake and assessment, counselling, administration, court reporting, Justices of the Peace and other services. Both Young Offenders and Family Court Services have been identified as elements of the Unified Family Court Division of the Supreme Court of Nova Scotia, under the Department of Justice, as proposed by the N.S. Court Structure Task Force in 1991. The recommendations of the Task Force, including the UFC, have been accepted by government, and an implementation committee has been formed to oversee the establishment of the Unified Family Court.

It is recommended that both Young Offender programs and Family Court be transferred from Community Services to Justice.

2.2 Premises for Health and Social Service Delivery in Nova Scotia

A number of key premises regarding the delivery of health and social services in Nova Scotia underlie the findings and recommendations described below. These premises are:

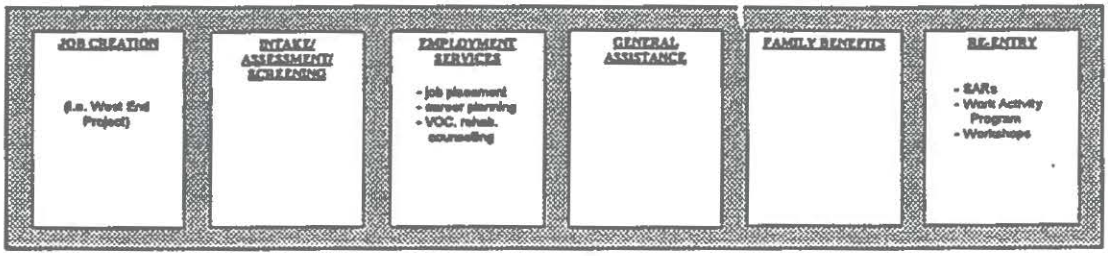
1. A key premise for this review was that programs and services should be designed and managed according to the concept of continuum of care. We defined a continuum of care as a logically sequenced stream of services for a particular population. Applying this definition to the Departments of Health and Community Services, we identified the following continua:

    - Income Support and Employment
    - Child Protection and Care
    - Adult Protection and Care
    - Long-Term Care
    - Mental Health
    - Acute Care

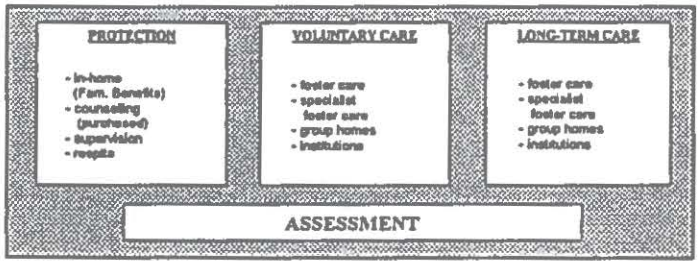
    The continua are illustrated in **Exhibit 2.1** (Community Services) and **Exhibit 2.2** (Health).

Exhibit 2.1
Proposed Continua of Care - Department of Community Services

INCOME SUPPORT AND EMPLOYMENT



CHILD PROTECTION AND CARE



ADULT PROTECTION AND CARE

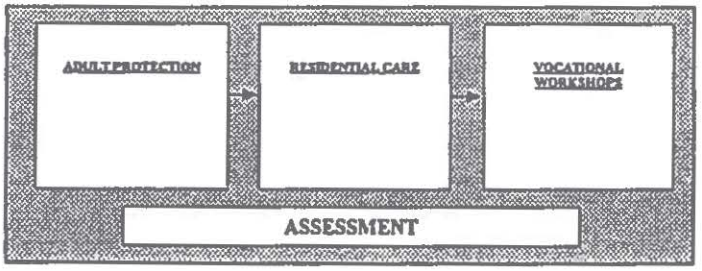
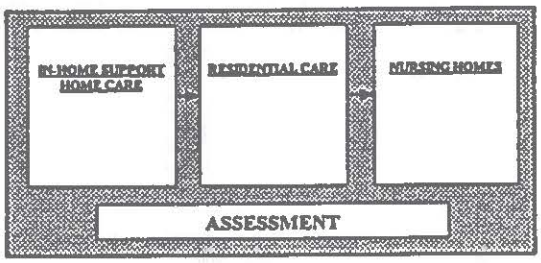
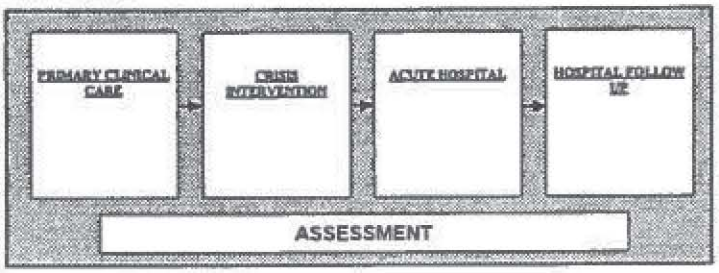


Exhibit 2.2
Proposed Continua of Care - Department of Health

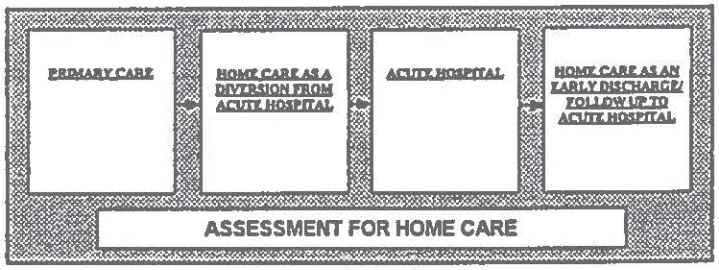
LONG TERM CARE



MENTAL HEALTH



ACUTE CARE



The continua suggest ways in which programs and services should be organized and managed to ensure the availability of services, appropriate entry through assessment and classification and the flow of clients/patients in the delivery system through coordination and/or integration. Also, the continua depict how gatekeeping can be used to minimize the reliance on the use of the more restrictive services at the back of each continuum.

For each continuum we have ensured that there is clear responsibility for its management by a Department and Division. To achieve this we recommend the following changes in responsibilities among Divisions to ensure that the continua are effectively managed:

- combine the Employment and Training programs of Vocational Rehabilitation with Family Benefits in a new division

- transfer services for mentally disabled and handicapped children from Rehabilitation and Community Services to the Family and Children's Services Division

- transfer responsibility for Adult Protection from the Department of Community Services to the Department of Health

- establish an acute home care component to the Coordinated Home Care Program

These recommended changes in responsibilities are reflected in the revised organization structures presented in the following chapter.

We have also assumed that the Department of Health would be responsible for the elderly and physically disabled and the Department of Community Services for the mentally disabled and handicapped.

2. Assessment, classification and screening are essential to ensure the most appropriate use of services. We have therefore included assessment and the related activities of classification and screening for each of the continua.

3. We share the position taken by the Government and supported by senior management in the two Departments regarding the drive for de-institutionalization. Our report emphasizes the importance of developing a policy on de-institutionalization with quantitative targets and an implementation plan which addressed the capacity issue (i.e. ensuring that the full benefits of de-institutionalization are achieved by optimizing the capacity of remaining institutions).

4. We assume regionalization for service delivery in both Departments and, although the models may differ for each, we emphasize the importance of both Departments using the same regional boundary definitions in order for the two Departments to work effectively together.

5. Health promotion and community action are assumed as important services which cut across the continua and warrant a strategic focus and direction from a Steering Committee with senior officials of the two Departments.

We recommend that the Departments adopt the continua of care described above, and make the organizational and policy changes needed to implement these continua.

2.3 Prevention and Community Services

Prevention and community services were identified as a Government priority and most Divisions in both Departments are involved in prevention, community action and/or health promotion activities and services including:

- Resource Centres in Family and Children's Services Division
- Parent Education
- Family Skills Workers
- Education, Prevention and Outreach Workers for Transition Houses
- Regional Resource Centres

- Community Action for Children
- Community Service Workers (Family Benefits Division)
- Community Animation in Drug Dependency
- Health Promotion

The nature of these services and the level of resources devoted to them is essentially driven by the Divisions. These services are not well coordinated, even though they may be directed toward common populations and offered through the same community institutions (such as schools or police) and may draw on the voluntary efforts of the same population. Therefore, there is no coherent and focused strategy to address the most pressing community needs.

We recommend that the Departments of Health and Community Services develop a model to integrate their prevention, community and health promotion programs. The Department of Community Services should assume the lead for the integrated prevention and community services, with resources coming from both Departments and policy direction from an interdepartmental Steering Committee. Consideration should be given to expanding the services to include those in other Departments with resources and their representation on the Steering Committee or other formal governance structure.

2.4 Responsiveness of Mental Health Services

The Family and Children's Services Division of Community Services purchased child mental health counselling services from private suppliers in the amount of approximately $1.8 million in 1992/93, rather than using the existing services of the Mental Health Division of the Department of Health. The rationale provided by Family and Children's Services for this high level of purchase are:

- hours of operation and long waiting periods for assessment appointments generally are inconsistent with the needs of F&CS clients, who may require crisis-level assistance often at times outside the normal operating hours of the Mental Health Clinics;

- the types of services offered in Mental Health clinics and institutions are not generally oriented toward children exhibiting severe conduct disorders and behaviourial problems, which are the typical F&CS clients.

- criteria for admission to mental health clinics and institutions are set by the physician in charge and are not always consistent with the F&CS client profile. For example, acceptance of children by the N.S. Hospital requires that they have a strong family environment in which therapy/treatment can occur. Very few F&CS clients come from this type of environment and are therefore unable to access the resources of the N.S. Hospital.

As a result, the Division purchases services from private practitioners on an as-required basis. There are no provincial standards for the provision of these services, which are purchased on a local, ad hoc basis according to needs.

From the perspective of the Department of Health, there is a shortage of child psychiatrists working in the public sector (approximately 6.7 full time equivalents, compared with a proposed complement of 29.5 fte's put forward by the Mental Health Services Division). While increased resource levels are considered to be a contributing cause of the lack of responsiveness, there is no formal policy/procedural directives which ensure that F&CS would have access to the types and levels of services needed by their clientele, at the time they are needed.

In three areas of the Province (New Glasgow, Shelburne, Halifax) contractual arrangements exist between child welfare agencies and mental health clinics for the provision of mental health services to F&CS clients in the Young Offenders assessment services program. The contracts specify the types and costs of services to be provided, the level of dedicated staff resources and the timing of these resources. The contractual approach has been found by both Departments to be successful. The purchase of service contract approach has not been pursued more widely.

The current situation has a number of implications:

- the F&CS Division is addressing the problem of non-responsiveness of mental health clinics to their clients' needs by purchasing services from private practitioners

- since many of these purchases are made on an ad hoc crisis basis, there is less flexibility in ensuring the most appropriate service is obtained and little control over the cost of these services

- there is no commonly-used framework for provision of services by the clinics to F&CS, other than the three existing agreements related to Young Offenders assessments

- there is a need to make mental health programs more responsive to the needs of F&CS needs by establishing a formal client-provider relationship through which specified, dedicated services are available at an agreed cost

We recommend that:

- **Family and Children's Services purchase, to the fullest extent possible, mental health services from local mental health clinics and institutions;**

- **F&CS and Mental Health Services Division jointly develop a consistent set of standards for delivery of services by all clinics and institutions to F&CS; and,**

- **the provision of mental health services should be governed by purchase of service contracts between F&CS offices and clinics. These contracts should be based on the agreed standards and should clearly identify the types of services (both at the outpatient and institutional levels) which will be provided, and the costs of these services.**

2.5 De-Institutionalization

De-institutionalization is included in the Government's priorities for health care reform and it is a goal shared by senior management in both Departments. Serving people in non-institutional settings is a much less expensive way of meeting a wide range of health and social services commitments. Both Departments have been taking some action regarding de-institutionalization, but Nova Scotia still has high rates of institutionalization for various types of health and social services and there are major opportunities for further de-institutionalization.

The full potential benefits of de-institutionalization are realized through effective capacity planning. In the absence of effective capacity planning there may be facilities that are currently operating which should be closed, allowing other institutions to operate at higher capacity to meet service needs and making more effective use of overall resources. Such capacity planning is not apparent and must be included in any strategic plan which deals with the overall issue of de-institutionalization.

We found that neither Department has set targets for de-institutionalization with the exception of acute care and psychiatric in-patient beds. Targets for other institutional facilities (alcohol and drug treatment, children in institutions who are under care with the Family and Children's Division; mentally disabled and handicapped children and adults; the elderly; and, young offenders) have not yet been set, and there are no plans to ensure that the full benefits of de-institutionalization are achieved through capacity planning.

Without a clear policy regarding de-institutionalization, targets and supporting strategic and operational plans, the large potential cost savings which can be achieved by de-institutionalization may not be realized and the opportunity to serve clients in a more effective, humane way through community-based care may be lost.

> **We recommend that the Departments prepare a policy for de-institutionalization, with targets regarding the number of beds for the various institutional facilities, and develop an implementation plan which optimizes the capacity of remaining institutional facilities.**

We recognize that there may be "political" constraints to taking action which the Departments have proposed, particularly in relation to de-institutionalization. Concerns about the loss of employment in communities has made it difficult to implement a rational approach to de-institutionalization which is based on the resources needed to meet needs. As part of a coordinated policy for de-institutionalization put forward by Community Services, the N.S. Youth Training Centre had been identified for closure prior to the closure of the Children's Training Centres. The government of the day, however, rejected this policy approach, with the result that there have been closures of Children's Training Centres, which are less costly to operate and serve more profoundly disabled individuals than the NSYTC, while the NSYTC has remained open. The politics of de-institutionalization has also occurred in relation to acute care facilities.

We recommend that the NSYTC closure should precede the closure of the remaining CTCs.

2.6 Assessment and Classification

In general, we found that assessment and classification has not been used effectively to ensure that clients have access to the most appropriate services including the least restrictive and least expensive services. We found this to be true for the majority of the continua examined. As a result, clients may be accessing services at any of a number of points in the system. Without clear and effective assessment functions, clients may be provided with services which are inappropriate and more costly than those which may be identified through a careful assessment process. As an example, inappropriate assessments may result in a client being placed in hospital to receive a level of care which may be provided at a much lower cost through home care services.

Family Benefits. The Department of Community Services has an employment thrust for recipients of Family Benefits. Recipients are involved in career and vocational counselling and other job re-entry programs such as Vocational Workshops and Work Activity Projects. This employment thrust was implemented for recipients of Family Benefits. Yet formal assessment, classification and screening for employment and training (and for the level of supervision as recipients for Social Assistance) can occur **before** the individual becomes a recipient of Family Benefits, and involvement can occur in job placement programs as well as career counselling and vocational counselling before being a recipient. Assessment at intake could classify clients as: potential for immediate placement in jobs, involvement in employment services, providing Family Benefits with re-entry for employment, and unemployable requiring long-term benefits. This approach would build upon the current employment thrust of the Family Benefits Division by placing such assessment at the front-end of the process. This should facilitate the diversion of people away from becoming social assistance recipients and allow the Department to vary the extent of supervision for those on Family Benefits according to the likely prospects for re-entering the labour market.

We recommend that the intake/assessment function be modified in ways that allow for:

- **classification and screening to determine whether applicants should be involved in employment programs before receiving Family Benefits and/or afterwards; and**
- **allow for varying levels of supervision for recipients of Family Benefits.**

Child Welfare. Currently there is no formal assessment and classification arrangement to ensure that the least restrictive services are used - i.e. the continuum includes the following range: purchase of services from relatives or family, foster care, specialist family care, group homes and institutions. Such assessment and classification arrangements would contribute toward providing services at lower costs and support the Government's priority of serving clients in the community.

We recommend that the Department of Community Services implement formalized assessment and classification procedures to serve as a gatekeeping function for voluntary care and long-term care, and to ensure that the least restrictive services are used to the extent possible.

The Department of Community Services uses residential crisis centres where children are placed for up to 6 weeks. These facilities provide emergency placement which is linked to assessment in these specially designed facilities. This limits the use of other forms of residential emergency care (i.e., other forms of placement such as specialized foster homes) and the flexibility in the types of assessments conducted (including assessments on an out-patient basis). Reduced costs could be achieved by considering alternatives to such centres which link emergency placements and assessments.

We recommend that the Department of Community Services reduce the use of emergency placement centres by up to 50% by using other placement options for emergency placements and arranging for the most appropriate assessments, which need not be linked to the length or type of emergency placement.

Long-Term Care. There is no coordinated entry and referral process among the various long-term care components to ensure that clients are appropriately placed. Entry points include:

- entry agencies for homemaker services
- provincial nursing assessors for in-home nursing
- placement officers for residential care and nursing homes
- municipal officers for in-home support

The absence of a coordinated long-term care entry and referral process may lead to the placement of clients in service arrangements which are not the most appropriate or least restrictive.

Clients can also experience a "run-around" in obtaining services, without a formalized approach. In addition, there is no coordinated process or approach to ensure that changes in client status are accompanied by a change in the service provided, to ensure that the client receives the most appropriate service.

We recommend that the Department of Health have the lead responsibility for long-term care and that it undertake the following activities:

- **establish a unified assessment/case management function which has responsibility for care planning decisions on the full range of long-term care services;**
- **develop or select a standardized long-term care assessment tool for implementation across the Province; and**
- **develop arrangements that involve staff responsible for delivering home care and in-home support in any decision to place a client in an institutional setting to ensure that all non-institutional options are exhausted before making such placements.**

2.7 Support to Education

There is a serious problem of children with severe social or mental disabilities not receiving adequate support to enable them to remain in the school. This is a "turf" issue among Departments and the children fall between the cracks. The Department of Education views the children who are difficult to handle in the schools as social service or mental health problems which should be handled by the Departments of Health and Community Services. These Departments feel that ensuring that the children receive support to remain in school is the responsibility of the educational system. These arguments are not complex and do not require lengthy deliberation. However, they do require immediate resolution.

We recommend that the officials of the three Departments propose a resolution to the Government within a three month time frame.

3.0 Organization

Three audit requirements related to organization of the Departments were identified in the Terms of Reference:

- To examine the feasibility of adopting the New Brunswick model for the delivery of health and social services programs and income assistance in Nova Scotia.

- To examine and assess the organization structure of the Departments in terms of economy, efficiency, effectiveness in fulfilling the Departments' mandate.

- To examine and assess the levels of decision making within the Departments' organization based on the Departments' responsibilities.

While not specifically identified as a requirement in the Terms of Reference, we have also reviewed the issue of integration of the Departments of Health and Community Services.

3.1 Assessment of the New Brunswick Model

The New Brunswick Model

The New Brunswick model encompasses total provincial responsibility for provision of health, community social services and income assistance programs. These responsibilities are divided between the Department of Health and Community Services, the Department of Income Assistance, the Regional Hospital Corporation and the Mental Health Commission. The Department of Health and Community Services is organized in five divisions: Family and Community Social Services; Institutional Services; Public Health and Medical Services; Planning and Education; and Administration and Finance. The Department of Income Assistance provides financial benefits to clients and a range of support services. The Department is structured in three divisions: Income Security; Planning and Evaluation; and Corporate Services. A Regional Health Corporation, separate from the Department, is responsible for the management and operations of 8 regional hospitals. A Mental Health Commission reporting directly to the Minister

of Health and Community Services is responsible for the delivery of government funded mental health services across the Province. The Commission operates mental health clinic's across the Province and purchases services from the eight regional hospitals.

Feasibility of Adopting the New Brunswick Model in Nova Scotia

We have examined the feasibility of adopting the New Brunswick model for the delivery of health and social service programs and income assistance in Nova Scotia. Our examination was based on: a review of documentation concerning the New Brunswick model; personal interviews with the Deputy Ministers of the Departments of Health and Community Services, Income Assistance and the Policy Secretariat of the New Brunswick Government; and, on our review of health and social services and income assistance delivery mechanisms in Nova Scotia.

Our assessment of the feasibility of adopting the New Brunswick model for Nova Scotia has taken into account such factors as: mandates of departments; plans for regionalization of health services; welfare reform; provincial take-over of municipal social assistance; and, program and services changes proposed for each department in Nova Scotia. The issue of adopting the New Brunswick model has been a topic of discussion with officials of both Departments throughout the management audit.

> **We recommend that the New Brunswick model for the delivery of health and social services programs and income assistance not be adopted in Nova Scotia.**

This recommendation is based on a number of factors, including:

- Separation of income assistance from social services programs into two departments as in New Brunswick would be a backward step when compared with the closer integration we recommend for Nova Scotia.

  We do not view separation of income assistance and social services programs into two Departments as appropriate for Nova Scotia. It is our view that closer integration of employment and training is better achieved in one department. We believe that emphasis on employment and training at the front end should facilitate

the diversion of people away from becoming social assistance recipients. It is, our view that emphasis on employment at the front end is better achieved through the integration of income assistance, employment and training programs and family benefits programs in one department in Nova Scotia.

- The New Brunswick model represents partial, not full regionalization, and does not utilize regional health authorities, as is planned for Nova Scotia in the near future.

The New Brunswick model does not have regional health authorities. The Department of Health and Community Services is organized on a regional office (8 regions) and district office structure. Field office operations are divided into three functional areas, including: Public Health and Medical Services; Family and Community Social Services; and, Institutional Services. Separate from the Department is the Regional Hospital Corporation which is responsible for 8 regional hospitals within these regions. It is our understanding that there are no plans to implement regional health authorities in New Brunswick at the present time. The New Brunswick Department of Income Assistance operates within a regional office structure, with each region reporting to the central office of the Department.

It is the stated health care strategy of the Province of Nova Scotia to establish regional health authorities (operating within Provincial guidelines) with local decision-making, service and program delivery and budget responsibilities. We do not view the partial regionalization and separation of key components, such as the Regional Hospital Corporation and the Mental Health Commission, as desirable or consistent with the health care strategy of the Province of Nova Scotia for the establishment of regional health authorities. This is a key reason for not adopting the New Brunswick model in Nova Scotia.

- Two key components of the health and community social services system in New Brunswick are outside of the Department of Health and Community Services, namely the Hospital Corporation and the Mental Health Commission.

  The Regional Hospital Corporation is responsible for the management and operations of 8 regional hospitals across the Province.

  The Mental Health Commission is responsible for all government funded health services across the Province. The Commission reports directly to the Minister of Health and Community Services and is headed by a Chief Executive Officer. The Commission operates mental health clinics across the Province and purchases services from the eight regional hospitals.

  Our review suggests that the delivery of health, social services, hospital, mental health and income assistance is somewhat fragmented under such a structure. The components of the system, to a large extent are likely to operate within their own structures ("stove-piping"). This type of structure tends to result in less effective communication, cooperation and coordination between operating units. Our review indicated that a measure of coordination and cooperation between components of the New Brunswick approach does exist, but it is acknowledged to have weaknesses. We believe that, with the establishment of regional health authorities and clear definition of the roles and responsibilities of the Department of Health and the Department of Community Services, Nova Scotia's two-department approach provides a more integrated and more effective organizational arrangement than the current approach taken in New Brunswick.

- The Nova Scotia Departments of Health and Community Services, each have different program and service orientations, with no compelling reason for the integration of the two Departments.

The distinct nature of the programs and services in each of the Departments in Nova Scotia do not appear to offer any significant opportunities for efficiencies or savings through integration. The integration issue is reviewed in Section 3.2 of this chapter.

3.2 Integration of the Departments of Health and Community Services

The issue of whether the two Departments should be merged into one new department is a matter that has been given considerable thought throughout the management audit. We have reviewed the organization structures of each of the Departments of Health and Community Services. Future organizational requirements of the departments in light of changed mandates have been taken into account. The New Brunswick model has been reviewed to assess its relevance to the future organization structure of the Departments of Health and Community Services. Specifically, our assessment of whether to continue with two departments or possibly establish one new department was made in light of such factors as:

- mandates of each department
- plans to regionalize health services across the Province
- welfare reform
- provincial take-over of municipal social assistance
- de-institutionalization plans of both Departments
- programs and services changes proposed for each department
- rationalization and re-alignment of functions within the departments

In our judgement, there is no compelling reason for the integration of the two Departments. Each of the Departments have different program and service orientations. In the section of our report dealing with the continuum of care recommendations are provided relating to integrating some services and re-aligning certain responsibilities within and between Departments. However, there are no apparent advantages for integration of the two Departments.

We recommend that the Departments of Health and Community Services remain as separate Departments, at this time.

3.3 Levels of Decision-Making

We have examined the issue of the levels of decision-making, with the Departments of Health and Community Services. We have reviewed Divisional organizational charts and staff complements in carrying out our examination.

Department of Health. The Department is comprised of eight divisions. Our review has determined that 6 of these divisions are relatively small and for each, there are two levels of decision making, below the Deputy Minister. The levels of decision-making for these 6 Divisions are believed to be appropriate and include:

- Information Systems
- Health Care Facilities
- Mental Health Services
- Policy, Planning and Research
- Insured Professional Services
- Corporate Services

Two other Divisions, Drug Dependency Services and Public Health, represent quite large organizational units involving central office regional office and directly managed programs with facilities. The levels of decision making within the Drug Dependency Services Division at the head office, regional office and directly operated facility levels were found to be generally appropriate.

The Public Health Division also represents a relatively large and diverse organizational unit. The Division is directed from a central office and operates through a network of 6 regional offices delivering services in such areas as: nursing; health units; inspection; dental hygiene; and nutrition. We have examined the levels of decision-making at the central and regional office levels and for program/service delivery units and have found the levels to be generally appropriate and that staff to supervisor ratios were generally consistent across programs, with the exception of several smaller programs where general supervision by regional management is typically provided.

Department of Community Services. The Department is organized into two major functional areas - head office and field services. The head office divisions include three administrative support functions (Audit Services; Research, Planning and MIS; and Financial Services), three program divisions (Family and Children Services; Family Benefits; Rehabilitation and Community Services) and the Field Services and Personnel Division, responsible for the administration of all Departmental field resources and staff engaged in program delivery.

The organization structures of the head office functions are relatively flat, with only two levels of management below the Deputy Minister in the administrative support divisions. The program division head office organizations generally have three levels of management below the Deputy level. In the case of Family Benefits, for example, the third level of management includes the Regional Supervisors of Family Benefits, who are located in the field.

In the field, Regional Administrators are responsible for all activities in their regional and district offices and in Family Courts. In general, there are two levels of management in the region, including the Regional Administrator, who is responsible for District Office Supervisors, Family Court Supervisors, Family Benefits Supervisors and, in the larger regions, Assistant Regional Administrator (Cape Breton) or a Regional Field Supervisor (Halifax).

The depth of decision-making authority with respect to applications or recommendations for assistance was reviewed for the Family Benefits and Family and Children Services Divisions. In both Divisions, the authority to make decisions on the disposition of individual cases is decentralized to the field level. In Family Benefits, the regional Family Benefits Supervisor has full authority to decide on individual applications for assistance generated by caseworkers. In Family and Children Services, protection and probation caseworkers have the authority needed to allow them to act in emergency situations.

The existing levels of management in Community Services would appear to be appropriate and the Department is not overburdened with excess layers of management. Decision-making authority for individual cases has been decentralized to the extent possible, given the need to maintain adequate supervisory control.

3.4 Proposed Departmental Organization Structures

The organization structures of the Departments of Health and Community Services clearly must change in response to new initiatives, such as regionalization, and to the proposed realignment of responsibilities according to the continua of care proposed in this report. Changes in structure must be accompanied by a corresponding review and definition of the skill sets (managerial, professional and technical) required in each Department to fulfil their respective mandates.

Proposed future organization charts for each Department have been prepared and are briefly described in the following paragraphs.

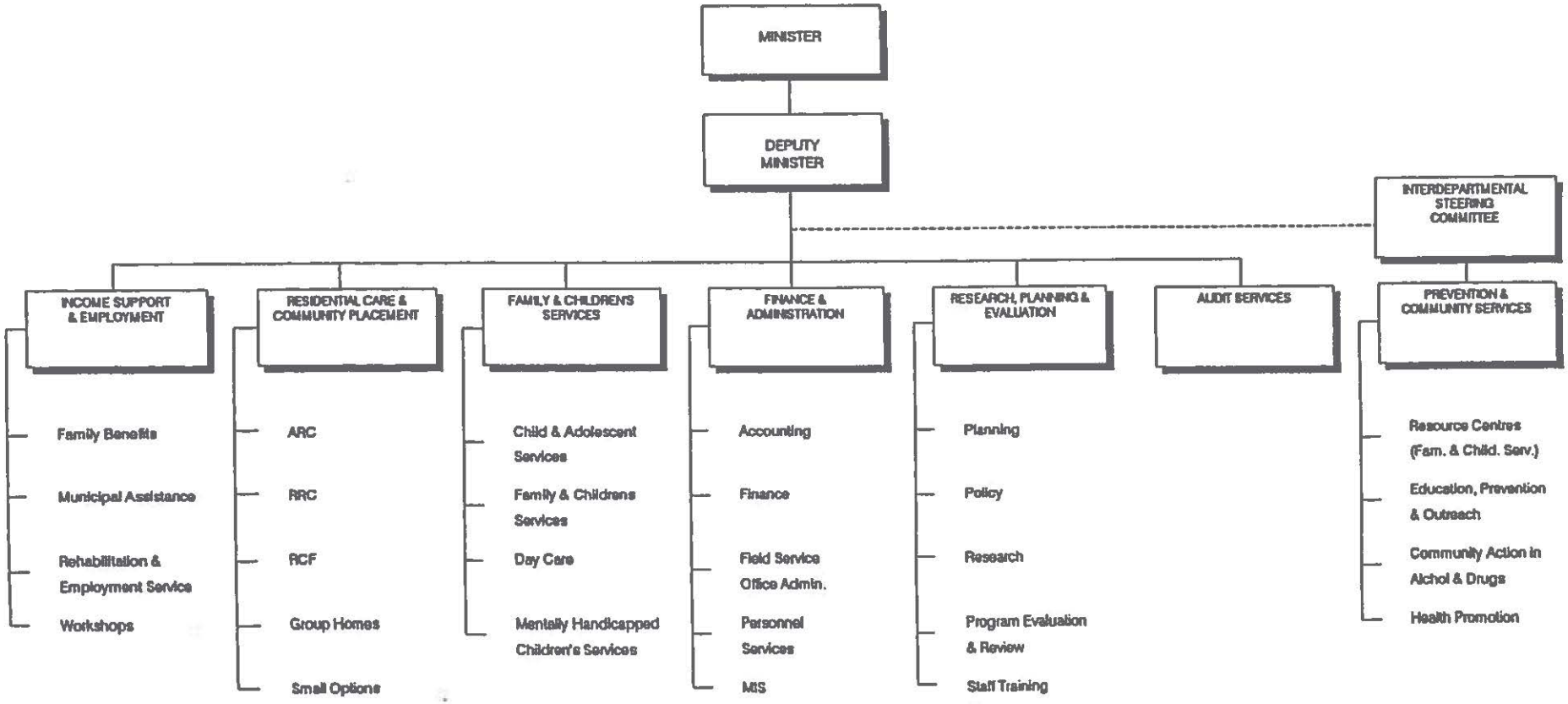
Community Services

Within the Department of Community Services there is an increasing emphasis on employment and training for family benefits recipients, and greater reliance on community-based resources to deliver social services. A change in name for the Department may contribute to the successful implementation of new directions being pursued by the Department.

> **We recommend that consideration be given to a change in name from the Department of Community Services to the Department of Social Development.**

A proposed organization chart for the Department of Community Services is provided as **Exhibit 3.1**. Within the Department three divisions are proposed which correspond to the major continua of care for which the Department would be responsible: Income Support and Employment; Residential Care and Community Placement; and, Family and Children's Services. In order to implement these continua, a realignment of Departmental responsibilities will be required, as discussed in the previous chapter.

Exhibit 3.1
Department of Community Services (Department of Social Development) *
Proposed Organization Structure



* Proposed new departmental name

We recommend the following organization changes in the Department of Community Services, consistent with the proposed continua of care:

- **transfer the Employment and Training programs from Vocational Rehabilitation Division to Family Benefits**
- **transfer services for mentally disabled and handicapped children from Vocational and Rehabilitation Services to Family and Children's Services**
- **transfer responsibility for Adult Protection from Community Services to Health**
- **establish an acute home care component to the Coordinated Home Care Program**

In addition to changes in the program divisions, realignment of the administrative divisions is needed to strengthen program evaluation capabilities, and coordinate a number of administrative functions which are currently spread amongst three divisions.

We recommend that:

- **program evaluation capabilities be strengthened under the Research, Planning and Evaluation Division**
- **audit services comprise a distinct administrative division**
- **all accounting, finance, personnel and MIS functions be consolidated under a new Finance and Administration Division**

It is proposed that the Department of Community Services will have support responsibility for an Interdepartmental Steering Committee with the Department of Health, which would coordinate joint initiatives relating to prevention and community action. These initiatives would include such activities as: counselling; resource centres; education, prevention and outreach; community action in alcohol and drugs; and, health promotion.

Other changes in organization of the Department which are intended to improve efficiency and effectiveness within the defined continua of care have been identified.

We recommend that the Department:

- **develop a plan for reducing the number of children and societies and district child welfare offices so there is one per region, plus the MicMac agency. Changes in the delivery structure for child welfare services should incorporate the results of in-depth consultations with delivery agencies**
- **centralize adoption services in Halifax and reduce the number of person year resources available, in response to current caseloads**
- **establish an agreement with the Department of Health on common regional boundary definitions, to facilitate joint planning and program implementation**

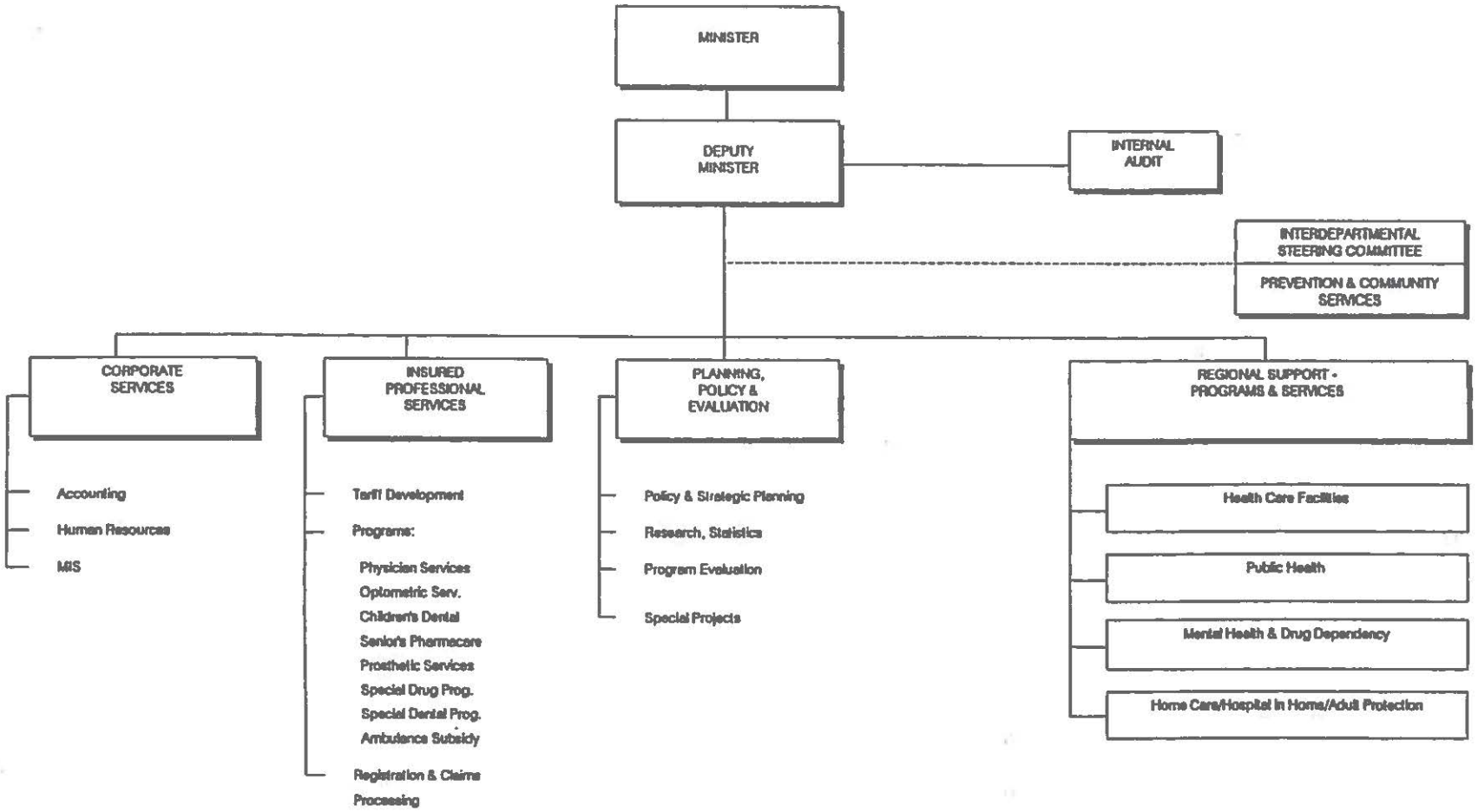
Department of Health

A proposed organization chart for the Department of Health is illustrated in **Exhibit 3.2**. The structure proposed in Exhibit 3.2 reflects a major shift in the role of the Department, from that of provider of services and facilities to one of planning, monitoring, evaluating and funding functions of regionalized health services across the Province, as delivered by regional health authorities.

Four major divisions are proposed. The Corporate Services Division would have responsibility for Accounting, Human Resources and Management Information System functions. The Insured Professional Services Division is proposed to remain essentially unchanged. The Planning Policy and Evaluation Division is proposed to be strengthened in order to provide the appropriate level of support required by the regional health authorities, by other divisions and to carry out program evaluation and review functions. The fourth Division, Regional Support - Programs and Services, would be comprised of four sections and provide services and support to each of the regional health authorities in the management of health care facilities, public health, mental health and drug dependency, home care and adult protection.

Detailed organizational structure arrangements for Regional Support will be required to be developed by the Department once a clearer understanding of functional requirements needed to support regional health authorities has been identified.

Exhibit 3.2
Department of Health
Proposed Organization Structure



4.0 Management Practices

The Terms of Reference identified the following audit requirements which pertain specifically to management practices:

- To examine and assess the management practices and operational procedures of the Departments in meeting their responsibilities with particular reference to the use of modern technology.

- To examine and assess the Department's procedures concerning the evaluation of the programs and services provided by the Departments and the timeliness of those evaluations.

- To examine and assess the process for negotiating federal cost sharing for job training programs and to identify the proper placement of this function in the government structure.

- To determine the feasibility and approach to developing provincial level of service standards for health and community services program coverage and delivery.

We have focused our attention on the management practices that relate to major policy and program issues, other than efficiency or productivity. Maintenance of this audit focus is justified, given that the major issues facing both Departments at present are primarily related to the design and delivery of programs. While issues of productivity and efficiency are important, over the past five years both Departments have seen expenditures and caseloads grow significantly, with little or no increase in staffing levels. Health services expenditures grew by 16%, from 1989/90 to 1993/94 while staff resources declined by 7%. Social services expenditures grew by 30% in the same period, with only a 4% increase in staff. As a result, in many areas of their operations, both Departments have been forced to do more with less.

The most significant opportunities for achieving greater value for money and realizing cost savings are to be found in dealing with strategic issues, such as: sorting out and establishing priorities and limiting services accordingly; de-institutionalization and better use of capacity of institutional facilities; ensuring that clients use the most appropriate services (least restrictive and expensive); and, establishment of a greater employment thrust for social assistance recipients. The potential savings from addressing these strategic issues also underline the importance of strategic and operational planning and the use of program evaluation as critical management practices.

Our overall finding is that the Departments have not developed formal and centrally driven procedures for strategic and operational planning, and program evaluation. Both Departments have addressed some strategic issues and some Divisions undertake operational planning and program evaluation. However, the Departments fall short of having satisfactory systems for these important management activities.

4.1 Strategic and Operational Planning

Strategic Planning

We found that there were neither formal strategic plans or formal strategic planning processes exist in either Department. While both Departments are addressing strategic issues, the lack of a formal process and a plan has the following consequences:

- priority setting within and between the Departments has not occurred in order to establish the resources which should be devoted to the different programs and client population groups. In the absence of Department-wide priority setting, the Divisions drive the priorities. The priorities established in this fashion may not be consistent with the seriousness of the problems/needs of client populations and the most cost-effective manner to address them. As an example, it is our general observation that the Department of Health may be devoting more resources to drug dependency services than other comparable jurisdictions. Without an integrated and coordinated Departmental priority setting process, it is unclear whether this level of effort is appropriate, given the other priorities of the Department.

- there are no clear directions for addressing the strategic issues, which serve as the basis for operational plans. An example of the practical consequences of this lack of direction is the associated lack of a policy for de-institutionalization, covering all the institutional programs in the two Departments. While we found targets for acute care and psychiatric in-patient beds, there were no targets for institutional facilities for: alcohol and drug treatment, children in institutions who are under care with the Family and Children's Division; mentally disabled and handicapped children and adults; the elderly; and, young offenders. The significance of this finding lies both in the large potential cost savings which could be achieved by de-institutionalization and a more effective and humane way of serving clients through community-based care.

  Addressing the issues of de-institutionalization and capacity planning requires comprehensive research and analysis of population demographics; prevalence of illness and social problems; current distribution and capacity of facilities; and, alternative forms of service to support the development of an appropriate strategy. The required level of information and analysis does not currently exist to support the development of strategies and the establishment of targets.

Operational Planning

We found that there are no formalized, Department-wide operational planning in either Department. The absence of such operational planning means that there are no systems and procedures to ensure strategic directions will be effectively and efficiently implemented by linking activities, responsibilities, time-frames, budgets and human resources.

In relation to strategic and operational planning, we recommend that:

- **the Departments of Health and Community Services develop formalized strategic and operational planning to better position them to deal with budget constraints by sorting out priorities, making fundamental changes in policy and program design, and implementing these policy changes in a timely and cost-effective manner.**

- **the strategic and operational plans of both Departments place particular attention to the issue of de-institutionalization and optimizing the use of institutional capacity because large savings can be realized. Other important issues which should be addressed are identified in Section 3 on Service Delivery.**

4.2 Program Evaluation

Both Departments were found to lack an evaluation policy, a process for developing departmental evaluation plans that identify priorities and a corporate capability to undertake evaluations of high priority programs. In spite of these short comings, there is a general sensitivity to program evaluation and extensive evaluation activities have recently been conducted by various divisions.

Most of the evaluation activities to date have been directed toward pilot or demonstration projects. This is an important use of program evaluation as it allows the Departments to launch reforms on a small scale and to expand programs on a wider scale if shown effective. There has, however, been little attention given to evaluation of the larger and longer-standing programs. Those activities which have been undertaken are very recent and the completion of very few studies to date means that there hasn't yet been opportunities to use evaluation findings for decision-making in regard to these programs. In addition, in the absence of clear Departmental evaluation plans, evaluation activities are driven more by Division or program managers and less by the priorities established by senior management.

We therefore recommended that:

- **each Department develop policies and plans for program evaluation; and**
- **corporate evaluation groups with the appropriate skills be established within each Department to implement and undertake evaluations.**

4.3 Information Technology

Our review of information technology management included examination of management practices, planning and documentation, resource utilization, use of technology, organizational structure, systems design and user satisfaction in both Departments.

Systems planning in Community Services is generally comprehensive and informative, but lacks linkage to long term operational plans and therefore fails to adequately address the future needs of the Department. In the Department of Health, systems development activities are generally not well supported by clear rationale and formal cost benefit studies.

In general, information system management practices in both Departments are considered to be sound. The most significant problems lie in the age of major systems in both Health and Community Services. In particular, the Family Benefits system is strong, but aging (the core system is 15 years old) and becoming more difficult to maintain. The systems' ability to respond to changes in legislation is limited. Long-term plans call for incremental enhancements, but do not address the need for a wholesale re-write of the system.

Similarly in Health, the largest and most critical systems (MSI Registration; Medicare; Pharmacare) are 25 years old and have outlived their usefulness. Some effort is now being put into replacing these systems, in conjunction with Maritime Medical Care.

Major recommendations related to information systems include:

- **development of a comprehensive cost-benefit framework for priority setting**
- **consider transfer of budget responsibility for systems to the Divisions to encourage greater end-user accountability for systems costs**
- **embark on strategies for re-developing major systems**
- **ensure that information technology planning is integrated with Departmental strategic and operational planning processes**

4.4 Federal Cost Sharing

Our review of management practices in regard to federal cost sharing focused on the negotiations process and cost sharing program development.,

At present, the negotiation of cost sharing programs is informally centralized in the Department of Community Services. Community Service staff (essentially one staff member) directly assists the Departments of Health and Education in the negotiation process. In addition, program staff are highly aware of cost recovery programs and actively participate in negotiations. This informal centralization appears to be an appropriate form of organization.

In regard to cost sharing program development, program staff are focused on maximizing available cost recoveries. Accordingly, programs are developed in consultation with "cost sharing" personnel to ensure shareability of costs is preserved wherever possible.

4.5 Standards

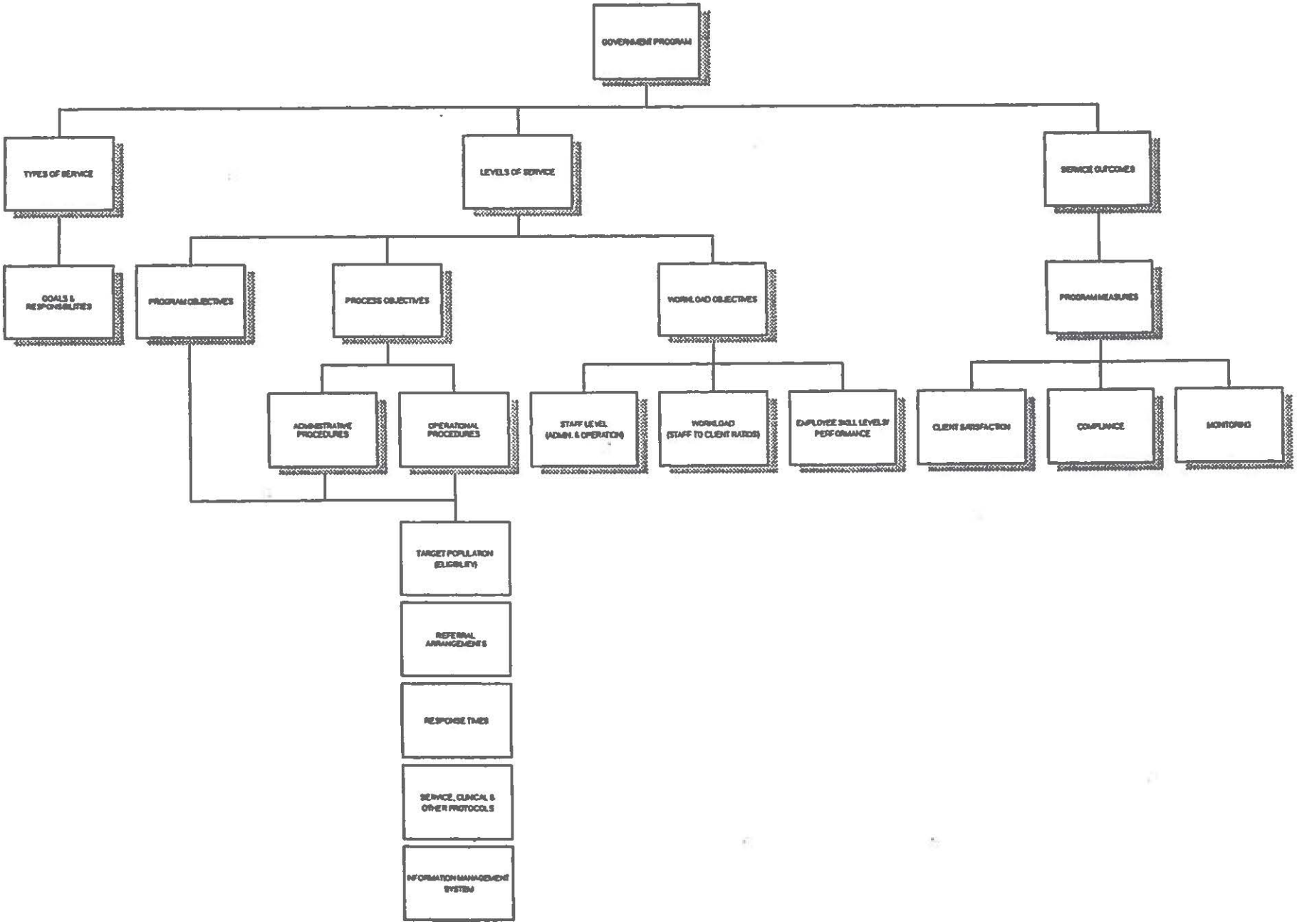
The establishment of standards for service delivery and operational activities is generally recognized as an important activity in both Departments, with progress having been made in the areas examined. Both Departments also participate in discussions on the establishment of national and international standards for the delivery of health care and social services.

The Terms of Reference focused on level of service standards that address program coverage and delivery. Our review took a broader view of standards and was based on the application of a model (see **Exhibit 4.1**) developed to provide the basis for a structured examination of specific programs in terms of:

- type of service to be provided
- levels of service
- service outcomes

Exhibit 4.1

Network of Standards



In addition to its role as a tool for assessing current activities, the model is also intended to provide a framework which may be used to guide the development of standards in both Departments in the future.

The model was used to assess two programs - Family Benefits program and the Communicable Disease Surveillance program. Using this model it was found that, for both of these programs, the types of service and eligibility standards are well documented in regulations and/or manuals. Standards for other program aspects did not appear to be as consistently well-documented.

The application of standards is important in the effective management of both individual program as well as on-going, non-programmatic operations in which the adherence to specific performance criteria (i.e. standards) will help to ensure that resources are utilized as efficiently as possible. Therefore, operational plans must include standards to provide the basis for reviewing resource requirements, implementing services, and monitoring/evaluating performance.

Our review demonstrated the feasibility of applying a structural approach to standards for the Departments of Health and Community Services.

We recommend that a formal, consistent approach to developing standards and monitoring their achievement be adopted and implemented in both Departments.