



## **NEW ORGANIZATIONAL STRUCTURE**

### **BACKGROUND**

**May 2009**

**Table of Contents**

Table of Contents ..... 1

Introduction ..... 2

Principles for New Structure ..... 2

Key Changes from Current (Enabling) Structure ..... 3

The Interface between Clinical Service Units, Provincial Business Units and Operational  
Policy Support Units ..... 3

Accountability and Decision Rights ..... 4

Operational Coordination..... 5

Geographic Coordination ..... 5

Medical Staff Structure ..... 6

Titles ..... 6

Culture change ..... 7

Transition ..... 7

## Introduction

The current formal organizational structure for Alberta Health Services (AHS) has a number of strengths, including linking within one group in the organization responsibility for the full 'continuum of care'. But equally, this interim or 'enabling' structure currently in place for AHS has attracted a lot of criticism:

- for being confusing in the sense of not providing clear lines of accountability;
- for being 'unbalanced' in the sense that more than two thirds of employees reported through the Continuum of Care Division, creating problems of equity in workload and responsibility at the top levels of the organization;
- like functions were not always linked with like;
- that it did not fully cover all critical functions for the organization (e.g. where did responsibility for capital planning lie);
- some critical functions (such as safety and quality) were relegated too far down the chart, given their importance; and
- that the rationale for some aspects of the design of the structure was unclear to many.

Structural changes should normally be avoided as they can:

- distract staff from their main job and/or create a hiatus because of delays in populating the structure and hence slow achievement of organizational goals;
- cause uncertainty amongst affected staff; and
- may involve significant transition costs.

The 'enabling' structure has been in place for almost a year and, despite these risks, it is apparent that the problems with the current structure are such that a further round of organizational change is warranted.

**The new formal structure will come into effect on June 1, 2009. The formal structure for the Executive and their direct reports is shown in this document. Details of other reporting relationships will be available on the web May 15 at <http://www.albertahealthservices.ca/53.htm> .**

## Principles for New Structure

The approach for the design of the new formal structure is based on the following key principles:

1. *Line accountability*: there should be clear and unambiguous accountability lines for every employee;
2. *Flat*: the length of the hierarchical chain should be minimized, thus generally requiring broader rather than narrower spans of control;
3. *Integrated*: the presumption should be that services and units should be integrated as close as possible to the front-line, with direct Province-wide accountability occurring only when there are clear and demonstrable benefits; and
4. *Strategy and implementation should be linked at the Executive level*: all members of the executive team should have a vested interest in, or shared ownership of, good operational policy and its implementation.

## Key Changes from Current (Enabling) Structure

The new formal structure:

- Realigns *clinical service units* (such as urban hospitals, community and primary care services) so that they report through a designated member of the executive team who also has corporate or clinical operational policy responsibilities. The COO (Acute) position is abolished. The COO (Primary and Community) is redesignated as Executive Vice-President with a similar range of operational policy responsibilities as currently.
- Groups strategic public health responsibilities together.
- Removes Glenrose Hospital from the Edmonton Zone, to be accountable with other Metropolitan Hospitals.
- Does not incorporate the proposal for therapy services to be run as a *provincial business unit* (with direct line accountability centrally). An *operational policy support unit* covering this field will be created responsible to the EVP, Strategy and Performance. This unit will lead the implementation of a provincial rehabilitation integration initiative.
- Creates an EVP position responsible for the safety and quality agenda (including service improvement).
- Groups strategy and accountability functions, together with monitoring capacity, under an EVP.
- Creates an *operational policy support unit* for nursing, to be led by a Vice-President Nurse Strategies.
- Reduces the number of management positions significantly (~ 100) and shortens reporting lines.
- Reduces the number of positions with Senior Vice-President and Vice-President titles, and bases these on breadth of responsibilities, not on the position to which they report.

## The Interface between Clinical Service Units, Provincial Business Units and Operational Policy Support Units

The core business of Alberta Health Services is the provision of treatment and/or care to our patients, clients and residents and to reduce the burden of illness in the communities we serve. The clinical service units are critical to how the community will judge our performance. Their work is facilitated by provincial business units (in areas such as laboratory, security services, and payroll) and operational policy support units. Some corporate units combine business unit and operational policy support functions.

Clinical service units (hospitals and zones) are supported by a number of provincial business units created to achieve greater sustainability through economies of scale and/or implementation of specialized management. The relationship between clinical service units and provincial business units will be governed by specific service level agreements. These agreements, to be signed off annually by the respective heads, will cover issues such as volume (and pricing) of services to be provided, quality metrics, and dispute resolution mechanisms. Internal prices and the basis of charging (per test, per head count, per m<sup>2</sup>) to be used in the service level agreements will be determined as part of the annual budget process. The provincial business units (and/or their out-sourced equivalents) will be accountable through their line management for the unit pricing of services they provide. Clinical service units will be

accountable for utilization of services through the effect on internal pricing and charging. Internal charging will be done monthly to minimize transaction costs.

Operational policy support units (in areas such as primary and seniors care) are also created to facilitate the work of clinical service units by developing provincial operational policies and procedures. These support units normally will not be involved in day-to-day operational issues. Their principal outputs will be developing the operational policy suite and facilitating and monitoring its implementation. They may also have a role in providing feedback to clinical service units and provincial business units in terms of access, quality and sustainability. Heads of operational policy support units do not have line management accountability for staff at the front line, even though those staff may be providing services encompassed within the operational policy suite for which they are accountable. Front line staff will be line managed through clinical service units or provincial business units and work within contemporary standards of professional practice and the operational policy suites endorsed by the Alberta Health Services executive and/or Board.

The new formal structure means that members of the Executive have both strategic and operational responsibilities. This links all the Executive very directly to the core business of Alberta Health Services: providing health care to Albertans and improving the health status of Albertans. In this sense all staff of Alberta Health Services are 'care givers' whether occupying designated clinical roles or not.

Although the new formal structure cannot be described as 'matrix management', operational policies and strategies may be continue to be developed through matrix style arrangements (involving corporate and operational staff). As policy only has relevance to the extent it is implemented, it will be important for there to be close links between corporate staff and operational staff in the development of our operational policies. In a sense the only way in which staff of operational policy units will be able to reach their accountabilities will be through developing and working in teams with operational staff. Although a team approach may be used in development of operational policies, implementation of these new operational policies will be through a single, unambiguous line management.

## Accountability and Decision Rights

The new structure is to be accompanied by revised accountability arrangements to be introduced as part of a new planning cycle for the organization. In particular, heads of major clinical service units will be required to develop and sign 'Annual accountability statements' which will outline budget and service delivery targets for the unit, and the unit's contribution to the areas of focus identified for Alberta Health Services. In line with the move to a global budget arrangement between the Ministry of Health and Wellness and Alberta Health Services, the budget for major units will minimize restrictions on movement of funds.

A new decision rights framework will be finalized and issued by the end of June to articulate the delegations each manager can exercise. The new framework will cover both human resource and financial delegations.

Although managers will have clear, formalized decision rights, these are expected to be exercised with appropriate consultation and engagement; indeed, it is proposed that a key principle for the whole organization will be appropriate *engagement*. Specifically, managers and

organizational units will be expected to have strategies and/or structures for appropriate consumer, clinician and colleague engagement.

Further work is underway on a proposed Alberta Health Services' approach to consumer engagement but the essential elements will include:

- a consistent approach across the province to Community Health Councils (together with centralized support for the councils);
- a mandate for all delivery units to develop community engagement strategies appropriate to their size, location and role, which incorporates consistent enterprise-wide approaches and methodologies; and
- consumer engagement strategies appropriate for each program area.

A new function, to lead the development across the province of new forms of clinician engagement is identified. New multi-disciplinary, clinician-led arrangements will be created to develop provincial standards, provincial clinical pathways, monitoring frameworks and quality improvement strategies in specific areas (e.g. emergency and urgent care, orthopedics). In addition, consideration is being given to an 'Alberta Clinical Council' to bring a clinical perspective to bear on critical system issues.

'Colleague engagement' is meant to be very broad, including that, where appropriate, colleagues from operational policy support units will be consulted by operational managers (and vice versa), colleagues from finance or human resources will be consulted when their expertise could contribute to improved decision making, colleagues from other disciplines are involved in clinical decision making, service improvement initiatives and review of adverse events and so on.

## Operational Coordination

Operational coordination across the province will be strengthened through the creation of a Provincial Operations Group consisting of the three acute Senior Vice-Presidents, the Zone and Cancer Corridor Vice-Presidents, the five Zone Medical Directors and the Vice-Presidents for pharmacy, laboratory services and diagnostic imaging. This group will meet at least monthly to discuss common operational issues. Corporate staff would also attend as required. Similarly, sub-groups, such as the Zone Vice-Presidents, may also meet regularly.

The Provincial Operations Group will meet with the Alberta Health Services Executive every two months to facilitate two-way communication: the Executive to receive updates on progress from the operational units against their accountabilities and the operational units to raise issues with the executive requiring development of provincial operational policy or strategy.

## Geographic Coordination

Both Edmonton and Calgary have multiple acute facilities which have developed with specific, complementary roles. Under both the current and new structures, line accountability for site management diverges (compared to the previous regional structures) and in the new structure will report to separate members of the Alberta Health Services executive. A city 'collaboration group' will be established in each city consisting of the relevant local managers (of both acute and community facilities) and the Zone Medical Director, tasked with ensuring that existing productive collaborative arrangements continue and that new opportunities to improve service delivery through collaboration be vigorously pursued. The Edmonton collaborative group will,

in the first instance, be convened by Deb Gordon, the Calgary group by Brenda Huband. Management and implementation will be through standard line accountability arrangements in addition to their Senior Vice-President roles. These two collaborative groups will also need to ensure that there is appropriate involvement with other acute facilities and communities which refer to and receive patients back from acute facilities in the two cities, as well as with the respective universities.

Similar, but probably less formal, arrangements need to be implemented across the province to ensure good linking between regional acute facilities and other services for the same population.

## Medical Staff Structure

An effective medical staff organizational structure is necessary to ensure the optimal functioning of the physician community in its mandate to contribute to timely, high quality, and sustainable health care, and to meet legislated responsibilities and requirements with respect to the regulation, accreditation, and appointment of physicians. With the creation of a single health authority, there is both need and opportunity for improvement, optimization, and innovation by bringing provincial consistency, best practices, and efficiency to the medical staff structure and function. To this end, the Senior Physician Executive will be assisted by two Associate Physician Executives and an administrative / support staff drawn from the existing pool of medical affairs expertise and personnel.

While central accountability and provincial consistency are essential, medical organization should be *managed*, and medical staff affairs *implemented*, in geographic units – units larger than the former regions but not as one central “head office” enterprise. This will permit the necessary degree of “local” flexibility. In order to align medical staff structure with the overall organizational model, the provincial medical staff will be organized and subdivided by Zones. Each of the five zones will have a Zone Medical Director, reporting to the Senior Physician Executive, who will manage the “local” medical staff structure, function, and affairs, and will ensure physician engagement and communication within the Zone. The Zone Medical Director will work in partnership with the Zone Vice-President, and, in many instances, will also serve as an acute care Site Medical Director.

To further enhance the engagement of physicians in clinical operations decision-making, Senior Medical Directors will work in partnership with the Senior Vice-President / Vice-President of key portfolios such as Mental Health & Addictions, Seniors Health, Primary Care & Chronic Disease Management, Emergency Medical Services, and others. The Senior Medical Directors will report to the Senior Physician Executive. Similarly, Site Medical Directors, reporting to the Zone Medical Director, will work in partnership with acute care and other facility Vice-Presidents and site leaders.

## Titles

In the previous structure titles (such as Senior Vice-President) were based on to whom the position reported, rather than the inherent complexity or scope of the position. In the new structure, titles will reflect the role being performed, regardless of the level to which the position reports. This means that an Executive Vice-President can have both Senior Vice-Presidents and Vice-Presidents as direct reports. The titles shown in the organizational charts will be subject to reviews as part of a formal job evaluation process which will also be used to determine the remuneration for each position.

## Culture change

The new formal structure is but one step in the creation of Alberta Health Services. Of far more importance is the change in culture: to take a provincial perspective on issues, to ensure good ideas developed in one part of the province are shared across the province, to live out better the values of the organization of respect, accountability, transparency and engagement. Creating and embedding this culture will be a critical task of all leaders in the organization, supported by the Executive and the Human Resources group.

A number of strategies will be required to achieve the requisite culture change but one will be to develop and nurture the senior leadership of the organization. As a first step meetings will be convened, at least annually, of the 'Provincial Leadership Group' (all Vice-Presidents and above, including Zone and Senior Medical Directors). The timing of the meeting will normally be determined in the light of the new planning cycle being developed but the first meeting will be in mid to late June 2009.

## Transition

Implementation of the new formal structure will be conducted according to the draft value set for Alberta Health Services included in the Draft Strategic Directions: respect, accountability, transparency and engagement. In general, however, transition issues will be minimized because whole organizational units are being realigned. Heads of these units will continue in their current roles although Regional Liaison roles will cease with the introduction of the new structure. A key guiding principle of the transition will be that existing responsibilities will continue in place until there has been a clear assignment and acceptance of the transition of responsibilities from the old formal assignment to the new. Staff unsure of assignment of roles or reporting arrangements should raise this with their supervisor after the full details of the new structure is released on May 15, 2009.

Permanent filling of newly created positions will occur as quickly as possible, with appropriate interim arrangements also put in place.

As implementation of, and transition to the new formal structure is finalized, there may be a need for further fine tuning to clarify precise responsibilities and accountabilities and salary levels. This process will be completed by June 30, 2009.

**S.J. Duckett**  
**President and Chief Executive Officer**  
**12 May 2009**