Improve Population Health, Enhance Patient & Provider Experience Of Care & Reduce Costs Of Providing Health Care

Population Health

- Disease, injury & disability prevention.
- Environmental health.
- Emergency health management.
- Health improvement.

Quality Clinical Services

- Effective
- Accessible
- Patient-centred
- Appropriate
- Safe

Sustainable Publicly Funded Health Care System

- Meet budget targets
- Efficient
- Value for money

Effective Health Promotion & Prevention

1. Improve population health through core public health programs and implement targeted health promotion and prevention initiatives to reduce the incidence of chronic disease.

Integrated & Targeted Primary & Community Health Care

3. Implement an integrated model of primary and community care to more effectively meet the needs of British Columbians, especially frail seniors and patients with chronic and mental health and substance use conditions.

High Quality Hospital Services

5. Implement a guideline-driven clinical care management system to improve the quality, safety and consistency of key clinical services and improve patient experience of care.

Service Transformation

Improved Innovation, Productivity & Efficiency In The Delivery Of Health Services

Driving Innovation & Efficiencies

4. Use patient focused funding to increase access and cost-effectiveness.
6. Drive LEAN across health service sector to redesign and improve services and functions.
7. Optimize the efficiency and effectiveness of emergency health services.
8. Achieve greater efficiency in the delivery of quality diagnostic services.
12. Reduce the cost of drugs, equipment and supplies.
13. Achieve savings through consolidating lower mainland administrative services.

Physicians & Health Human Resources

9. Optimize use of health human resources to improve clinical care and productivity.
16. Strengthen assessment and support for performance of medical professionals.

IM/IT

10. Improve patient safety and access to records through enhancements to the health carecard.
11. Complete the implementation of ehealth.

System Accountability

15. Optimize governance, leadership and operational and change management capacity.

Service Transformation Enablers

March 2012

British Columbia

Innovation & Change Agenda
2010-2013 Key Result Areas

BRITISH COLUMBIA | THINKHEALTHBC.CA

Ministry Vision
A sustainable health system that supports people to stay healthy, and when they are sick, provides high quality publicly funded health care services that meet their needs.

Strategic Actions
Our strategic direction, known as the Innovation and Change Agenda, was developed to achieve the Ministry's vision. This strategy is focused on making positive impacts to the quality of life for those who are facing increasing frailty, are managing chronic diseases or dealing with mental illness, as well as continuing to contribute to a sustainable health system. For fiscal 2012/13, the agenda consists of 3 service transformation KRAs, as well as a suite of enabling KRAs that will support the service transformation.

2012/13 Key Result Areas

2012/13 Key Result Areas

1. Improve population health through core public health programs and implement targeted health promotion and prevention initiatives to reduce the incidence of chronic disease.
3. Implement an integrated model of primary and community care to more effectively meet the needs of British Columbians, especially frail seniors and patients with chronic and mental health and substance use conditions.
5. Implement a guideline-driven clinical care management system to improve the quality, safety and consistency of key clinical service and improve patient experience of care.

Process/Enabler KRAs

4. Use patient focused funding to increase access to cost-effective elective surgeries and improve efficiencies.
6. Drive LEAN across the health service sector to redesign and improve services and functions.
7. Optimize the efficiency and effectiveness of emergency health services.
8. Achieve greater efficiency in the delivery of quality diagnostic services.
9. Optimize use of health human resources to improve clinical care and productivity.
10. Improve patient safety and access to records through enhancements to the Health CareCard.
11. Complete the implementation of eHealth.
12. Reduce the cost of drugs, equipment and supplies.
13. Achieve savings through the consolidation of administrative services across the Lower Mainland.
15. Optimize governance, leadership and operational and change management capacity.
16. Strengthen assessment and support for performance of medical professionals.

Key Result Areas – Complete

2. Streamline core public health services to improve delivery.
14. Redesign capital planning to optimize use of budget capacity.

Pages 6 through 45 redacted for the following reasons:
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s. 13

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
EVENTS AND REPORTS		
Launch of ParticipACTION/Healthy Families BC co-branded "Bring Back Play" Campaign October 9	• ParticipACTION will be launching their new National Social Marketing Campaign at an event in Vancouver. • From the launch day TV ads and print and digital marketing material will appear throughout BC under the co-branding of Healthy Families BC and ParticipACTION. • The marketing is focused towards mums to encourage them to incorporate play as a key form of physical activity for their children.	• Announcement planned for early October (possibly October 9, 2012).
MoH Internal Investigation	• Investigation launched in response to allegations of inappropriate or irregular data access arrangements and contracting practices, as well as Standards of Conduct Policy conflicts of interest involving MoH staff and contractors.	• Minister to be briefed ASAP / GCPE preparing communications materials.
Provincial Territorial (PT), and Federal, Provincial , Territorial (FPT) Health Ministers' Meeting – Halifax, NS, September 27 & 28, 2012	• Annual meeting of Health Ministers. The PT meeting will primarily focus on the follow up work required from the Council of the Federation Meeting in July 2012 and the work of the Health Care Innovation Working Group (HCIWG) on Clinical Practice Guidelines, Health Human Resources, Scope of Practice. • The FPT meeting will discuss the federal and provincial roles, and potential areas for collaboration. As PTs feel they have been fairly successful on their work through the HCIWG, some are not keen on collaborating with the federal government except in areas where the federal government has clear jurisdiction (e.g., regulation of drugs). The agenda includes a discussion on progress on promoting Healthy Weights in children.	• Decision regarding Minister's attendance required ASAP. • MoH's IGR branch will prepare briefing materials for the Minister and, assuming Minister will attend, provide a briefing the week of September 17.
BUDGET		
BC Health Services Purchasing Organization (HSPO) release of Annual Report for 2011/12	• HSPO preparing 2011/12 annual report on patient focused funding implementation. • HSPO is expecting to make the annual report available to the Ministry by September 2012.	• Review by Ministry • Approval from Minister • GCPE communications approval and decision on timing of release.

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30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Release of Health Authority Service Plans for 2012/13 – 2014/15	• Health Authority Service Plans are due to be published in early September. • In the past there has been media interest in the plans – primarily in the out years of the budget section (showing the rate of budget growth), performance measures and sometimes the strategies. • Media coverage has been both positive and negative.	• The Minister and potentially Premier will need to be prepared to answer questions about the plans. Issues note is being prepared prior to the plans' release (early September).
CAPITAL		
Lakes District Hospital (Burns Lake) – replacement hospital – Release of Request for Proposal (RFP) to shortlisted design/build proponents	• Release of RFP to short listed companies to bid on the design/build contract for the new hospital. Shortlisted firms will receive request for proposal document on which to develop their individual project bids. • Release RFP – September 2012. • Construction of new hospital to begin in Spring 2013.	• Announcement
Queen Charlotte/Haida Gwaii Hospital – replacement hospital – tender site preparation work	• Tender contract for work to prepare the site for the new hospital (work entails construction of new foundations, relocation of existing building, etc.). • Construction of new hospital to begin in 2013.	• Announcement of Tender
LABOUR		
Anaesthetists and other - Physician Specialities	• s.13 • Coordinated approach and messaging will continue between MoH and HAs. • Specialist Recruitment and Retention Fund adjudication under renewed PMA to consider which specialties receive part of $20M. • S. 13	• Minister may need to respond.
BC Government and Employees Union (BCGEU) and Professional Employees Association (PEA) strike continues	• Experiencing rotating job action throughout the province. • Province-wide (all site) job action on September 5, 2012. • MoH Strike Contingency Plan in place and key staff continue to monitor/report out on situation.	/A

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Co-located worksites during the British Columbia Government and Service Employees' Union (BCGEU) strike	• BCGEU will stage a one day full-scale strike on Wednesday, September 5th. PEA and COPE are participating in this action. • Health employers distributed a letter to their employees indicating their obligation to work as usual. • The Labour Relations Board has been alerted to the possibility that orders or other assistance may be required on extremely short notice should disruption of health care services occur.	N/A
Community Bargaining Association (CBA) is proceeding with a strike vote	• The current agreement expired March 31, 2012. • Negotiations with CBA broke off on August 24, 2012. • Essential service orders must be in place across the health sector before any union is able to take job action. • The Labour Relations Board anticipates being able to begin issuing essential service orders during the week of September 4, 2012. Although this may be optimistic.	• Communications issue – potential for Minister to comment when strike vote results are released (anticipated at end of September).
Health Science Association (HSA) regional meetings	• HSA's annual fall regional meetings have been scheduled starting September 24 through to October 25, 2012.	• Communications Issue
Negotiations with the Professional Association of Residents of British Columbia (PARBC)	• Current agreement expired March 31, 2010. Although PARBC has taken a strike vote, it has not announced the results. Given the passage of time, the strike vote will need to be retaken, before any action. • Residents' services are now included in essential services planning; s.13 s.13 • After the employer presented a proposal for a four year collective agreement in June, the Professional Association of Residents of British Columbia informed the employers that it would not be providing a counter offer to the proposal. • All essential service orders must be issued before any union can engage in strike action. • Essential service negotiations are expected to resume during the week of September 4, 2012; mediations may begin the following week.	• Communications Issue

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Negotiations with Nurses Bargaining Association (NBA)	• Negotiations will continue until September 5, 2012. • NBA Executive Council meeting scheduled for September 5, 2012. • Council will make a decision on whether to proceed on a strike vote or not.	• Create Communications information note for the Minister, if Council decides to proceed with strike vote.
Negotiations with Facilities Bargaining Association (FBA)	• FBA bargaining is scheduled to resume from September 6-15, 2012.	• Communications Issue
Negotiations with Health Science Professionals Bargaining Association (HSPBA)	• HSPBA bargaining is scheduled to resume from September 11-14, 2012.	• Communications Issue
Potential renewed provincial agreement with the British Columbia Dental Association	• The parties reached an agreement in principle on July 24, 2012 for a two year Master Agreement and Payment Schedule. Details are being determined through drafting. • Request for approval to sign off on negotiated agreement is anticipated at the end of September.	• Communications Issue – potential for Minister to comment at the end of September.
Renewed Physician Master Agreement (PMA)	• Negotiation completed with BCMA on the renewed PMA in May 2012. • Agreement ratified by the BCMA with 92.4% support on July 24, 2012. Agreement signed July 25, 2012. • MoH has developed PMA Implementation Plan.	• MSHHR is working with BCMA and ministry/ health authority staff to implement the required changes from the 2012 PMA.
Results of the Licensed Practical Nurse (LPN) representation vote are expected	• British Columbia Nurses Union has applied to represent (raid) LPNs in the Facilities Bargaining Association (FBA) who are currently members of HEU/BCGEU. • LPNs have voted on which union they wish to represent. • The Labour Relations Board will determine any objections and announce the outcome of the vote. • The Ministry, Health Employers Association of BC and health employers are neutral. • The vote outcome will impact bargaining at the FBA and Nurses Bargaining Association.	• s.13
LEGISLATION		

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30-DAY ISSUES

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Implementation of ban for youth under 18 from using commercial UV tanning	• Regulation will ban youth under 18 from using commercial UV tanning. • Implementation plan in place	• OIC scheduled for September 24 Cabinet meeting. • Communications material to be prepared and signs distributed.

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30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
PROGRAM ISSUE OR CHANGE		
Age Friendly Grants	• Since 2007, age-friendly planning and project grants have been administered through UBCM, with funding from MoH. • Preparations for another round of grants (approx $500,000) are nearing completion and can soon be announced.	• Decision to be made on timing and form of announcement. Could take place at or during the UBCM convention September 24-28 in Victoria.
Annual Progress Report (Tripartite Committee on First Nations Health)	• The BC Tripartite Framework Agreement on First Nation Health Governance commits the Tripartite Committee on First Nations Health to prepare and make public an annual progress report for the Minister of Health (BC), the Minister of Health (Canada), and the First Nations Health Council on the progress of the integration and the improvement of health services for First Nations in BC.	• Ministerial approval of the annual progress report required in early October 2012.

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30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Assisted Living Registration of Mental Health and Substance Use Residences	• The Assisted Living Registrar is working toward implementing registration of all public and private pay MHSU residences that meet the criteria for assisted living under the *Community Care and Assisted Living Act*.	• Possible announcement by Minister when registration gets underway (could be fall).
BC Services Card Project Implementation	• MoH is working CITZ, ICBC, and HIBC on development of BC Services Card project to November 30, 2012; consulting with internal and external stakeholders; MoH responsible for post-implementation program, and re-enrolment of all eligible BC Residents before November 17, 2017. • Focus Groups with Health Sector including Health Authorities, professional associations, laboratories and other stakeholders that use the current Health Card and will be using the new BC Services Card. • Focus Groups with Patients as Partners to obtain Health Literacy input on all MoH communication materials. • Potential delay in November 30 launch date due to increased labour pressures particularly at ICBC.	• Minister briefing required within 30 days as there is potential delay in November 30, 2012 launch date.
Cataract Fee Proposal	• Government pursuing reduction in cataract surgery fees via PMA process. • Ad hoc joint review panel to provide majority recommendation by early October. • Final decision by Medical Services Commission is highly likely later in the Fall of 2012.	• Possible media coverage to supplement past coverage of ophthalmologist earnings. • Possible negative reaction from ophthalmologists if government proposal succeeds.
Choice in Supports for Independent Living (CSIL) client living out of country	• Client has previously received CSIL services through VCH while out of country for 4-5 months per year. • Client has now transferred to FHA where they do not allow clients to live out of country and still receive funding. • Consistent policy to be developed to set limits to the amount of time a CSIL client can be out of the country	• Potential for media attention.
Colorectal Cancer Screening	• Ministry is working with BCCA/PHSA to implement a province-wide program including the transition from the current guaiac Fecal Occult Blood Test to the fecal immunochemical test.	• Communications materials are being prepared. • Possible media event/announcement September 2012.

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Dementia Action Plan	• The Dementia Action Plan is intended to support collaborative action over the next two years by individuals, health professionals, health authorities, and community organizations to achieve quality care and support for people with dementia, from prevention through to end of life.	• Dementia Action Plan could be publicly released in the coming weeks.

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Fraser Health Authority (FHA) directive	• Minister issued directive to FHA Board on June 12, 2012 to take a number of priority measures to improve infection control and congestion within the acute care hospitals in FHA over the next 30, 60, 90 and 150-days. • Internal 60 day report on progress due September 10. • October 2012 is potential publication timeframe for 90-day results. • 150 day progress report due December 5.	• Briefing with the Minister to be established. • Next steps TBD. • Communication materials to be prepared.
Healthy Minds, Healthy Campuses (HMHC) annual provincial summit, September 26-29, 2012 in Victoria:	• Annual conference of HMHC Community of Practice members attended by students, faculty, campus professionals, administrators, government, researchers and community members. • HMHC is a province-wide Community of Practice to promote mental wellness and reduce problematic substance use on campuses of BC's post-secondary institutions. • HMHC activities contribute to achieving outcomes identified in *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*.	• GCPE is working on an event proposal for Minister's consideration to attend part of the summit and announce the government's new $500K investment to support Healthy Minds, Healthy Campuses – it is expected to be submitted to Minister's Office in early September.

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Issuance of Billing Integrity Program Audit Report on the Specialist Referral Clinic (SRC) and Cambie Surgeries Corporation (CSC)	• MoH report presented to MSC at May 2012 meeting; further discussion by MSC June 2012; on the agenda for discussion September 2012. Cabinet briefing and public announcement have both taken place. • Audit identified that significant extra billing had occurred contrary to the Medicare Protection Act and that the extra billing often would overlap with physician claims of the Medical Service Plan. • The President of the above companies, Dr. Brian Day, has launched a Charter challenge of BC's health insurance laws saying people are being unfairly prevented from spending their own money to receive health care services in the private sector. • Two pending court cases (AB & ON) on this matter. • July 2012, MSC provided Clinics with 30 days' notice to stop extra billing. • MSC initiated injunction proceedings on August 17, 2012. • S. 13	• Minister to be briefed and communications material to be prepared in advance of the announcement of date for the court hearing.
Kaslo – Proposed permanent change in ED service hours	• IHA is proposing to change the service levels of the emergency department at the Victorian Community Health Centre from 24/7 to only weekday service. • Proposal developed in response to notice provided by the Kaslo physician group that they can no longer sustain 24/7 coverage effective October 1, 2012 as well as RN staffing changes.	• Communications material to be prepared.
Medical Services Plan premium rate increase effective January 1, 2013	• Full MSP premium rates will increase. • There will be no changes to the existing Adjusted Net income levels and all rates except the full premium rate, will remain the same as in 2012. • Systems changes underway at HIBC to accommodate rate adjustment. • Stakeholder engagement with public and Ministry of Finance.	• Communications materials to be prepared for distribution in October 2012.

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**

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North-eastern BC Oil and Gas Human Health Risk Assessment	• News Release June 4 announcing the completion of Phase 1. Phase I report was released to the public. • RFP for Phase II posted to BC Bid on June 28, 2012 and closed on BC Bid August 10, 2012. MoH received 6 proponent submissions. • Submissions are currently being evaluated. HPB hoping to have a contract in place before the end of October 2012, with work to begin shortly thereafter. • Project will be approx $ 900,000 and will take 18 months. • Monitor Stakeholder and Media responses	• Communications plan under development for late October announcement of successful proponent.
Options for Laboratory Transformation prepared by Sector Consulting	• The Ministry procured an independent, comparator study of laboratory service delivery in jurisdictions in Canada and elsewhere, to inform the development of a strategy to improve BC's laboratory service delivery. • Consultation with BC's laboratory stakeholders was also required so that comprehensive options could be proposed. • This report will be completed in September 2012 and presented to Laboratory Reform Committee on September 27.	• Communications strategy to be identified and approved by GCPE.

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Pan-Canadian Pricing Alliance: Procurement of Brand Name Drugs & recommendation to include Generic Drugs	• CoF Working Group on Health Care Innovation announced July 26, 2012 (Premiers Wall and Ghiz) to continue to accelerate and expand Pan-Canadian procurement for brand name drugs; and identifying 3 to 5 generic drugs for a competitive bidding process to achieve better prices. • A national competitive bidding process to be initiated by Fall 2012 to achieve lower prices as soon as possible. • S. 13 •	• Minister briefing to occur prior to September 2012 FPT Health Ministers' meeting.
Phase 1 of the Provincial Radiologist Peer Review Project	• The contract with the selected vendor for Phase 1 (proof of concept at VIHA) will be finalized and signed by all parties. This project is an important part of the Cochrane Action Plan and a News Release should be issued.	• Development and approval of a News Release.

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30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Physician Quality Assurance (PQA) – commitment to public report	• In the fall of 2011, Dr Cochrane submitted a report to MoH entitled *Investigation into Medical Imaging, Credentialing and Quality Assurance.* • An Action Team, , led by the Ministry and including membership from the health authorities and the College of Physicians and Surgeons of BC, was replaced with a PQA Steering Committee in June 2012 and is currently overseeing a series of projects under the umbrella of a Physician Quality Assurance Portfolio. • The portfolio includes a provincial protocol for adverse events, as well as initiatives touching on the full cycle of physician performance management including licensure, credentialing, privileging and performance assessment.	• The Ministry has committed publicly to report back on the PQA progress in September 2012.
Privacy Commissioner – Lyme Investigations	• The provincial Privacy Commissioner announced two new investigations on July 30, 2012. • One includes reference to PHSA/BCCDC/Government's failure to disclose public health information about Lyme disease. • Investigation began in August 2012.	• Communications materials to be prepared to respond to any media enquiries.

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Public reporting of paediatric and cancer surgery wait times, and hip fracture fixation rates, on the provincial Surgical Wait Times website	• The Surgical Wait Time website was expanded in a test environment to publically report paediatric surgical wait times. This expanded capacity also includes adult cancer surgical wait times and hip fracture fixation rates. • While some of the available data is positive, there are other areas where service delivery does not meet target benchmarks. Media attention tends to focus on the latter.	• Website release date anticipated in early September • Media interest / queries could be generated.

30-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Seek and Treat to Optimally Prevent HIV (STOP HIV) Pilot	• Pilot ends March 2013. • Decision to provincially expand pilot was made on June 22, 2012. • Primary partners still awaiting government's decision on provincial expansion. • Next opportunity to communicate a decision occurs on September 19, 2012 during the STOP HIV Steering Committee meeting.	• Potential communication on government decision to provincially expand the pilot in September.

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60-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
EVENTS AND REPORTS		
Announcement of $6M funding over 2 years to Childhood Obesity Foundation	• Funding for new province-wide interventions for children with unhealthy weights and their families. Likely media event end of October in Vancouver with Premier/Minister. • Supports Health Families BC agenda to improve healthy eating, physical activity and healthy weight. Part of continuum of services needed to address childhood obesity that includes prevention and management. • Involves expanding services in health authorities and adding new community services in partnership with YMCA and BC Recreation and Parks Association. Also potential to leverage telehealth services at HealthLink BC.	• Announcement to be scheduled, likely late October.

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UBCM Convention September 24, 2012	• Resolutions submitted by local government bodies and advocacy groups for endorsement by UBCM memberships. • Local and group-specific (e.g. seniors) concerns are submitted as resolutions for discussion. • Materials to support Minister in meetings with municipalities to be initiated as soon as meetings confirmed.	• Minister's participation in UBCM to be confirmed ASAP – including participation in September 26 Cabinet Panel re: Healthy Families • Minister meetings at UBCM still TBC.
BUDGET		

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60-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
CAPITAL		
Cancer Centre for the North (Prince George)	• Official celebration to mark the grand opening of the new BC Cancer Agency Centre for the North. • The opening date of the Centre for first treatment is November 1.	• Event and ribbon cutting ceremony.
Children's & Women's Hospital – Clinical Support Building – construction completion	• Completion of the construction phase for the new Clinical Support Building – part of the first phase of redevelopment of Children's & Women's Hospital.	• Announcement and potential ribbon cutting ceremony.
Hope Centre (new mental health building, Lions Gate Hospital, N. Vancouver – tender of construction contract	• Tender and award contract for construction of the building.	• Announcement and potential ground breaking ceremony.
Queen Charlotte/Haida Gwaii Hospital – replacement hospital – Shortlist design/build proponents	•	Announcement
	•	
	•	
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Queen Charlotte/Haida Gwaii Hospital – replacement hospital – Award tender site preparation work	•	Announcement of contract award. Potential ground breaking ceremony for minor site works.
	•	
LABOUR		
Health Science Association (HSA) regional meetings	• HSA's annual fall regional meetings have been scheduled starting September 24 through to October 25 2012.	• Communications Issue

LEGISLATION

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PROGRAM ISSUE OR CHANGE

- Approval of submission to Priorities and Planning Committee for possible January 2014 implementation.

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60-DAY ISSUES		
ISSUE	KEY FACTS/IMPLICATIONS	REQUIRED ACTION/DECISION
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Tripartite Health Partnership Accord	S. 16, S. 13	

90-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
EVENTS AND REPORTS		
Federal/Provincial/Territorial Ministers (F/P/T) Responsible for Seniors Annual Meeting	• The proposed agenda includes: review and approval of 2011/12 deliverables; strategic discussions in three areas: supporting active participation (older workers balancing work and elder care responsibilities); planning for aging in place; and supporting seniors though technology and improving access to information; priority-setting and confirmation of future work.	• Decision re: Minister's attendance at the November 15-16, 2012 meeting in Halifax, Nova Scotia. • The Seniors' Healthy Living Secretariat will provide briefing materials.
BUDGET		
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CAPITAL		
Queen Charlotte/Haida Gwaii Hospital – replacement hospital – Release of Request for Proposal (RFP) to shortlisted design/build proponents	• • • • S. 13	• Announcement
LABOUR		
Hospital Employees' Union (HEU) convention	• HEU's convention has been scheduled from November 4-9, 2012.	• Communications Issue
PROGRAM ISSUE OR CHANGE		
		• Create Communications information note for the Minister.
	S. 13	• Create Communications information note for the Minister.

90-DAY ISSUES		
ISSUE	**KEY FACTS/IMPLICATIONS**	**REQUIRED ACTION/DECISION**
Care Aide and Community Health Worker Registry Review	• Minister of Health has directed an independent review be undertaken • The Ministry has contracted with Dr. Vicki Foerster and James Murtagh to conduct the review. • Review will examine the strengths and weaknesses of the registry and identify opportunities to build on existing successes and identify potential gaps in progress.	• Recommendations in a final report to Minister by November 2012. • Announcement opportunity.

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90-DAY ISSUES

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ANNOUNCEMENTS

30 Days

- September 7 – News release about new nursing paging system at Kiwanis Care Centre in North Vancouver
- September 9 (5 – 9 p.m.) – 9th annual "Passions" event at the Dr. Peter Centre to support the Dr. Peter AIDS Foundation
- September 12 (1 p.m.) – Kootenay Lake Hospital ER Redevelopment Project grand opening in Nelson
- September 13 (10 a.m. MT) – Event to reopen heliport at Invermere & District Hospital
- September 17 (10 a.m.) – Official opening of new emergency department at Nanaimo Regional General Hospital
- September 18 – UBC Pharmaceutical Science Building Opening Vancouver
- September 18 (10 a.m.) – Countdown to the opening of the BC Cancer Agency Centre for the North in Prince George
- September 18 (8:40 a.m. – 8:50 a.m.) – Minister MacDiarmid to participate in Sher-E-Punjab Radio radiothon
- September 21 (10 a.m.) – Goldcorp to announce $5M mental health gift
- September 23 (11 a.m.) – Ismaili Walk 2012 ($25K)
- September 24 – Sports Day in Canada Media Tour
- September 24 – News release on regulations allowing nurse practitioners to admit and discharges patients from health care facilities
- September 26 – 29 – Healthy Minds/ Health Campuses Summit 2012, an annual summit to support mental wellness among post-secondary students in B.C.
- September 27 – UBCM session Focus on Seniors: A collaborative approach
- September 27 – 28 - Halifax, Ministers of Health meeting
- September 28 – Announce new seniors website
- September 28 - UBCM ParticipACTION walk
- September 29 – Sports Day in Canada (CBC live hit in Kamloops)
- September 29 (7 p.m.) – Funding announcement for Michael Cuccione Foundation at 17th annual fundraising gala
- September 30 – Canadian Breast Cancer Foundation annual Run for the Cure event
- Late September/ early October – Announcement of mobile MRI service on Vancouver Island
- UBC to open new Health Sciences building, part of its distributed medical program
- News release / information bulletin on new BC Services Card
- Joint announcement with BCMA of new Rural General Practitioner Anesthesia Locum program
- Physician Quality Assurance (Cochrane report and commitment to report publicly in September
- Announce funding ($48M) for Michael Smith Foundation for Health Research
- Announce First Nations Community Gardens ($700,000)
- Fraser Health programs open at Quibble Creek (Surrey) – BC Housing event to take place in late September

30 Days (cont.)

- Topping event to mark final concrete pour in critical care tower at Surrey Memorial Hospital – last two weeks of September
- Provincial Dementia Action Plan release

60 Days

- Flu shot event to tie in with Influenza Immunization Awareness Month
- Marketing campaign for BC Services Card to launch
- Announce Vancouver Coastal Health dashboard for emergency departments
- Launch workplace Wellness Fits tool to tie in with Healthy Workplace Month
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- Roll out colorectal screening program
- Official opening of the Silver Kettle Village in Grand Forks
- Opening of new BCAS station on Denman Island
- Opening of new BCAS station on Quadra island
- Early-mid October – Groundbreaking for Interior Heart and Surgical Centre surgical building
- Week of October 9 – Launch of ParticipAction's Bring Back Play campaign and funmobile tour
- October 11 – World's first International Day of the Girl.
- October 18 TBC – HOpe Centre construction milestone event
- October 29 or 30 TBC – RIH Hospital Medical Device Reprocessing unit official unit opening
- November 1 – Cancer Centre for the North open to patients

90 Days and beyond

- Early November – $1M for Heart and Stroke Foundation for province wide defibrillator program
- November 30 – New BC Services Card to come into effect
- Completion of full phase of renovations for the $44 million St Mary's Hospital expansion
- BC elder abuse strategy to be published
- BC Seniors Guide to be published
- Dec. 10 – Event to mark the first ever cardiac surgery in the Interior
- January 2013 – Standardized benefits and protections for all residential clients regardless of where care is received.
- April 2013 – Announce the commissioning of the Royal building at Kelowna General Hospital as part of the Interior Heart and Surgical Centre project
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LEGISLATIVE AGENDA FOR 2013

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MINISTRY PROFILE

Ministry:

HEALTH

Ministry Mandate:

The Ministry of Health has overall responsibility for ensuring that quality, appropriate and timely health services are available to all British Columbians with a mandate to guide and enhance the Province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry works with health authorities, care providers, agencies and other groups to provide access to care. The Ministry provides leadership, direction and support to these service delivery partners and sets province-wide goals, standards and expectations for health service delivery by health authorities. The Ministry enacts this leadership role through the development of social policy, legislation and professional regulation, through funding decisions, negotiations and bargaining, and through its accountability framework for health authorities.

The Ministry directly manages a number of provincial programs and services. These programs include: the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; the B.C. Vital Statistics Agency, which registers and reports on vital events, such as a birth, death or marriage; and HealthLink BC, a telehealth care platform providing comprehensive self-care and health system navigation services to British Columbians and health care professionals. The Ministry is in the process of working with the Provincial Health Services Authority (PHSA) to transfer operational responsibilities for the Emergency and Health Services Commission, which oversees the BC Ambulance Service across the province, to PHSA.

The Province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities are responsible for delivering a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, co-ordination and accessibility of selected province-wide health programs and services. These include the specialized programs and services provided through the following agencies: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Women's Hospital and Health Centre, BC Provincial Renal Agency, BC Transplant Society, Cardiac Service BC, and BC Mental Health and Addiction Services including Riverview Hospital and the Forensic Psychiatric Services Commission.

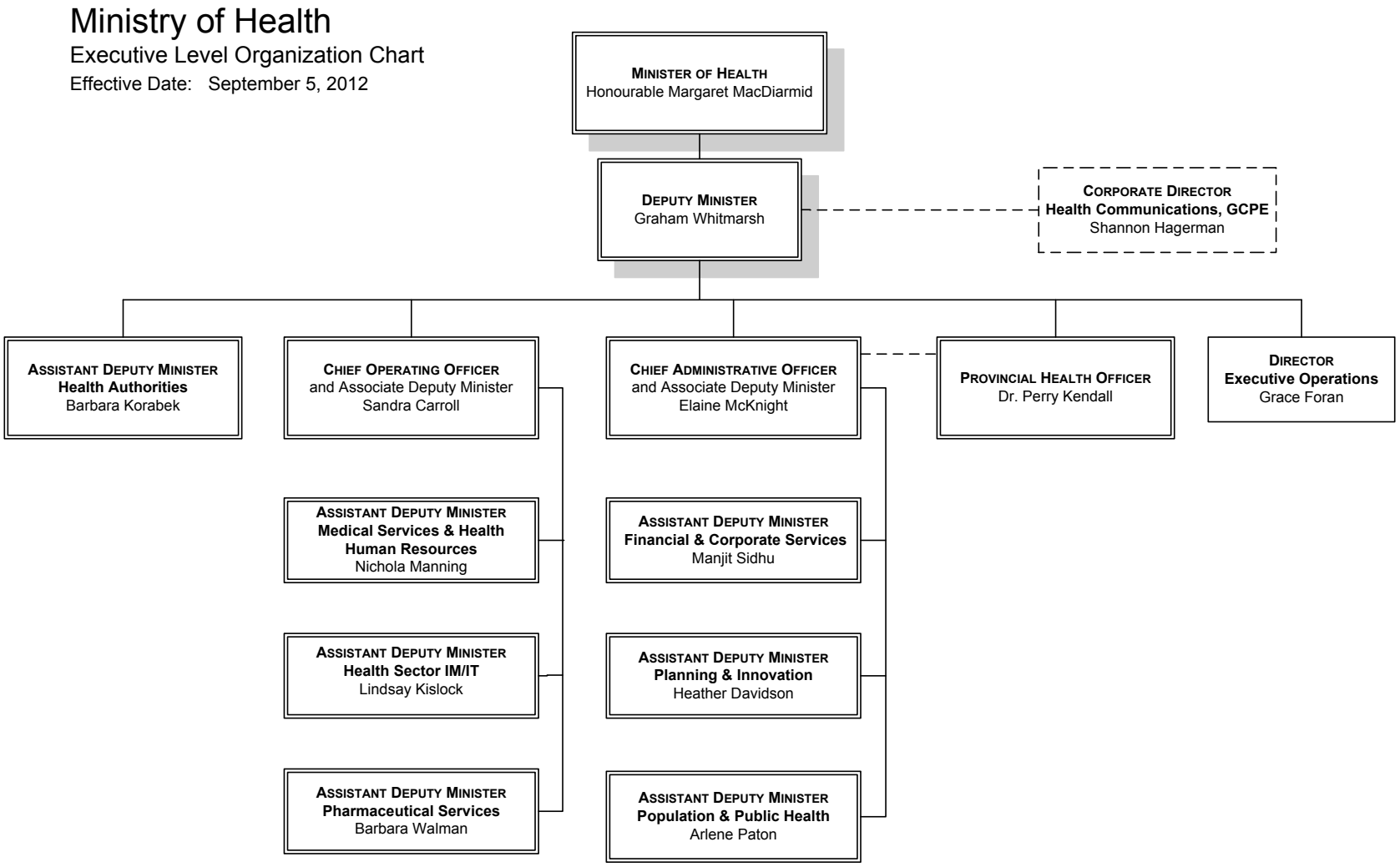
The delivery of health services and the health of the population are monitored by the Ministry on a regular basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health services continues to meet the needs of British Columbians.

Budget:

Core Business Area	2011/12 Restated Estimates[1]	2012/13 Estimates	2013/14 Plan	2014/15 Plan
Operating Expenses ($000)				
Health Programs				
Regional Services	10,561,534	10,858,769	11,286,809	11,651,528
Medical Service Plan	3,796,811	3,894,537	4,026,739	4,120,496
PharmaCare	1,139,722	1,185,330	1,229,208	1,266,429
Health Benefits Operations	34,410	35,123	35,560	36,005
HealthLink BC	33,322	34,741	34,741	34,741
Vital Statistics	6,734	6,863	7,000	7,140
Recoveries from Health Special Account Services	(147,250)	(147,250)	(147,250)	(147,250)
Executive and Support Services	160,391	164,754	164,756	164,756
Health Special Account	147,250	147,250	147,250	147,250
Total	**15,732,924**	**16,180,117**	**16,784,813**	**17,281,095**
Ministry Capital Expenditures (Consolidated Revenue Fund) ($000)				
Executive and Support Services	31,207	16,614	277	255
Total Capital Expenditures	**31,207**	**16,614**	**277**	**255**
Capital Grants ($000)				
Health Facilities	463,255	437,838	394,652	415,125
Total Capital Grants	**463,255**	**437,838**	**394,652**	**415,125**

[1] The amounts have been restated, for comparative purposes only, to be consistent with Schedule A of the 2012/13 *Estimates*.

Executive Organizational Chart:

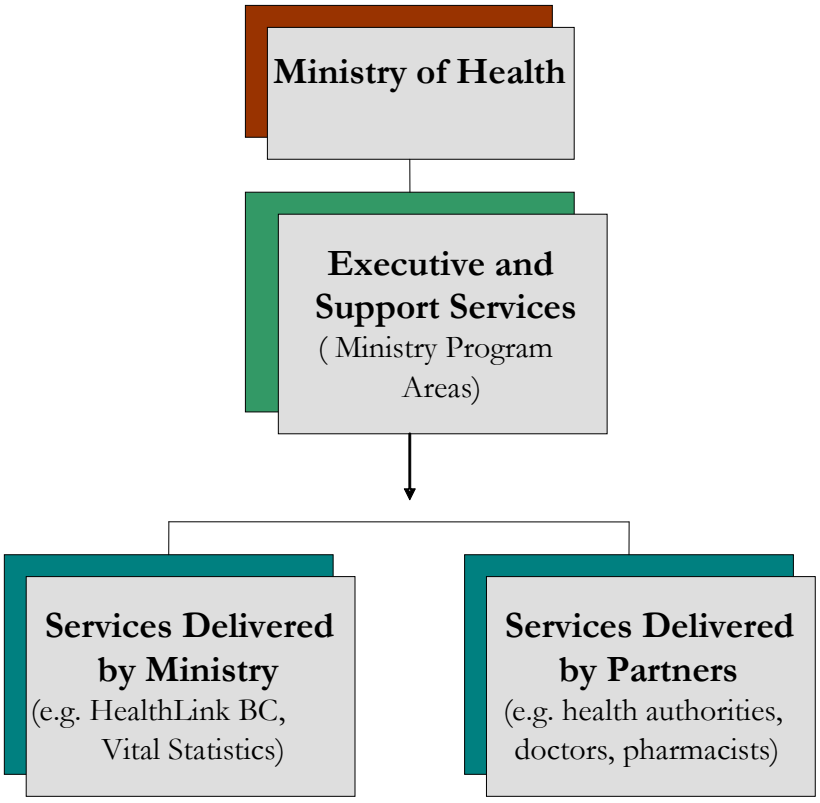


CORE BUSINESS AREAS

OVERVIEW

The Ministry of Health's core business areas are organized to reflect the major partnerships and roles that combine to form a high quality, coordinated health system for British Columbians. The Ministry's primary role is to provide leadership, direction and support to service delivery partners and set province-wide goals, standards and expectations for health service delivery. The vast majority of health services are delivered by system partners such as health authorities, care providers, agencies and other groups that provide access to care. The Ministry directly delivers some provincial programs such and HealthLink BC and the B.C. Vital Statistics Agency.

To reflect these roles the Ministry has three broad core business areas: *Services Delivered by Partners, Services Delivered by Ministry* and *Executive and Support Services*. The Ministry program areas (led by Assistant Deputy Ministers) reside in the *Executive and Support Services* core business area and provide leadership and oversight to the budgets and services delivered through the other two core business areas. Where applicable, this relationship is identified in the program area descriptions contained in this section.



PROGRAM AREA DESCRIPTION

Deputy Minister: **Graham Whitmarsh**

Program Area Description: **Deputy Minister's Office**

The Office of the Deputy Minister leads and coordinates the work of all areas of the Ministry. The Office provides leadership to ensure timely decision-making, effective service delivery and positive relationships between the Ministry and the executive offices of government, and between the Ministry and the health authorities.

The Office is responsible for articulating government's goals, commitments and priorities to the Ministry, and works with Ministry program areas in support of achieving these goals.

To enact this role, the Office provides a number of key central functions for the Ministry and broader health system including corporate services for executive operations support, Minister's Correspondence Unit and the Health and Seniors Information Line.

Related Legislation:

Ministry of Health Act: Specifies the functions and duties of the Minister and the Ministry of Health.

PROGRAM AREA DESCRIPTION

ADM Responsible: **Sandra Carroll**

Program Area Description: **Chief Operating Officer and Associate Deputy Minister**

The Chief Administrative Officer (CAO) provides leadership and oversight for the Medical Services and Health Human Resources Division responsible for both Medical Services and Health Human Resources, Health Sector Information Management/Information Technology Division, and Pharmaceutical Services Division. The CAO is also responsible for primary health care, legislation and professional regulation, and labour strategies. The CAO provides corporate leadership for the health system innovation and change agenda and ensures Ministry activities, policies and legislation are aligned to the ministry's strategic objectives.

Organization:

- Health Sector Information Management/Information Technology Division
- Medical Services and Health Human Resources Division
- Pharmaceutical Services Division
- Emergency and Medical Assistants Licensing
- HealthLink BC
- Labour Relations and Negotiations

Related Legislation:

Emergency Health Services Act: Establishes the Emergency Health Services Commission which is responsible for providing ambulance services and the recruitment and training of emergency medical assistants (EMAs). Also establishes the EMA Licensing Board.

Health Professions Act: Provides an umbrella framework for regulation of the following professions; acupuncturists, dentists, dental hygienists, dental technicians, denturists, dietetics, licensed practical nurses, massage therapists, medical practitioners, midwives, naturopaths, nursing, occupational therapists, opticians, pharmacists, physical therapists, psychologists, psychiatric nurses and traditional Chinese medicine practitioners.

Podiatrists Act: Regulates the practice of podiatry (foot care).

PROGRAM AREA DESCRIPTION

ADM Responsible: **Elaine McKnight**

Program Area Description: **Chief Administrative Officer & Associate Deputy Minister**

The Chief Operating Officer (COO) provides oversight to the Population and Public Health Division, Financial and Corporate Services Division, Planning and Innovation Division, and provides input to the Deputy Minister on individual Assistant Deputy Minister (ADM) performance. The COO is also the Executive lead for the Emergency Management Unit, Intergovernmental Relations and Strategic Human Resources.

The Planning and Innovation Division is responsible for supporting government in setting the strategic direction, objectives and initiatives to provide a quality, sustainable, high performing publicly funded BC health system that delivers clinical, operational and service excellence. The Division leads and supports the Ministry of Health and health authorities to establish clear strategic direction, strategic objectives and initiatives that are aligned to Government's priorities for the health system. The Division works collaboratively with key health service professional associations and unions where they have an interest in developing their strategic direction, objectives and initiatives to better align and work in conjunction with Government's health system priorities in the interests of improved patient care.

The Division also provides leadership to the Primary Health Care Strategic Project which is responsible for supporting the implementation of British Columbia's *Primary Health Care Charter* with the health authorities, B.C. Medical Association and other key stakeholders.

Related Legislation: N/A

Organization:

- Finance and Corporate Services Division
- Health Sector Information Management/Information Technology Division
- Planning and Innovation Division
- Population and Public Health Division
- Intergovernmental Relations
- Strategic Human Resources

PROGRAM AREA DESCRIPTION

ADM Responsible: **Manjit Sidhu**

Program Area Description: **Financial and Corporate Services Division**

The Financial and Corporate Services Division supports the Ministry Executive, programs and health authorities by managing and ensuring a consistent approach to financial and corporate services planning, policy, performance oversight/reporting, and critical financial and corporate services issues management.

Services provided include Capital Services Management, Health Authority Regional Grants Decision Support, and Finance and Decision Support. These services assist program areas and health authorities to meet their strategic goals and operational plans, and ensure compliance with relevant legislation, regulations and central agency directives.

Related Legislation:

Health Care Costs Recovery Act: Provides for the province to recover costs and expenses that it incurred in providing health care to an injured person resulting from a wrongful act or omission of a third party.

Health Special Account Act: Establishes a special account where half of lottery proceedings will be used to finance urgent health care priorities.

Hospital District Act: Establishes regional hospital districts to oversee the financing of hospitals. Establishes governance rules for boards in each hospital district. Provides for an annual capital grant to be paid to each board.

Organization:

- Capital Services Branch
- Regional Grants and Decision Support
- Finance and Decision Support

PROGRAM AREA DESCRIPTION

ADM Responsible: **Barbara Korabek**

Program Area Description: **Health Authorities Division**

The Health Authorities Division is the primary link between the Ministry and B.C.'s six health authorities to ensure the public has reasonable access to coordinated healthcare services, provided at an affordable and sustainable cost. The Division develops broad provincial policy and planning for acute care, home and community care, mental health and addictions and patient care quality, as well as patient safety initiatives. The Division represents the Ministry at the federal/provincial/territorial level on issues that require a pan-Canadian approach.

Health Authorities Division also is responsible for Clinical Care Management and collaborates with academia, health authorities and other health system partners to identify evidence-based innovation and best practices for the purpose of improving health service delivery and patient outcomes. The Division, on behalf of the Executive, provides effective monitoring systems to track, report, review and manage health authority performance linked to the Government Letter of Expectations and broader health authority performance management framework.

The Division provides oversight to the Regional Health Sector budget line in the Ministry's Services Delivered by Partners core business area. B.C.'s six health authorities are the Ministry's key partners in delivering services to British Columbians and more than 90 per cent of the Regional Health Sector funding is provided to the health authorities for the provision of most local health services. Regional Health Sector Funding provides for the management and delivery of health services, including mental health services to adults, acute care services, provincial programs and home and community care services.

Related Legislation:

Health Authorities Act: Provides for the establishment of five regional health authorities (Vancouver Coastal, Fraser, Interior, Northern and Vancouver Island) and the roles and responsibilities of health authority boards.

Hospital Insurance Act: Establishes in-patient and out-patient general hospital services available to British Columbia residents and provides for the payment of those services from the Hospital Insurance Fund.

Continuing Care Act: Authorizes funding and provision of one or more health care services to persons with a frailty or with an acute or chronic illness or disability that do not require admission to a hospital.

Hospital Act: Provides for the designation, licensing and administration of hospitals according to standards of management and care.

Community Care and Assisted Living Act: Licenses, regulates and overseas adult and child community care facilities and establishes a registration system for assisted living residences.

Health Care (Consent) and Care Facility (Admission) Act: Governs consent to health care and to facility admission as well as establishing a scheme for substitute decision makers.

Mental Health Act: Provides for facilities and services to mentally disordered persons, including detention of persons requiring supervision for their own protection, or the protection of others. Provides for the review of that detention.

Forensic Psychiatry Act: Establishes a Commission to provide psychiatric services to the court, to accused persons remanded for psychiatric examination, and to persons held at the direction of the LGIC under the Criminal Code or Mental Health Act. Commission is also authorized to plan related research and educational programs.

Human Resource Facility Act: Allows for government to issue grants for a residence or facility for the support or treatment of persons with addictions. [s. 1 (d)] [The remainder of the Act is the responsibility of the Minister of Children and Family Development]

Patient Care Quality Review Board Act: Establishes a province-wide patient complaints management and review system through Patient Care Quality Offices housed in health authorities, and through independent Patient Care Quality Review Boards associated with each health authority.

Access to Abortion Services Act: Places limits on protests and demonstrations in public places that are specifically intended to interfere with a person's right to access abortion services.

*Anatomy Ac*t: Allows for use of unclaimed bodies for anatomical research. The Coroner's office determines if a body is unclaimed.

Human Tissue Gift Act: Allows organs to be donated for therapeutic purposes, medical education or scientific research. Sale of any tissue for those purposes (except blood) is prohibited.

Health and Social Services Delivery Improvement Act: Provides employers in the health sector with flexibility in the application of collective agreements to alternative service delivery arrangements. [excluding Part 3, which is the responsibility of the Minister of Children and Family Development]

Health Sector Partnerships Agreement Act: Facilitates the development and implementation of public-private partnerships in the health sector to enable alternative delivery of non-clinical services to the public.

Organization:

- Acute Care and Performance Accountability (VCHA, FHA)
- Home and community Care and Performance Accountability (PHSA, NHA)
- Mental Health & Addictions and Performance Accountability (IHA, VIHA)
- Strategic Management Branch
- Innovation & Transformation Directorate

PROGRAM AREA DESCRIPTION

ADM Responsible: **Lindsay Kislock**

Program Area Description: **Health Sector IM/IT Division**

The Health Sector IM/IT Division is responsible for the Ministry's information management and information technology (IM/IT) systems. The Division provides IM/IT leadership and ensures that IM/IT strategies, policies, standards and technology initiatives support the integrated delivery of sound system wide health information management. The Division is responsible for the overall strategic development and implementation of the Ministry of Health annual *Information Resource Management Plan* and province wide planning, implementation and delivery of BC's eHealth program.

The Division also provides leadership and oversight to the Vital Statistics Agency (budget line in the Ministry's Services Delivered by Ministry core business area) and Health Benefits Operations (budget line in the Services Delivered by Partners core business area). The Vital Statistics Agency is responsible for the administration, registration, record maintenance, certification, statistical analysis, and reporting of births, deaths and marriages occurring in the province. There are two primary outputs of the Agency's vital event registration activities: the production of accurate, timely and relevant health statistics and information, and the issuance of certified documents pertaining to individual vital events (e.g. birth certificates).

Health Benefits Operations provides the administration of the Medical Services Plan and PharmaCare programs. The Division oversees the contractual agreement with Health Insurance BC for the services of registering beneficiaries, processing medical and pharmaceutical claims from health professionals, and responding to inquiries from the public. Recoveries are received from federal, provincial, territorial and municipal governments, organizations and individuals for services provided or funded by the Ministry.

Related Legislation:

E-health (Personal Health Information Access and Protection of Privacy) Act: Establishes a frame work to enable personal health information to be collected, used and disclosed using an electronic health record. Provides the legal basis for individuals to access their own personal health information.

Marriage Act: Provides for registration of persons authorized to solemnize marriages and issue marriage licenses.

Name Act: Provides for registration of a change of name with the Division of Vital Statistics.

Vital Statistics Act: Provides for a central registry of births, stillbirths, adoptions, marriages, and deaths.

***Wills Act* (Part 2)**: Provides for filing of notice of execution of a will with the Director of Vital Statistics. [The remainder of the Act is the responsibility of the Attorney General]

Organization:

- Corporate Management and Operations
- Business Management Office
- Integrated Health IT
- eHealth Privacy, Security & Legislation
- Vital Statistics
- Strategic Policy, Information Management & Data Stewardship
- Public Health Systems

PROGRAM AREA DESCRIPTION

ADM Responsible: **Nichola Manning**

Program Area Description: **Medical Services and Health Human Resources Division**

The Medical Services and Health Human Resources Division is responsible for managing the provision of physician medical services and supplementary allied health care provider services; preparing and negotiating the provincial agreement with the BC Medical Association and managing the implementation of the agreement; preparing and negotiating compensation agreements for supplementary benefit practitioners; developing provincial direction and policy to ensure there is a sustainable, qualified workforce to support health care in BC, and providing leadership and strategic direction on the provision of blood and blood products by the national blood authority.

The Division supports and liaises with the Medical Services Commission, which operates under the *Medicare Protection Act,* to facilitate reasonable access to quality medical care, health care and diagnostic facility services through the Medical Services Plan.

The Medical Services Plan (budget line in the Services Delivered by Partners core business area) provides funding for eligible services provided by medical practitioners, health care practitioners, diagnostic facilities and human resource and planning initiatives with respect to physicians. Physician services may be funded in a variety of ways: through fee-for-service, service contracts, salaried positions or sessions (3.5 hour blocks of time). Physicians are also paid for being on-call to health authorities, are provided with a suite of benefits, and are provided incentives to practice in rural areas. Funding also provides supplementary benefits to low-income British Columbians for a range of services, including physical therapy, naturopathy and chiropractics.

The Division is the primary link between the Ministry and the health authorities for physician services and health system workforce planning, policy, performance oversight/reporting and critical issues management in support of system service delivery. This is achieved through optimizing the contribution of knowledge, research and practice by working collaboratively with leaders in health authorities; unions and associations; regulatory bodies; educational institutions; and the research community.

Related Legislation:

Medicare Protection Act: Establishes the role and responsibilities of the Medical Services Commission and benefits under the Medical Services Plan (MSP). The Commission administers and operates the Plan, which pays for health care services that are benefits under MSP. [Except sections 5 (1) (b), 7 (5), 8 (4), 8.1, 8.2 and 32 which are the responsibility of the Minister of Finance]

Organization:

- Physician Human Resource Management
- Medical Services Branch
- Health Human Resources
- Health Human Resources Planning – Physicians
- Health Human Resources Planning – Nursing and Allied Health

PROGRAM AREA DESCRIPTION

ADM Responsible: **Barbara Walman**

Program Area Description: **Pharmaceutical Services Division**

Pharmaceutical Services Division is responsible for the overall coordination and performance of the publicly funded pharmaceutical programs throughout the province. The Division supports a therapeutically oriented pharmaceutical management strategy that will maintain and improve the health of British Columbians by optimizing their use of prescription drugs. This includes drugs that are funded through the PharmaCare program, the Provincial Health Services Authority (BC Cancer Agency, BC Renal, and Transplant Society), BC Centre for Excellence in HIV/AIDS, and the other Health authorities (acute care and residential care facilities and Public Health) and indirectly influences those funded by private insurers and individuals.

The Division oversees the PharmaCare Program ((budget line in the Ministry's Services Delivered by Partners core business area) program provides funding to individuals, agencies or other organizations for the full or partial cost of designated prescription drugs, dispensing fees, and other approved items and services that complement PharmaCare programs. PharmaCare includes seven benefit plans, the largest being the income-based Fair PharmaCare plan which providing assistance to B.C. families for eligible prescription drugs and designated medical supplies.

Related Legislation:

Pharmacy Operations and Drug Scheduling Act: Regulates the licensing and operation of pharmacies and the scheduling of drugs.

Organization:

- Drug Use Optimization
- Policy Outcomes, Evaluation & Research
- Drug Intelligence
- Business Management, Supplier Relations & Systems

PROGRAM AREA DESCRIPTION

ADM Responsible: **Heather Davidson**

Program Area Description: **Planning and Innovation Division**

The Planning and Innovation Division was created in March 2011 to include the former division of Stakeholder Relations, HealthLink BC, which transitioned into the Ministry of Health from the Emergency Health Services Commission, and the Emergency Medical Assistants Licensing Branch. In addition to these newly combined functions, the division will also provide leadership and support to priority transformation initiatives.

Related Legislation:

Emergency and Health Services Act: *[provisions related to the EMA Licensing Board]*. Establishes the Emergency and Health Services Commission which is responsible for providing ambulance services and the recruitment and training of emergency medical assistants (EMAs). Also establishes the EMA Licensing Board.

Organization:

- HealthLink BC
- Emergency Management Assistants Licensing
- Stakeholder Relations

PROGRAM AREA DESCRIPTION

ADM Responsible: **Arlene Paton**

Program Area Description: **Population and Public Health**

The Population and Public Health Division focuses on improving people's overall health and well-being by promoting health; preventing disease, disability, and injury; protecting them from harm; and assisting them to acquire the self-care and self-management skills they need. The intent of these actions is to promote a healthier population, and reduce current and future demands on the health care system.

The Population and Public Health Division exercises stewardship for public health services and invests resources strategically, based on the best available research, data, and evidence of best outcomes. All of the Division's business areas fulfill their work through stewardship, including planning, directing and evaluating programs, policies, and legislation; providing leadership and expert advice based on best practices and evidence in relation to their program-specific issues; and building partnerships with program-specific stakeholders.

Related Legislation:

Public Health Act: Stipulates the powers and duties of public health officials to prevent and control communicable disease, chronic disease and environmental health hazards. Provides measures for public health emergency response and stipulates health monitoring and reporting requirements.

Drinking Water: Protects public health by ensuring comprehensive regulation of water supply systems, establishing mechanisms for improved source protection and providing greater public accountability for water suppliers.

Food Safety: Addresses the safety, licensing, inspection, designation and regulation of food establishments.

Milk Industry Act (s. 12 except with respect to tank milk receiver licenses.)***:*** Provides for the Minister to issue licenses for the operation of dairy plants, except in respect of tank milk receivers.

Tobacco Control: Regulates the sale, distribution, promotion, and advertising of tobacco products.

Tobacco Damages and Health Care Costs Recovery: Establishes legal procedures for government to recover health care costs from parties who have contributed to illnesses caused by tobacco products.

Organization:

- Aboriginal Healthy Living Branch
- Seniors' Healthy Living Secretariat
- Women's Health Living Secretariat
- Chronic Disease/Injury Prevention and Built Environment
- Communicable Disease, Mental Health & Substance Use
- Health Protection Branch
- Business Operations & Surveillance

PROGRAM AREA DESCRIPTION

ADM Responsible: **Dr. Perry Kendall, Provincial Health Officer**

Program Area Description: **Provincial Health Officer**

Under the *Public Health Act*, the Provincial Health Officer is the senior medical health officer for B.C. and provides independent advice to the Ministry of Health and the public on public health issues and population health.

Each year, the Provincial Health Officer must report publicly, to the legislature, on the health status of the population.

Related Legislation:

Public Health Act: Stipulates the powers and duties of public health officials to prevent and control communicable disease, chronic disease and environmental health hazards. Provides measures for public health emergency response and stipulates health monitoring and reporting requirements.

Organization:

- Deputy Provincial Health Officer
- Provincial Drinking Water Officer
- Aboriginal Health Physician Advisor

BRITISH COLUMBIA

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Board Resourcing and Development Office

Directory of Agencies

BC Health Services Purchasing Organization

The British Columbia Health Services Purchasing Organization (BCHSPO) was incorporated under the *Society Act* in January 2010. The BCHSPO was registered to oversee the implementation of patient-focused funding. The organization builds on the successes of the $75-million Lower Mainland Innovation and Integration Fund. Under a patient-focused funding approach, hospitals receive financial incentives for delivering acute-care services for a competitive, set price.

The Board...

...Composition

Bylaw 4.5 of the BCHSPO requires that Directors be appointed by the Minister immediately following the incorporation of the society.

In addition, for the board of directors, Bylaw 4.1 states that the board shall consist of the representatives as follows: (a) the Deputy Minister of Health Services or their delegates, (b) Ministry of Health Services Representatives, (c) a Chair, and (d)other Directors at the discretion of the Minister or such other number, configuration or representation as determined by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Korabek, Barbara	Ministerial Letter ML 927293, May 18, 2012	Ministry Representative	March 29, 2014
McKnight, Elaine	Ministerial Letter Letter 921581, March 5, 2012	Ministry Representative	February 10, 2013
Powell, G. Wynne	Ministerial Letter Letter 921706, April 13, 2012	Director	April 13, 2013
Ramsden, Murray G.	Ministerial Letter 931401, June 29, 2012	Director	June 30, 2014
Thompson, David A.	Ministerial Letter Letter 921706, April 13, 2012	Chair	April 13, 2013

5 current members.

...Mandate

The BCHSPO's purpose is to make decisions for the procurement of health care services using a funding model that will encourage improvement and create a competitive environment.

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Board Resourcing and Development Office

Directory of Agencies

BC Patient Safety and Quality Council

The purpose of the British Columbia Patient Safety and Quality Council is to provide advice and make recommendations to the Minister on matters related to patient safety and quality of care, and to bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative, and patient-centered approach to patient safety and quality improvement in British Columbia.

The Board...

...Composition

The council will consist of not more than six members selected for their personal credibility, expertise and experience as it relates to patient safety and quality improvement.

The Minister shall appoint one member to the position of Chair. This individual will assume full responsibility for the management of Council operations, and will be accountable in this role to the Minister through the Deputy Minister (or delegate thereof). All other Council members shall be appointed by the Deputy Minister on the advice of the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carroll, Evelyn D.	Minister 249/10, October 31, 2010	Member	October 31, 2012
Cochrane, D. Douglas	Minister 103/11, April 24, 2011	Chair	April 30, 2014
Stamp, Brian A.	Minister 249/10, October 31, 2010	Member	October 31, 2012
Taylor, John G.	Minister 32/12, February 1, 2012	Member	April 30, 2014

4 current members.

...Mandate

The Council will:

- Bring a provincial perspective to patient safety and quality improvement activities;
- Facilitate the building of capacity and expertise for patient safety and quality improvement;

HTH-2012-00182

- Support health authorities and other service delivery partners in their continuous effort to improve the safety and quality care; and,
- Improve health system transparency and accountability to patients and the public for the safety and quality of care provided in British Columbia.

What's Involved

The timing and frequency of the meetings will be determined by the tasks the Council is required to fulfill and as part of its work plan approved by the Minsiter.

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Board Resourcing and Development Office

Directory of Agencies

Emergency and Health Services Commission

The Emergency and Health Services Commission (EHSC) provides emergency health and ambulance services and assists hospitals, municipalities and others to provide emergency health services.

The Emergency and Health Services Commission is cross-appointed to the **Provincial Health Services Authority**.

The Board...

...Composition

The EHSC consists of one or more persons appointed by the Minister. The Minister may designate a member of the Commission as Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Armitage, James E.	Minister 243/11, March 31, 2012	Member	March 31, 2014
Brooks, Donald E.	Minister 41/12, February 20, 2012	Member	December 31, 2012
Gibbons, Elizabeth (Betsy) E.	Minister 84/11, April 1, 2011	Member	February 6, 2013
Manning, Tim F.	Minister 84/11, April 1, 2011	Member	September 30, 2012
McDougall, Mary	Minister 243/11, September 17, 2011	Member	September 30, 2014
McGrath, Lorraine	Minister 243/11, September 30, 2011	Member	September 30, 2012
Powell, G. Wynne	Minister 84/11, April 1, 2011	Chair	December 31, 2012
Ritchie, Allan G.	Minister 139/11, July 31, 2011	Member	July 31, 2013
Rowlatt, J.D. (Don)	Minister 243/11, March 31, 2012	Member	March 31, 2013
Sadler, Q.C., W. Murray	Minister 84/11, April 1, 2011	Member	October 31, 2013

Sidhu, Charanjeet (CJ) S.	Minister 84/11, April 1, 2011	Member	December 31, 2013

11 current members.

...Mandate

The EHSC has the legislated mandate to ensure the provision of high quality and consistent levels of pre-hospital emergency health care services throughout the province. The BC Ambulance Service (BCAS) is the service delivery vehicle for the EHSC and provides direct pre-hospital emergency care, inter-facility transfers, standby at public events and disaster preparedness. The EHSC also recruits and trains emergency medical assistants.

What's Involved

The Commission meets on a bi-monthly basis.

For more Information...

700 - 1380 Burrard Street
Vancouver, BC V6Z 2H3

Tel: 604 675-7400
Fax: 604 708-2700

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B.C. Home BRDO Directory of Agencies

Board Resourcing and Development Office

Directory of Agencies

Health Authority - Fraser

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Fraser Health Authority (FHA) has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bubber, Arvinder S.	Minister 149/10, August 31, 2010	Member	September 30, 2012
Forrest, Robert E.	Minister 069/10, March 21, 2010	Member	December 31, 2013
Gill, Gurpreet K.	Minister 069/10, March 21, 2010	Member	December 31, 2012
Grinnell, Marlene M.	Minister 26/12, March 31, 2012	Member	March 31, 2014
Kolybabi, Deanie L.	Minister 069/10, March 21, 2010	Member	December 31, 2012
Matty, Karen	Minister 142/12, August 1, 2012	Member	March 31, 2014
McLeod, George M.	Minister 26/12, March 31, 2012	Member	March 31, 2014
Mitchell, David W.	Minister 313/10, November 2, 2010	Chair	December 31, 2012
Sumal, Inde	Minister 354/11, December 31, 2011	Member	December 31, 2013

9 current members.

...Mandate

The Fraser Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Fraser Health Authority
300 - 10334 152A Street
Surrey, BC V3R 7P8

Tel: 604 587-4600
Fax: 604 587-4666

Or

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Board Resourcing and Development Office

Directory of Agencies

Health Authority - Interior

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Interior Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Burrows, Kenneth W.	Minister 351/11, December 31, 2011	Member	December 31, 2013
Embree, Norman	Minister 27/12, March 31, 2012	Chair	December 31, 2014
Gillespie, David W.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Goldsmith, David W.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Goodings, Virginia J.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Malzer, Erwin J.	Minister 070/10, March 21, 2010	Member	December 31, 2013
McGregor, Rosanna	Minister 229/09, October 9, 2009	Member	October 9, 2012
Quinn, Findlay (Frank) J.	Minister 351/11, December 31, 2011	Member	December 31, 2013
Sutherland, Glenn	Minister 27/12, March 31, 2012	Member	December 31, 2014

9 current members.

...Mandate

The Interior Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Interior Health Authority
#220 Â¿ 1815 Kirschner Road
Kelowna, BC V1Y 4N7

Tel: 250 862-4200
Fax: 250 862-4201

OR

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Health Authority - Northern

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Northern Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Caldwell, Barbara Y.	Minister 28/12, March 31, 2012	Member	March 31, 2014
Hartwell, Sharon L.	Minister 182/11, July 11, 2011	Member	July 31, 2013
Jago, Charles (Chuck)	Minister 071/10, August 31, 2010	Chair	December 31, 2013
McIntyre, Cameron D.	Minister 071/10, March 21, 2010	Member	December 31, 2013
Milne, Gordon	Minister 28/12, March 31, 2012	Member	March 31, 2014
O'Neil, Kathleen (Kate)	Minister 28/12, March 31, 2012	Member	March 31, 2014
Shannon, Deborah Lynn	Minister 28/12, March 31, 2012	Member	March 31, 2014
Townsend, Gary William	Minister 15/12, January 12, 2012	Member	December 31, 2014

8 current members.

...Mandate

The Northern Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet regularly, usually once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Northern Health Authority
Suite 300 - 299 Victoria Street
Prince George, BC

Tel: 250 565-2649
Fax: 250 565-2640

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Board Resourcing and Development Office

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Health Authority - Provincial Health Services Authority

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority (PHSA).

The Provincial Health Services Authority is cross-appointed to the **Emergency and Health Services Commission**.

The Board...

...Composition

The Provincial Health Services Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Armitage, James E.	Minister 247/11, March 31, 2012	Member	March 31, 2014
Brooks, Donald E.	Minister 51/12, February 20, 2012	Member	December 31, 2012
Gibbons, Elizabeth (Betsy) E.	Minister 259/09, February 6, 2010	Member	February 6, 2013
Manning, Tim F.	Minister 304/10, October 11, 2010	Member	September 30, 2012
McDougall, Mary	Minister 247/11, September 17, 2011	Member	September 30, 2014
McGrath, Lorraine	Minister 247/11, September 30, 2011	Member	September 30, 2012
Powell, G. Wynne	Minister 304/10, December 9, 2010	Chair	December 31, 2012
Ritchie, Allan G.	Minister 138/11, July 31, 2011	Member	July 31, 2013
Rowlatt, J.D. (Don)	Minister 247/11, March 21, 2012	Member	March 31, 2013
Sadler, Q.C., W. Murray	Minister 304/10, October 11,	Member	October 31,

	2010		2013
Sidhu, Charanjeet (CJ) S.	Minister 304/10, December 1, 2010	Member	December 31, 2013

11 current members.

...Mandate

The Provincial Health Services Authority is responsible for:

- working with the five health authorities to plan and co-ordinate the delivery of provincial programs and highly-specialized services, and;
- ensuring that access and issues for these services are equitably addressed.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Provincial Health Services Authority
700 - 1380 Burrard Street
Vancouver, BC V6Z 2H3

Tel: 604 675-7400
Fax: 604 708-2700

Or

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Health Authority - Vancouver Coastal

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Vancouver Coastal Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Brown, Kenneth M.	Minister 143/12, June 29, 2012	Member	March 31, 2014
Di Blasio, Alfredo G.	Minister 38/10, March 21, 2010	Member	October 29, 2013
Heath, Sandra L.	Minister 248/10, September 28, 2010	Member	September 30, 2013
Hsieh, James C.	Minister 29/12, March 31, 2012	Member	March 31, 2014
Nocente, Daniel L.	Minister 143/12, June 29, 2012	Member	March 31, 2015
Rehkatsch, Axel F.	Minister 242/06, October 18, 2006	Member	December 31, 2013
Spitz, Grant	Minister 230/09, October 16, 2009	Member	October 18, 2012
Withers, Victoria L.	Minister 260/09, November 15, 2009	Member	November 15, 2012
Woodward, C.C. (Kip)	Minister 29/12, April 13, 2012	Chair	March 31, 2014

9 current members.

...Mandate

The Vancouver Coastal Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet regularly, usually once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Vancouver Coastal Health Authority
Suite 200, 520 West 6th Avenue
Vancouver, BC V5Z 4H5

Tel: 604 736-2033
Fax: 604 874-7661

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Health Authority - Vancouver Island

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Vancouver Island Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carson, S. Frank B.	Minister 326/10, November 22, 2010	Member	December 31, 2015
Costello, J. Michael	Minister 328/10, December 2, 2010	Member	December 31, 2012
Garside, Shelley E.	Minister 31/12, March 21, 2012	Member	March 31, 2014
Hubbard, Don	Minister 325/10, November 22, 2010	Chair	December 31, 2015
Kruyt, David C.	Minister 31/12, March 21, 2012	Member	March 31, 2014
Slaney, Vernard (Vern) G.	Minister 096/07, May 3, 2007	Member	December 31, 2013
Watson, Matthew G.	Minister 30/12, February 1, 2012	Member	March 31, 2014
Wheeler, Jean T.	Minister 30/12, February 1, 2012	Member	March 31, 2014
van de Sande, Johan (Hans)	Minister 31/12, March 21, 2012	Member	March 31, 2014

9 current members.

...Mandate

The Vancouver Island Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Vancouver Island Health Authority
1952 Bay Street
Victoria, BC V8R 1J8

Tel: 250 370-8699
Fax: 250 370-8750

Or

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Health Professions Review Board

The Health Professions Review Board is an administrative tribunal created under the *Health Professions Act* to provide an independent review of certain decisions made by the self-governing colleges of designated health professions regarding the registration of their members and the timeliness and disposition of complaints made against their registrants. Through its reviews, dispute resolution processes and hearings, the Review Board monitors the activities of the colleges' complaints inquiry committees and registration committees, in order to ensure they fulfill their duties in the public interest and as mandated by legislation. The Review Board provides a neutral forum for members of the public as well as for health professionals to resolve disputes or seek review of the colleges' decisions.

The Review Board also helps to improve the health care system and serve the public interest in BC by developing and publishing guidelines and recommendations for the purpose of assisting colleges to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair.

The Board...

...Composition

The board consists of one Chair and 15 - 25 members appointed by the Lieutenant Governor in Council.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Alexandor, Michael J.B.	OIC 740/10, December 31, 2010	Member	December 31, 2012
Bennett, Lorianna	OIC 740/10, December 31, 2010	Member	December 31, 2013
Berg, Judith J.	OIC 740/10, December 31, 2010	Member	December 31, 2012
Blane, Rex D.	OIC 138/12, March 8, 2012	Member	December 31, 2014
Clark, D. Marilyn	OIC 740/10, December 31, 2010	Member	December 31, 2012
Doll, Arlene M.	OIC 138/12, March 8, 2012	Member	December 31, 2014

English, Q.C., John Thomas	OIC 597/11, December 31, 2011	Chair	December 31, 2012
Hobbs, David Arthur	OIC 740/10, December 31, 2010	Member	December 31, 2013
Kuhl, Victoria (Vicki)	OIC 740/10, December 31, 2010	Member	December 31, 2012
McDowell, Lori	OIC 740/10, December 31, 2010	Member	December 31, 2012
Morris, Michael J.	OIC 740/10, December 31, 2010	Member	December 31, 2013
Mourton, Maurice R.	OIC 740/10, December 31, 2010	Member	December 31, 2013
O'Fee, John H.	OIC 187/12, March 29, 2012	Member	December 31, 2014
Scott, W. Laurence	OIC 139/12, March 8, 2012	Member	December 31, 2014
Silber, Herbert (Herb) S.	OIC 138/12, March 8, 2012	Member	December 31, 2014
Silversides, Q.C., Donald A.	OIC 740/10, December 31, 2010	Member	December 31, 2013
del Val, Helen Ray	OIC 740/10, December 31, 2010	Member	December 31, 2013

17 current members.

...Mandate

The main purpose of the HPRB is to provide a fair, impartial, accountable and transparent mechanism for the review of decisions of colleges of designated health professions regarding registration, management of complaints, and discipline.

What's Involved

For More Information...

www.hprb.gov.bc.ca

Health Professions Review Board
Suite 900, 747 Fort Street
Victoria BC V8W 2E9

Mailing Address
PO Box 9429 Stn Prov Govt
Victoria BC V8W 9V1

Telephone: 250-953-4956
Facsimile: 250-953-3195
Toll-free telephone number (within BC): 1-888-953-4986

E-mail: hprbinfo@gov.bc.ca

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Board Resourcing and Development Office

Directory of Agencies

Health Shared Services BC

Health Shared Services BC finds opportunities for health authorities across the province to improve cost effectiveness and enhance service quality. By working collaboratively on common services, Health Shared Services BC ensures health authorities get the most value for every dollar spent.

The number one priority of our health care system is making sure that patients get the best care possible. Health Shared Services BC is committed to consistently seeking ways to get the most out of every health care dollar in order to maximize resources going to direct patient care.

Health Shared Services BC is a unique initiative for the province. The organization has been designed in a way that enables health authorities to achieve more collectively together than they could independently.

Health Shared Services BC contributes to the Ministry of Health Services' goal of sustaining high quality patient care through more efficient and cost-effective services. Together, ensuring a sustainable, publicly funded health care system.

The Board...

...Composition

The HSSBC Management Board shall be composed of the following individuals and no substitutes or alternates shall be permitted:

(a) the President and CEO from time to time of the Provincial Health Services Authority;
(b) the Chief Executive Officers, from time to time, of each customer;
(c) one Ministry representative designated from time to time by the Minister:
(d) up to two independent individuals recommended by the HSSBC Management Board and designated from time to time by the Minister; and
(e) the Chief Executive Officer of Providence Health Care Society, for as long as that entity remains an affiliate of Vancouver Coastal Health Authority, to have non-voting observer status only.

Click here for biographies of all Members

Current Members			

Name:	By order:	Position:	Expiry:
Leighton, Peter R.	Ministerial Letter Letter, February 1, 2011	Independent Director	January 31, 2014
Longworth, Thomas J.	Ministerial Letter ML 924100, April 24, 2012	Member	April 24, 2015
McKnight, Elaine	Ministerial Letter 919210/919221, February 15, 2012	Ministry Representative	At Pleasure

3 current members.

...Mandate

To establish a province-wide Health Authority Shared Services Organization that will create enhanced value to the health system through the effective and efficient delivery of agreed upon support services.

What's Involved

For More Information...

Health Shared Services BC
700-1380 Burrard Street
VANCOUVER BCÂ Â Â V6Z 2H3

Tel: 604 875-7381

E-mail: contact@hssbc.ca

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Directory of Agencies

Medical Services Commission

Medicare is the cornerstone of Canada's health care system, ensuring that all Canadians, regardless of their financial status, have reasonable access to adequate health care and diagnostic facility services.

In British Columbia, the Medical Services Plan, which covers the cost of care delivered by fee-for-service health care practitioners in the province, is administered by the Medical Services Commission.

The majority of these costs is apportioned to medical doctors by the Medical Services Commission which is composed of representatives of the BC Medical Association, the Government of British Columbia and the beneficiaries of the Medical Services Plan (most citizens of the province).

The Board...

...Composition

The Commission consists of up to nine persons (and their alternates) appointed by the Lieutenant-Governor in Council. Three of these members are nominated by the BC Medical Association; three are nominated on the joint recommendation of the Minister of Health and the BC Medical Association to represent beneficiaries; and three are public servants who represent the Government of British Columbia.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Collins, Carol A.	OIC 72/12, February 16, 2012	Beneficiary Rep	June 30, 2014
Davidson, Heather Anne	OIC 74/12, February 16, 2012	2nd Alternative Government	At Pleasure
Gillespie, Ian A.	Nominated 459/11, October 1, 2011	1st Alternate BCMA	October 1, 2012
Gregory, Brian W.	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Halpenny, Robert	OIC 22/05, January 14, 2005	Government Rep	At Pleasure
Mackenzie, Isobel	OIC 194/11, June 30, 2011	Beneficiary Rep	June 30, 2013

Manning, Nichola S. M.	OIC 74/12, February 16, 2012	1st Alternate Government	At Pleasure
McKenzie, Melanie L.	OIC 194/11, June 30, 2011	Beneficiary Rep	June 30, 2014
Norton, Bryan R.	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Power, Stephanie A.	OIC 74/12, February 16, 2012	3rd Alternate Government	At Pleasure
Ross, Shelley N.	OIC 459/11, October 1, 2011	2nd Alternate BCMA	October 1, 2012
Seckel, Allan P.	OIC 73/12, April 1, 2012	3rd Alternate Member	June 30, 2014
Taylor, Sheila A.	OIC 74/12, February 16, 2012	Government Rep - Deputy Chair	At Pleasure
Thomson, Darrell	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Vincent, Thomas E.	OIC 240/12, April 19, 2012	Government Rep - Chair	At Pleasure

15 current members.

...Mandate

The Mandate of the Commission is to facilitate the reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facilities, under the Medical Services Plan (MSP). The commission is responsible for the administration and operation of the Medical Services Plan, a health insurance policy for residents of the province, and establishes a schedule for the payment of insured services.

What's Involved

Members are asked to be available for monthly meetings.

For More Information...

Medical Services Commission
Ministry of Health Services
3-1, 1515 Blanshard Street
Victoria, BC V8W 3C8

Tel: 250 952-3073
Fax: 250 952-3131

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Mental Health Review Board

The Mental Health Review Board is an independent, quasi-judicial administrative tribunal established in April 2005 to conduct review panel hearings under the *Mental Health Act*. It is made up of a chair and members appointed by the Minister under the *Act*. The Board conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the *Act*.

The Board...

...Composition

Under the *Act*, the Minister appoints the Chair of the Board and all legal, medical and community members authorized to sit as review panel members and conduct hearings throughout the Province. The Chair of the Board serves full time and the members serve part time.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Ali, Naved A.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Baird, Maureen E.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Bilsbarrow, Jennifer	Minister 77/11, April 3, 2011	Member	April 30, 2013
Boon, John	Minister 77/11, April 3, 2011	Member	April 30, 2014
Borowicz, QC, Frank S.	Minister 353/11, December 31, 2011	Member	December 31, 2013
Bubbs, Joan	Minister 273/11, October 4, 2011	Member	December 31, 2013
Buckley, L. Ralph	Minister 77/11, April 3, 2011	Member	April 30, 2013
Cardinal, Roger J.A.	Minister 252/10, September 7, 2010	Member	December 31, 2012
Cheema, Q.C., Pinder K.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Cherneski, Heather M.	Minister 189/11, July 15, 2011	Member	December 31, 2014
Chow, Kenmau	Minister 189/11, July 15, 2011	Member	December 31, 2014
Daroux, Danielle K.	Minister 211/10, July 9, 2010	Member	December 31, 2012

Deliyannides, Alexandra	Minister 273/11, October 4, 2011	Member	December 31, 2014
Dionne, Michael D.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Dirksen van Schalkwyk, Reinette	Minister 100/10, March 30, 2010	Member	December 31, 2012
Doll, Arlene M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Dowey, Michael	Minister 77/11, April 3, 2011	Member	April 30, 2014
Duffy, Helen P.	Minister 189/11, July 15, 2011	Member	December 31, 2013
Eaves, Derek	Minister 77/11, April 3, 2011	Member	April 30, 2014
Fabriel-Leclerc, Christin	Minister 273/11, October 4, 2011	Member	December 31, 2014
Fairweather, Tanya M.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Gowans, Helen M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Graves, Carl	Minister 77/11, April 3, 2011	Member	April 30, 2014
Gray, Elizabeth R.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Griffiths, Robert A.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Grigg, Harvey M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Hargreaves, Bob	Minister 77/11, April 3, 2011	Member	April 30, 2013
Higgins, Roger S.	Minister 278/10, October 5, 2010	Member	December 31, 2013
Hodge, Gillian M.	Minister 54/12, February 29, 2012	Member	December 31, 2015
Holan, Jan	Minister 55/11, February 22, 2011	Member	December 31, 2013
Hyatt, Stan L.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Ingram, Marie	Minister 77/11, April 3, 2011	Member	April 30, 2013
Jackson, Nora	Minister 59/12, February 29, 2012	Member	December 31, 2014
Jiwa, Abdulkarim M.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Joly, Guy C.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Kolsteren, Ingrid A.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Lamb, Diane M.	Minister 77/11, April 3, 2011	Member	April 30, 2013
LeRose, Kenneth B.	Minister 55/11, February 22, 2011	Member	December 31, 2013
Leong, Judith M.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Lewis, Thomas G.	Minister 189/11, July 15, 2011	Member	December 31, 2013

Martin, Joseph B.	Minister 211/10, July 9, 2010	Member	December 31, 2012
Massam, John	Minister 77/11, April 3, 2011	Member	April 30, 2013
Maurice, William (Bill)	Minister 77/11, April 3, 2011	Member	April 30, 2014
May, David	Minister 77/11, April 3, 2011	Member	April 30, 2014
McPherson, Kathleen E.	Minister 273/11, October 4, 2011	Member	December 31, 2014
Moore, Tracy Rae	Minister 77/11, April 3, 2011	Member	April 30, 2013
Murray, Alistair Stuart	Minister 77/11, April 3, 2011	Member	April 30, 2014
Naccarato, Saverio (Sam)	Minister 77/11, April 3, 2011	Member	April 30, 2014
Ngan, Elton T.C.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Noone, Joseph	Minister 77/11, April 3, 2011	Member	April 30, 2014
Ostrowski, Q.C., Margaret	Minister 285/09, December 10, 2009	Chair	December 31, 2013
Parfitt, Hugh	Minister 77/11, April 3, 2011	Member	April 30, 2014
Parnell, Peter	Minister 77/11, April 3, 2011	Member	April 30, 2013
Pfeifer, Mary-Ann A.	Minister 77/11, April 3, 2011	Member	April 30, 2013
Pfliger, Jennifer	Minister 77/11, April 3, 2011	Member	April 30, 2013
Plenert, Wayne N.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Pope, Q.C., Dale B.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Preston, June C.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Richardson, J.A. (Gus)	Minister 77/11, April 3, 2011	Member	April 30, 2013
Rogers-Rainey, Tanya	Minister 77/11, April 3, 2011	Member	April 30, 2013
Sahota, Manmohan	Minister 273/11, October 4, 2011	Member	December 31, 2014
Schieldrop, Peter	Minister 77/11, April 3, 2011	Member	April 30, 2014
Smerychynski, Linda J.	Minister 77/11, April 3, 2011	Member	April 30, 2013
Soroka, Allen H.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Stilling, Wayne	Minister 273/11, October 4, 2011	Member	December 31, 2013
Symonds, Vance Brian	Minister 189/11, July 15, 2011	Member	December 31, 2013
Tapper, Christopher Mark	Minister 77/11, April 3, 2011	Member	April 30, 2014
Tomchenko, Oleg H.	Minister 278/10, October 5, 2010	Member	December 31, 2013
Uhlmann, Ralph P.	Minister 189/11, July 15, 2011	Member	December 31, 2014
Waddington, Sandra J.	Minister 54/12, February 29, 2012	Member	December 31, 2014
Walters, Sandra	Minister 189/11, July 15, 2011	Member	December 31, 2013
Warner, Q.C., Peter D.	Minister 100/10, March 30, 2010	Member	December 31, 2012

Westwood, Kevin Ralph	Minister 273/11, October 4, 2011	Member	December 31, 2013
Williams, Laurie	Minister 77/11, April 3, 2011	Member	April 30, 2013
Williams, Tiina P.	Minister 189/11, July 15, 2011	Member	December 31, 2013
Wong, Kum C.	Minister 273/11, October 4, 2011	Member	December 31, 2014
Wong, Lisa M.	Minister 55/11, February 22, 2011	Member	December 31, 2013

77 current members.

...Mandate

The Board has jurisdiction to conduct hearings and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the *Mental Health Act*.

What's Involved

Board members are scheduled for review panel hearings within statutory time limits of either 14 or 28 days from when applications are received. They typically need to set aside a half-day or full day to conduct one or two hearings at a nearby mental health facility. They may sometimes be asked to travel or accept a case assignment on exceptionally short notice where necessary to provide a hearing within the statutory time limit.

For More Information...

Mental Health Review Board
#302 - 960 Quayside Drive
New Westminster, BC V3M 6G2

Tel: 604 660-2325
Fax: 604 660-2403

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Patient Care Quality Review Board - Fraser

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Fraser Patient Care Quality Review Board is cross-appointed to the **Vancouver Coastal Patient Care Quality Review Board**, and the **Provincial Health Services Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 256/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 256/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 298/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 256/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 256/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 298/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC Â V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Interior

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Fairey, Randall N.	Minister 297/10, October 15, 2010	Member	October 15, 2012
Horning, Donna A.	Minister 70/12, March 12, 2012	Member	March 31, 2014
Humphries, Thomas R.	Minister 257/11, October 15, 2011	Member	October 15, 2013
Morgan, Gloria A.	Minister 297/10, October 15, 2010	Member	October 15, 2012
Ross, Robert J.	Minister 83/12, March 25, 2012	Member	March 31, 2014
Sharman, Roger C.	Minister 257/11, October 15, 2011	Chair	October 15, 2014

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board

PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Northern

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 50/12, February 20, 2012	Member	March 31, 2014
Dittmar, Lorna E.	Minister 299/10, October 15, 2010	Member	October 15, 2012
MacRitchie, W. Elizabeth	Minister 191/11, July 15, 2011	Member	October 15, 2012
Norton, William E.	Minister 261/11, October 15, 2011	Chair	October 15, 2014
Read, Allison A.	Minister 260/11, September 14, 2011	Member	October 15, 2012

5 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Provincial Health Services

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Provincial Health Services Patient Care Quality Review Board is cross-appointed to the **Vancouver Coastal Patient Care Quality Review Board**, and the **Fraser Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 255/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 255/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 300/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 255/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 255/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 3001/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to

improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Vancouver Coastal

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Vancouver Coastal Patient Care Quality Review Board is cross-appointed to the **Fraser Patient Care Quality Review Board**, and the **Provincial Health Services Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 254/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 254/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 301/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 254/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 254/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 301/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Vancouver Island

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Beamish, R. Ann	Minister 288/11, October 20, 2011	Member	October 15, 2013
Patterson, Michael F.	Minister 302/10, October 15, 2010	Member	October 15, 2012
Swift, Q.C., Richard J.	Minister 258/11, October 15, 2011	Chair	October 15, 2014
Thomson, Linda J.A.	Minister 258/11, October 15, 2011	Member	October 15, 2014

4 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Professional College - College of Chiropractors of British Columbia

Chiropractic is the branch of the healing arts concerned with the restoration and maintenance of health through adjustment by hand of the human body's skeletal articulations, especially the spinal column.

The College of Chiropractors of BC is the professional body responsible for the registration of practitioners of chiropractic in the Province.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of eight professional representatives and four public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bucher, Robert B.	Minister 289/10, December 31, 2010	Public/Lay Member	December 31, 2013
Hall, Derek A.	Minister 159/12, September 1, 2012	Public/Lay Member	September 1, 2015
Kellner, Douglas K.	Minister 159/12, September 1, 2012	Public/Lay Member	September 1, 2015
Kesteloo, Karen L.	Minister 42/12, February 20, 2012	Public/Lay Member	March 31, 2014

4 current members.

...Mandate

The Board governs the affairs of the College and establishes the qualifications of persons to be admitted to and registered with the College of Chiropractors of BC. It makes rules for the discipline and control of chiropractors, providing for the imposition of sanctions, including suspension or cancellation of registration. It makes rules regarding examinations and registration, including fees and the

appointment of the examining board, and may make rules regarding continuing education and liability insurance.

What's Involved

For More Information...

College of Chiropractors of British Columbia
#125-3751 Shell Road
RICHMOND BC V6X 2W7

Tel: 604 270-1332
Fax: 604 278-0093

E-mail: registrar@bcchiro.com

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Professional College - College of Dental Hygienists of British Columbia

Dental hygienists are the providers of primary dental care such as cleaning, fluoride treatments and preventative maintenance measures. They may be employed by clinics or by dental practitioners in private practice as part of a dental health care team.

The College of Dental Hygienists is responsible for the registration of professional dental hygienists practising in British Columbia.

The Board...

...Composition

The board consists of nine members, six of whom are registrants of the college and are elected by registrants of the college (non-BRDO), and three of whom are appointed by the Minister Responsible (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Logan, Kim J. C.	Minister 55/12, February 23, 2012	Public/Lay Member	March 31, 2014
McPhail, Tara	Minister 55/12, February 28, 2012	Public/Lay Member	February 28, 2015
Smith, Paul W.	Minister 55/12, February 28, 2012	Public/Lay Member	February 28, 2015

3 current members.

...Mandate

The purpose of the Board is to regulate the standards of practice for the profession of dental hygiene.

What's Involved

Board members must attend three meetings per year, with each meeting lasting up to two days. Members will also be asked to serve on committees or panels of the board and can expect to spend an additional five to seven days per year on committee work.

For More Information...

College of Dental Hygienists of BC
219 Yarrow Building - 645 Fort Street
Victoria, BC V8W 1G2

Tel: 250 383-4101
Fax: 250 383-4144

E-mail: cdhbc@cdhbc.com

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Professional College - College of Dental Surgeons of British Columbia

The College of Dental Surgeons of British Columbia registers, licenses and regulates dentists and certified dental assistants in the public interest.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of 12 professional representatives and six public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Crombie, Melanie M.	Minister 272/11, October 6, 2011	Public/Lay Member	October 1, 2014
De Vita, Dan C.	Minister 31/09, April 3, 2009	Public/Lay Member	October 1, 2015
Johal, Julie J.	Minister 330/11, November 30, 2011	Public/Lay Member	November 30, 2013
Lemon, Richard	Minister 31/09, April 3, 2009	Public/Lay Member	October 1, 2015
Pusey, David	Minister 330/11, November 30, 2011	Public/Lay Member	November 30, 2013
Soda, Anthony L.	Minister 330/11, October 19, 2011	Public/Lay Member	October 1, 2013

6 current members.

...Mandate

The College of Dental Surgeons of BC assures British Columbians of professional standards of oral health care, ethics and competence by regulating dentistry in a fair and reasonable manner.

We fulfill our mission statement by setting requirements to practice; establishing, monitoring and enforcing standards of conduct and care; and where necessary disciplining registrants; as well as monitoring the continuing education of more than 3,170 dentists and over 6,500 CDAs working in BC.

What's Involved

For More Information...

Professional College - College of Dental Surgeons of British Columbia
500 - 1765 8th Avenue West
VANCOUVER BC V6J 5C6

Tel: 604 736-3621
Fax: 604 734-9448

E-mail: info@cdsbc.org

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Professional College - College of Dental Technicians of British Columbia

Dental technicians work on the referral of dentists in the construction of crowns, bridges dentures and other oral appliances.

The College of Dental Technicians is the professional body responsible for the accreditation of dental technicians in British Columbia.

The Board...

...Composition

The College's board is made up of five elected Dental Technicians (non-BRDO), one elected Dental Technician Assistant (non-BRDO), and three government appointed public members (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Grigg, Harvey M.	Minister 82/12, May 1, 2012	Public/Lay Member	May 30, 2014
Minichiello, Diane B.	Minister 085/10, May 16, 2010	Public/Lay Member	September 30, 2013

2 current members.

...Mandate

The Council's mandate is to serve and protect the public, and to exercise its powers and discharge its responsibilities under all enactments in the public interest. The Council supervises the education of dental technicians and may appoint an examining committee. The Council registers qualified applicants, issues certificates of registration, holds disciplinary hearings and may impose sanctions including suspension or cancellation of registration. The Council may also make rules respecting registration, continuing education, examinations, fees, specialization and advertising.

What's Involved

The Council meets at least six times per year. Members will be asked to sit on committees or panels of the Council, with varying degrees of time-commitment.

For More Information...

College of Dental Technicians of BC
400 - 1727 West Broadway
Vancouver, BC V6J 4W6

Tel: 604 736-4776
Fax: 604 734-4779

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Professional College - College of Denturists of British Columbia

Denturists work with patients without referrals from a dentist for the construction of dentures.

The College of Denturists is the body responsible for the regulation of the profession and for governing the licensing and accreditation of denturists in British Columbia.

The Board...

...Composition

The board consists of six elected registrants (non-BRDO) and three lay members appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bains, Jag S.	Minister 14/12, January 12, 2012	Public/Lay Member	December 31, 2012
Gardner, Pamela J.	Minister 088/10, March 31, 2010	Public/Lay Member	September 30, 2013
Harden, Deborah J.	Minister 112/11, April 27, 2011	Public/Lay Member	March 31, 2014

3 current members.

...Mandate

The Council supervises the education of denturists and may appoint an examining committee. The Council registers qualified applicants, issues certificates of registration, holds disciplinary hearings and may impose sanctions including suspension or cancellation of registration. The Council may also make rules respecting registration, continuing education, examinations, fees, specialization and advertising.

What's Involved

The Council five times per year. Members will be asked to sit on committees or panels of the board, with varying degrees of time-commitment.

For More Information...

College of Denturists of British Columbia
305 - 321 Sixth St.
New Westminster, BC V3L 3A7

Tel: 604 515-0533
Fax: 604 515-0534

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Professional College - College of Dietitians of British Columbia

The College of Dietitians of British Columbia is the regulatory body established to superintend the practice of dietetics. The College's primary function will be to register dietitians to practise in BC, establish standards of practice and deal with complaints about Dietitians.

The Board...

...Composition

The board consists of six elected registrants (non-BRDO) and three lay members appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Kershaw, Adrian	Minister 262/11, October 31, 2011	Public/Lay Member	October 31, 2012
Pagely, Buncy	Minister 43/12, March 31, 2012	Public/Lay Member	March 31, 2015
Stephenson, Diana L.	Minister 111/11, April 27, 2011	Public/Lay Member	March 31, 2013

3 current members.

...Mandate

The College's mandate is to protect the public interest under the *Health Professions Act* and to fully administer the regulation of dietitians in the Province.

What's Involved

Members will be expected to sit on the Council's committees. The workload and meeting times of the committees will vary.

For More Information...
The College of Dietitians of British Columbia
103 - 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Tel: 604 736-2016
Fax: 604 736-2018

E-mail: info@collegeofdietitiansbc.org

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Professional College - College of Licensed Practical Nurses of British Columbia

The College of Licensed Practical Nurses of British Columbia is the regulatory body established to govern the practice of licensed practical nursing.

The Board...

...Composition

The College Board is comprised of both elected and appointed members.

- Eight directors (non-BRDO) represent the five electoral districts of the CLPNBC and are elected by the registrants in their districts.
- Four public representatives (BRDO) are appointed by the provincial government. The *Health Professions Act* requires that one-third of all board members be public representatives.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Khakzad, Pirouz	Minister 332/11, December 2, 2011	Public/Lay Member	September 30, 2014
Spina, Margaret L.	Minister 291/10, October 18, 2010	Public/Lay Member	September 30, 2013

2 current members.

...Mandate

The College is responsible for the licensing of licensed practical nurses in British Columbia. Additionally, the Council has the authority of general supervision of the examinations and schools for training practical nurses throughout the Province.

What's Involved

Members should be prepared to meet at least once per month; additional meetings may be scheduled as required. Members may also be asked to sit on subcommittees or panels of the council.

For More Information...

College of Licensed Practical Nurses of British Columbia
260-3480 Gilmore Way
Burnaby, BC V5G 4Y1

Tel: 778 373-3100
Toll Free: 1 877 373-2201
Fax: 604 660-3102

E-mail: info@clpnbc.org

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Professional College - College of Massage Therapists of British Columbia

The College of Massage Therapists of British Columbia is the regulatory body for massage therapy in British Columbia.

It is the duty of the College at all times:

- To serve and protect the public.
- To exercise its powers and discharge its responsibilities under all enactments in the public interest.

The Board...

...Composition

At least one-third of the Council consists of public representatives appointed by the Minister Responsible to represent the public interest. The Board shall be composed of six elected board members (non-BRDO) and no less than three public representatives (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Crawford, W. David	Minister 92/12, March 30, 2012	Public/Lay Member	December 31, 2014
Darnell, Rebecca	Minister 292/10, December 31, 2010	Public/Lay Member	December 31, 2012
Gulamhusein, Naseem L.	Minister 44/12, February 20, 2012	Public/Lay Member	March 31, 2014
Harris, B. Lynne	Minister 166/12, August 1, 2012	Public/Lay Member	August 1, 2014
Waithman, Marilynne	Minister 25/12, February 1, 2012	Public/Lay Member	March 31, 2014

5 current members.

...Mandate

The College of Massage Therapists of BC serves and protects the public by regulating the profession

of massage therapy in BC in accordance with the duties and objects set out in the *Health Professions Act*. We believe in personal integrity, administrative fairness and professional accountability.

What's Involved

Council members are required to attend ten meetings per year. In addition, all members will be asked to served on committees with varying degrees of time-commitment.

For More Information...

College of Massage Therapists of British Columbia
103 - 1089 West Broadway
Vancouver, BC V6H 1E5

Tel: 604 736-3404
Fax: 604 736-6500

E-mail office@cmtbc.bc.ca

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Professional College - College of Midwives of British Columbia

Registered midwives in British Columbia provide primary care to healthy pregnant women and their newborn babies from early pregnancy, throughout labour and birth, and up to six weeks postpartum. Individuals who wish to practice midwifery in BC must have appropriate education and training and pass examinations for registration with the College, which was established as the regulatory body for midwives under the *Health Professions Act*.

The Board...

...Composition

The College is comprised of six elected registered midwife members (non-BRDO) and three appointed public members.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Blais, Pauline	Minister 187/11, July 31, 2011	Public/Lay Member	July 31, 2013
Masini Pieralli, Laura S.	Minister 187/11, July 31, 2011	Public/Lay Member	July 31, 2014

2 current members.

...Mandate

The College's mandate is to serve and protect the public interest by regulating midwifery practice in accordance with the *Health Professions Act* and the College's bylaws. The goal of the College is to register qualified, competent midwives to provide safe, high-quality care to women and their families in the province of British Columbia.

The College has the following duties and objectives:

- to set the standards of education and qualifications for registration;
- to examine candidates for registration, assess competency and register qualified candidates;
- to set the standards of practice, and to monitor and enforce them;
- to monitor the continuing competency of registrants, and;
- to establish a program to prevent professional misconduct of a sexual nature.

What's Involved

Council members are required to attend four board meeting per year on a quarterly basis, and to serve on at least two committees. Committee work involves a time commitment of up to one day each month.

For More Information...

College of Midwives of BC
Suite 210 - 1789 West 7th Ave
Vancouver, BC V6J 4S6

Tel: 604 742-2234
Fax: 604 730-8908

E-mail: admin@cmbc.bc.ca

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Professional College - College of Naturopathic Physicians of British Columbia

Naturopathic medicine is medicine that treats the underlying nature or cause of a disease. It is the art of healing by supporting the natural healing processes of the patient and removing any impediment to the healing process; the prevention, diagnosis and treatment of physical and mental diseases, disorders and conditions; and the promotion of good health using not only natural methods but methods which support or enhance the patient's overall health.

The Board...

...Composition

The Council consists of eight members. Four of these are elected by members of the College of Naturopathic Physicians of British Columbia (non-BRDO) and the remainder are appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Barnaby, Wesley L.	Minister 158/12, July 31, 2012	Public/Lay Member	July 31, 2015
Bechard, Gary M.	Minister 329/11, December 2, 2011	Public/Lay Member	September 30, 2013
Manning, Mary Doris	Minister 158/12, July 31, 2012	Public/Lay Member	July 31, 2015

3 current members.

...Mandate

The Council makes rules governing the education, licensing and conduct of naturopathic physicians practising in British Columbia and administers the affairs of the Association of Naturopathic Physicians of British Columbia.

What's Involved

The Council meets once per month. Members must be available for an additional one day per month to participate in board conference calls.

Members will be expected to attend the annual general meeting and to appear at special events and

conferences as they relate to the profession.

For More Information...

College of Naturopathic Physicians of BC
1698 West 6th Avenue
Vancouver, BC V6J 5G4

Tel: 604 688-8236
Fax: 604 688-8476

E-mail: office@cnpbc.bc.ca

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Professional College - College of Occupational Therapists of British Columbia

The College of Occupational Therapists is the professional regulatory body, designated under the *Health Professions Act*, overseeing professional Occupational Therapists in BC.

The Board...

...Composition

The Council consists of nine persons, including three lay members appointed by the Responsible Minister to represent the public interest. The remaining members are elected by and from the professional registrants of the College (non-BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Baker, Sherry	Minister 017/11, January 31, 2011	Public/Lay Member	January 31, 2014
Carvalho, Vila Nova	Minister 017/11, January 31, 2011	Public/Lay Member	January 31, 2014
Williams, Carol Ann	Minister 028/10, January 31, 2010	Public/Lay Member	January 31, 2013

3 current members.

...Mandate

The College of Occupational Therapists is the regulatory body responsible for the registration and licensing of occupational therapy practitioners in British Columbia.

The Council makes rules respecting:

- the management of the business and property of the College;
- the maintenance of a register of occupational therapists;
- the holding of examinations; and,
- fees.

What's Involved

Members should be prepared to attend at least four meetings per year, including the Annual General Meeting. Members may be asked to sit on disciplinary committees or other panels of the Council.

For More Information...

College of Occupational Therapists of BC
219 Yarrow Building
645 Fort Street
Victoria, BC V8W 1G2

Tel: 250 386-6822
Fax: 250 383-4144

E-mail: info@cotbc.org

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Opticians of British Columbia

Opticians are professionals skilled in the precision grinding of eyeglasses and the fitting of contact lenses to persons requiring optical prescriptions. The College of Opticians (COBC) is the professional organization responsible for the registration of opticians and contact lens-fitters in BC.

The Board...

...Composition

As a self-regulating profession, the COBC is governed by a Board of Directors comprised of elected and appointed members. Of the 10 board members, six are elected from the profession (non-BRDO) and four are appointed by the Minister Responsible (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Virk, Dalminder (Del) S.	Minister 145/12, June 29, 2012	Public/Lay Member	June 30, 2014
Wood Bernbaum, Lesley	Minister 014/11, January 31, 2011	Public/Lay Member	January 31, 2013

2 current members.

...Mandate

The College is charged, under the *Health Professions Act*, with the duty to serve and protect the public while superintending the profession. The College is also responsible for the registration and licensing of professional opticians and contact lens-fitters practising in British Columbia.

What's Involved

Council meetings are held no less than four times per year. In addition, members will be asked to serve on committees with varying degrees of time-commitment. Board and committee meetings are usually held on weekends and evenings, to accommodate members' work schedules.

For More Information...

College of Opticians of BC
420 - 2025 West Broadway
Vancouver, BC V6J 1Z6

Tel: 604 278-7510
Fax: 604 278-7594

E-mail: reception@cobc.ca

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Optometrists of British Columbia

Under the *Health Professions Act*, the College of Optometrists of British Columbia is committed to serving and protecting the public interest by guiding the profession of optometry in British Columbia.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of six professional representatives and three public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Buchanan, Barbara E.	Minister 155/12, September 1, 2012	Public/Lay Member	September 1, 2015
MacPherson, David	Minister 155/12, September 1, 2012	Public/Lay Member	September 1, 2015

2 current members.

...Mandate

The Board regulates the practice of optometry in the province through registration of practitioners, investigation of complaints, and maintenance of a hearing and disciplinary process. The Board may make rules concerning the practice of optometry, including the discipline of practitioners and the use of drugs for diagnostic purposes. The Board issues and revokes permits to optometric corporations.

What's Involved

For More Information...

College of Optometrists of British Columbia
1204 - 700 West Pender Street

VANCOUVER BC V6C 1G8

Tel: 604 623-3464
Fax: 604 623-3465

E-mail: optometry_board@telus.net

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Pharmacists of British Columbia

The College of Pharmacists of BC is the regulatory body for pharmacy in British Columbia and is responsible for registering pharmacists and licensing pharmacies throughout the province.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of seven professional representatives and four public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Denton, Penelope (Penny) Ann	Minister 294/10, October 18, 2010	Public/Lay Member	October 1, 2012
Gustavson, Kris J.	Minister 188/11, July 15, 2011	Public/Lay Member	October 1, 2012
Scholtens, John J.	Minister 305/10, October 21, 2010	Public/Lay Member	October 1, 2012
Slater, Jeff	Minister 305/11, November 17, 2011	Public/Lay Member	October 1, 2013

4 current members.

...Mandate

To ensure British Columbia pharmacists provide safe and effective pharmacy care to help people achieve better health.

What's Involved

For More Information...

Professional College - College of Pharmacists of British Columbia
200 - 1765 8th Avenue West
VANCOUVER BC V6J 5C6

Tel: 604 733-2440
Fax: 604 733-2493

E-mail: Marshall.Moleschi@bcpharmacists.org

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Physical Therapists of British Columbia

The College of Physical Therapists of British Columbia (CPTBC) is a not-for-profit organization responsible for regulating the practice of physical therapists in the public interest.

CPTBC is a regulatory organization that operates within the legislative framework provided by the *Health Professions Act*.

The College sets standards for entry into the profession, registers physical therapists, sets and enforces a set of rules that registrants must follow and develops programs to promote the highest standards of physical therapy practice.

The CPTBC also investigates complaints and disciplines physical therapists who have been found guilty of professional misconduct or incompetence.

The Board...

...Composition

The College consists of nine members. Six members (non-BRDO) are elected physical therapists and three members are public representatives appointed by the Responsible Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carter, Wendy L.	Minister 45/12, February 20, 2012	Public/Lay Member	May 31, 2014
Lam, Michael Chi Chiu	Minister 118/11, May 31, 2011	Public/Lay Member	May 31, 2014
Tevington, Marilyn J.	Minister 118/11, May 3, 2011	Public/Lay Member	March 31, 2013

3 current members.

...Mandate

CPTBC is mandated by the *Health Professions Act* of British Columbia. This mandate includes:

- the regulation of the practice of the profession;

- the establishment of the entry-to-practice requirements and the registration;
- the assurance of the quality of professional practice;
- the promotion of continuing competence;
- the setting of ethical standards; and,
- the investigation of complaints against its registrants.

What's Involved

The Council meets approximately once every two months. Members will be asked to participate in committees, panels, or both, each of which may have varying degrees of additional time commitment.

For More Information...

College of Physical Therapists of BC
407 - 1755 West Broadway
Vancouver, BC V6J 4S5

Tel: 604 730-9193
Fax: 604 737-6809

E-mail: info@cptbc.org

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Physicians and Surgeons of British Columbia

The College of Physicians and Surgeons of British Columbia protects the public by establishing and endorsing high standards of medical practice by licensed physicians.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of 10 professional representatives and six public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Charvat, Lori	Minister 118/12, September 1, 2012	Public/Lay Member	September 1, 2014
Corfield, Michelle M. A.	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2013
Creed, Walter M.	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2014
Gill, Satvir S.	Minister 118/12, May 8, 2012	Public/Lay Member	May 30, 2014
Jenkinson, Valerie	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2013

5 current members.

...Mandate

The College of Physicians and Surgeons of British Columbia (the "College") was established by the Provincial Legislature in 1886 as the licensing and regulatory body for all physicians and surgeons in the province. The College is entrusted with the responsibility to establish, monitor and enforce high standards of qualification and medical practice across the province.

What's Involved

For More Information...

Professional College - College of Physicians and Surgeons of British Columbia
400 - 858 Beatty Street
VANCOUVER BC V6B 1C1

Tel: 604 733-7758
Fax: 604 733-3503

E-mail: droetter@cpsbc.ca

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Board Resourcing and Development Office

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Professional College - College of Podiatric Surgeons of BC

The College of Podiatric Surgeons is working through a transitional implementation period and will assume responsibility for regulating the profession when the current *Podiatrists Act* is repealed on February 1, 2011. Until then, the BC Association of Podiatrists and the Board of Examiners in Podiatry will continue to regulate the profession.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of professional representatives and twopublic representatives who will hold office until the first election is held under the *Health Professions Act* which must be held by February 1, 2012.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Awan, Mahmood A.	Minister 144/12, June 29, 2012	Public/Lay Member	June 30, 2014
Shergill, Jagdeep S.	Minister 144/12, June 29, 2012	Public/Lay Member	June 30, 2014

2 current members.

...Mandate

The College of Podiatric Surgeons was established under the *Health Professions Act* on July 1, 2010, to regulate the profession of podiatric medicine.

What's Involved

For More Information...

Professional College - College of Podiatric Surgeons of BC
#617 - 938 Howe Street
VANCOUVER BCÂ Â Â V6Z 1N9

Tel: 604 602-0400
Fax: 604 602-0399

E-mail: bcap@foothealth.ca

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Psychologists of British Columbia

Psychology is the scientific study of the brain, mind and behaviour, which is useful in treating mental illness and behavioural problems. In order to practice in British Columbia, professional psychologists must be licensed by the BC College of Psychologists.

The Board...

...Composition

Under the *Health Professions Act*, the Board of the college consists of six elected registrants (non-BRDO) of the College and three government appointed public members.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Fellman, Michael	Minister 46/12, February 20, 2012	Public/Lay Member	March 31, 2014
Hynes, Jenelle M.	Minister 364/10, January 31, 2011	Public/Lay Member	January 31, 2013
Readman, J. Dean	Minister 46/12, February 20, 2012	Public/Lay Member	March 31, 2014

3 current members.

...Mandate

The BC College of Psychologists is the regulatory body responsible for the accreditation and licensing of psychology practitioners in British Columbia.

The Council makes rules respecting:

- the management of the business and property of the College;
- the maintenance of a register of psychologists;
- the holding of examinations, and;
- fees.

The Council also determines the bylaws regarding registration, qualifications, discipline, ethics, and

other matters. The Council may, if necessary, take disciplinary action against a registered psychologist.

What's Involved

There is one meeting each month, of approximately five hours in duration. There is also some preparation time involved. Members will be asked to sit on disciplinary committees or other panels of the Board.

For More Information...

College of Psychologists of BC
404 - 1755 West Broadway
Vancouver, BC V6J 4S5

Tel: 604 736-6164
Fax: 604 736-6133

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Professional College - College of Registered Nurses of British Columbia

Nursing in British Columbia has been a self-regulating profession since 1918. Under the *Health Professions Act*, it is the duty of College of Registered Nurses of British Columbia (CRNBC) to protect the public through the regulation of registered nurses, nurse practitioners and licensed graduate nurses.

The Board...

...Composition

The Council consists of 12 members elected by and from registrants of the College (non-BRDO) and six public members appointed by the Responsible Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Anderson, Catherine I.	Minister 156/12, August 31, 2012	Public/Lay Member	August 31, 2014
Cheng, Chilwin C.	Minister 016/11, January 31, 2010	Public/Lay Member	January 31, 2013
Hobrough, Ana-Maria	Minister 156/12, August 31, 2012	Public/Lay Member	August 31, 2015

3 current members.

...Mandate

The mandate of the College is to ensure that registered nurses in British Columbia practice in a manner that serves and protects the public.

What's Involved

Regular meetings are held five times per year. Members are also expected to attend the College's two day Conference for Leaders in late fall and the two day Annual General Meeting in the spring. Members will be asked to sit on committees or panels of the board, with varying degrees of time-commitment.

For More Information...
College of Registered Nurses of BC

2855 Arbutus Street
Vancouver, BC V6J 3Y8

Tel: 604 736-7331
Fax: 604 738-2272

E-mail: info@crnbc.ca

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Board Resourcing and Development Office

Directory of Agencies

Professional College - College of Registered Psychiatric Nurses of BC

The College of Registered Psychiatric Nurses of BC is the regulatory body for professional psychiatric nurses in British Columbia.

The Board...

...Composition

The Council consists of nine members. One-third of the Council members are lay members appointed by the Responsible Minister to represent the public interest. The remaining two-thirds are registered psychiatric nurses elected by members of the profession (non-BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Anderson, Paul John	Minister 027/10, January 26, 2010	Public/Lay Member	December 20, 2012
Ribeyre, Paul (Ted)	Minister 47/12, February 20, 2012	Public/Lay Member	March 31, 2014
Robinson, Carol E.	Minister 251/10, November 30, 2010	Public/Lay Member	November 30, 2012

3 current members.

...Mandate

The Council may make rules respecting ethics, discipline, duties and the procedure for investigating a complaint against a member of the association. The Council may make bylaws regarding its procedure and the registration of psychiatric nurses.

What's Involved

Regular meetings are held once every three months. Members may also be required to serve on external committees or disciplinary hearings which could intermittently require a greater time commitment. Public members may also be required to serve on the executive committee, which meets more frequently.

For More Information...

College of Registered Psychiatric Nurses of BC
307 - 2502 St John's Street
Port Moody, BC V3H 2B4

Tel: 604 931-5200
Fax: 604 931-5277

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Board Resourcing and Development Office

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Professional College - Traditional Chinese Medicine Pract and Acupuncturists

The College of Traditional Chinese Medicine Practitioners and Acupuncturists (CTCMA) of British Columbia is the regulatory body established under the *Health Professions Act* to oversee the practice of Traditional Chinese Medicine and Acupuncture in British Columbia.

The Board...

...Composition

The Council consists of six members elected by and from the registrants of the College (non-BRDO) and three lay members appointed by the Minister to represent the general public.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Lee, Bar-Chya	OIC 153/12, June 30, 2012	Public/Lay Member	June 30, 2014
MacLeod, William (Bill) D.	Minister 330/10, December 31, 2010	Public/Lay Member	December 31, 2012
Stewart, Vivienne H.	Minister 330/10, December 31, 2010	Public/Lay Member	December 31, 2012

3 current members.

...Mandate

The Council is charged with regulating standards of practice for the professions of Traditional Chinese Medicine and Acupuncture; it is also responsible for the registration and licensing of professional acupuncturists and practitioners of Traditional Chinese Medicine in British Columbia.

What's Involved

Members should be prepared to meet at least once per month, as well as for additional and subcommittee meetings as required.

For More Information...

College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC
1664 West 8th Avenue

Vancouver, BC V6J 1V4

Tel: 604 738-7100
Fax: 604 738-7171

E-mail: info@ctcma.bc.ca

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BC Health Services Purchasing Organization

The British Columbia Health Services Purchasing Organization (BCHSPO) was incorporated under the *Society Act* in January 2010. The BCHSPO was registered to oversee the implementation of patient-focused funding. The organization builds on the successes of the $75-million Lower Mainland Innovation and Integration Fund. Under a patient-focused funding approach, hospitals receive financial incentives for delivering acute-care services for a competitive, set price.

The Board...

...Composition

Bylaw 4.5 of the BCHSPO requires that Directors be appointed by the Minister immediately following the incorporation of the society.

In addition, for the board of directors, Bylaw 4.1 states that the board shall consist of the representatives as follows: (a) the Deputy Minister of Health Services or their delegates, (b) Ministry of Health Services Representatives, (c) a Chair, and (d)other Directors at the discretion of the Minister or such other number, configuration or representation as determined by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Korabek, Barbara	Ministerial Letter ML 927293, May 18, 2012	Ministry Representative	March 29, 2014
McKnight, Elaine	Ministerial Letter Letter 921581, March 5, 2012	Ministry Representative	February 10, 2013
Powell, G. Wynne	Ministerial Letter Letter 921706, April 13, 2012	Director	April 13, 2013
Ramsden, Murray G.	Ministerial Letter 931401, June 29, 2012	Director	June 30, 2014
Thompson, David A.	Ministerial Letter Letter 921706, April 13, 2012	Chair	April 13, 2013

5 current members.

...Mandate

The BCHSPO's purpose is to make decisions for the procurement of health care services using a funding model that will encourage improvement and create a competitive environment.

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BC Patient Safety and Quality Council

The purpose of the British Columbia Patient Safety and Quality Council is to provide advice and make recommendations to the Minister on matters related to patient safety and quality of care, and to bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative, and patient-centered approach to patient safety and quality improvement in British Columbia.

The Board...

...Composition

The council will consist of not more than six members selected for their personal credibility, expertise and experience as it relates to patient safety and quality improvement.

The Minister shall appoint one member to the position of Chair. This individual will assume full responsibility for the management of Council operations, and will be accountable in this role to the Minister through the Deputy Minister (or delegate thereof). All other Council members shall be appointed by the Deputy Minister on the advice of the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carroll, Evelyn D.	Minister 249/10, October 31, 2010	Member	October 31, 2012
Cochrane, D. Douglas	Minister 103/11, April 24, 2011	Chair	April 30, 2014
Stamp, Brian A.	Minister 249/10, October 31, 2010	Member	October 31, 2012
Taylor, John G.	Minister 32/12, February 1, 2012	Member	April 30, 2014

4 current members.

...Mandate

The Council will:

- Bring a provincial perspective to patient safety and quality improvement activities;
- Facilitate the building of capacity and expertise for patient safety and quality improvement;

- Support health authorities and other service delivery partners in their continuous effort to improve the safety and quality care; and,
- Improve health system transparency and accountability to patients and the public for the safety and quality of care provided in British Columbia.

What's Involved

The timing and frequency of the meetings will be determined by the tasks the Council is required to fulfill and as part of its work plan approved by the Minsiter.

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Board Resourcing and Development Office

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Emergency and Health Services Commission

The Emergency and Health Services Commission (EHSC) provides emergency health and ambulance services and assists hospitals, municipalities and others to provide emergency health services.

The Emergency and Health Services Commission is cross-appointed to the **Provincial Health Services Authority**.

The Board...

...Composition

The EHSC consists of one or more persons appointed by the Minister. The Minister may designate a member of the Commission as Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Armitage, James E.	Minister 243/11, March 31, 2012	Member	March 31, 2014
Brooks, Donald E.	Minister 41/12, February 20, 2012	Member	December 31, 2012
Gibbons, Elizabeth (Betsy) E.	Minister 84/11, April 1, 2011	Member	February 6, 2013
Manning, Tim F.	Minister 84/11, April 1, 2011	Member	September 30, 2012
McDougall, Mary	Minister 243/11, September 17, 2011	Member	September 30, 2014
McGrath, Lorraine	Minister 243/11, September 30, 2011	Member	September 30, 2012
Powell, G. Wynne	Minister 84/11, April 1, 2011	Chair	December 31, 2012
Ritchie, Allan G.	Minister 139/11, July 31, 2011	Member	July 31, 2013
Rowlatt, J.D. (Don)	Minister 243/11, March 31, 2012	Member	March 31, 2013
Sadler, Q.C., W. Murray	Minister 84/11, April 1, 2011	Member	October 31, 2013

Sidhu, Charanjeet (CJ) S.	Minister 84/11, April 1, 2011	Member	December 31, 2013

11 current members.

...Mandate

The EHSC has the legislated mandate to ensure the provision of high quality and consistent levels of pre-hospital emergency health care services throughout the province. The BC Ambulance Service (BCAS) is the service delivery vehicle for the EHSC and provides direct pre-hospital emergency care, inter-facility transfers, standby at public events and disaster preparedness. The EHSC also recruits and trains emergency medical assistants.

What's Involved

The Commission meets on a bi-monthly basis.

For more Information...

700 - 1380 Burrard Street
Vancouver, BC V6Z 2H3

Tel: 604 675-7400
Fax: 604 708-2700

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Health Authority - Fraser

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Fraser Health Authority (FHA) has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bubber, Arvinder S.	Minister 149/10, August 31, 2010	Member	September 30, 2012
Forrest, Robert E.	Minister 069/10, March 21, 2010	Member	December 31, 2013
Gill, Gurpreet K.	Minister 069/10, March 21, 2010	Member	December 31, 2012
Grinnell, Marlene M.	Minister 26/12, March 31, 2012	Member	March 31, 2014
Kolybabi, Deanie L.	Minister 069/10, March 21, 2010	Member	December 31, 2012
Matty, Karen	Minister 142/12, August 1, 2012	Member	March 31, 2014
McLeod, George M.	Minister 26/12, March 31, 2012	Member	March 31, 2014
Mitchell, David W.	Minister 313/10, November 2, 2010	Chair	December 31, 2012
Sumal, Inde	Minister 354/11, December 31, 2011	Member	December 31, 2013

9 current members.

...Mandate

The Fraser Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Fraser Health Authority
300 - 10334 152A Street
Surrey, BC V3R 7P8

Tel: 604 587-4600
Fax: 604 587-4666

Or

British Columbia Health Authorities

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Board Resourcing and Development Office

Directory of Agencies

Health Authority - Interior

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Interior Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Burrows, Kenneth W.	Minister 351/11, December 31, 2011	Member	December 31, 2013
Embree, Norman	Minister 27/12, March 31, 2012	Chair	December 31, 2014
Gillespie, David W.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Goldsmith, David W.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Goodings, Virginia J.	Minister 27/12, March 31, 2012	Member	March 31, 2014
Malzer, Erwin J.	Minister 070/10, March 21, 2010	Member	December 31, 2013
McGregor, Rosanna	Minister 229/09, October 9, 2009	Member	October 9, 2012
Quinn, Findlay (Frank) J.	Minister 351/11, December 31, 2011	Member	December 31, 2013
Sutherland, Glenn	Minister 27/12, March 31, 2012	Member	December 31, 2014

9 current members.

...Mandate

The Interior Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Interior Health Authority
#220 Â¿ 1815 Kirschner Road
Kelowna, BC V1Y 4N7

Tel: 250 862-4200
Fax: 250 862-4201

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British Columbia Health Authorities

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Health Authority - Northern

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Northern Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Caldwell, Barbara Y.	Minister 28/12, March 31, 2012	Member	March 31, 2014
Hartwell, Sharon L.	Minister 182/11, July 11, 2011	Member	July 31, 2013
Jago, Charles (Chuck)	Minister 071/10, August 31, 2010	Chair	December 31, 2013
McIntyre, Cameron D.	Minister 071/10, March 21, 2010	Member	December 31, 2013
Milne, Gordon	Minister 28/12, March 31, 2012	Member	March 31, 2014
O'Neil, Kathleen (Kate)	Minister 28/12, March 31, 2012	Member	March 31, 2014
Shannon, Deborah Lynn	Minister 28/12, March 31, 2012	Member	March 31, 2014
Townsend, Gary William	Minister 15/12, January 12, 2012	Member	December 31, 2014

8 current members.

...Mandate

The Northern Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet regularly, usually once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Northern Health Authority
Suite 300 - 299 Victoria Street
Prince George, BC

Tel: 250 565-2649
Fax: 250 565-2640

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Health Authority - Provincial Health Services Authority

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority (PHSA).

The Provincial Health Services Authority is cross-appointed to the **Emergency and Health Services Commission**.

The Board...

...Composition

The Provincial Health Services Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Armitage, James E.	Minister 247/11, March 31, 2012	Member	March 31, 2014
Brooks, Donald E.	Minister 51/12, February 20, 2012	Member	December 31, 2012
Gibbons, Elizabeth (Betsy) E.	Minister 259/09, February 6, 2010	Member	February 6, 2013
Manning, Tim F.	Minister 304/10, October 11, 2010	Member	September 30, 2012
McDougall, Mary	Minister 247/11, September 17, 2011	Member	September 30, 2014
McGrath, Lorraine	Minister 247/11, September 30, 2011	Member	September 30, 2012
Powell, G. Wynne	Minister 304/10, December 9, 2010	Chair	December 31, 2012
Ritchie, Allan G.	Minister 138/11, July 31, 2011	Member	July 31, 2013
Rowlatt, J.D. (Don)	Minister 247/11, March 21, 2012	Member	March 31, 2013
Sadler, Q.C., W. Murray	Minister 304/10, October 11,	Member	October 31,

	2010		2013
Sidhu, Charanjeet (CJ) S.	Minister 304/10, December 1, 2010	Member	December 31, 2013

11 current members.

...Mandate

The Provincial Health Services Authority is responsible for:

- working with the five health authorities to plan and co-ordinate the delivery of provincial programs and highly-specialized services, and;
- ensuring that access and issues for these services are equitably addressed.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Provincial Health Services Authority
700 - 1380 Burrard Street
Vancouver, BC V6Z 2H3

Tel: 604 675-7400
Fax: 604 708-2700

Or

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Health Authority - Vancouver Coastal

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Vancouver Coastal Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Brown, Kenneth M.	Minister 143/12, June 29, 2012	Member	March 31, 2014
Di Blasio, Alfredo G.	Minister 38/10, March 21, 2010	Member	October 29, 2013
Heath, Sandra L.	Minister 248/10, September 28, 2010	Member	September 30, 2013
Hsieh, James C.	Minister 29/12, March 31, 2012	Member	March 31, 2014
Nocente, Daniel L.	Minister 143/12, June 29, 2012	Member	March 31, 2015
Rehkatsch, Axel F.	Minister 242/06, October 18, 2006	Member	December 31, 2013
Spitz, Grant	Minister 230/09, October 16, 2009	Member	October 18, 2012
Withers, Victoria L.	Minister 260/09, November 15, 2009	Member	November 15, 2012
Woodward, C.C. (Kip)	Minister 29/12, April 13, 2012	Chair	March 31, 2014

9 current members.

...Mandate

The Vancouver Coastal Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet regularly, usually once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Vancouver Coastal Health Authority
Suite 200, 520 West 6th Avenue
Vancouver, BC V5Z 4H5

Tel: 604 736-2033
Fax: 604 874-7661

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Health Authority - Vancouver Island

In December 2001, authority for the governance and management of most health services was transferred to five regional health authorities. In addition, there is one Provincial Health Services Authority.

The Board...

...Composition

The Vancouver Island Health Authority has a governing board appointed by the Minister of Health Services, who also designates the Chair.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carson, S. Frank B.	Minister 326/10, November 22, 2010	Member	December 31, 2015
Costello, J. Michael	Minister 328/10, December 2, 2010	Member	December 31, 2012
Garside, Shelley E.	Minister 31/12, March 21, 2012	Member	March 31, 2014
Hubbard, Don	Minister 325/10, November 22, 2010	Chair	December 31, 2015
Kruyt, David C.	Minister 31/12, March 21, 2012	Member	March 31, 2014
Slaney, Vernard (Vern) G.	Minister 096/07, May 3, 2007	Member	December 31, 2013
Watson, Matthew G.	Minister 30/12, February 1, 2012	Member	March 31, 2014
Wheeler, Jean T.	Minister 30/12, February 1, 2012	Member	March 31, 2014
van de Sande, Johan (Hans)	Minister 31/12, March 21, 2012	Member	March 31, 2014

9 current members.

...Mandate

The Vancouver Island Health Authority is primarily responsible for:

- identifying regional health needs and planning appropriate programs and services;
- ensuring that programs and services are properly funded and managed;
- managing the delivery of health services in their respective areas;
- meeting performance objectives set by their regions, and;
- ensuring community input into health service planning and evaluation for their areas.

What's Involved

Members of Health Authorities should be prepared to meet once per month. Health Authorities may also strike subcommittees on particular issues and members should be prepared to participate.

For More Information...

Vancouver Island Health Authority
1952 Bay Street
Victoria, BC V8R 1J8

Tel: 250 370-8699
Fax: 250 370-8750

Or

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Health Professions Review Board

The Health Professions Review Board is an administrative tribunal created under the *Health Professions Act* to provide an independent review of certain decisions made by the self-governing colleges of designated health professions regarding the registration of their members and the timeliness and disposition of complaints made against their registrants. Through its reviews, dispute resolution processes and hearings, the Review Board monitors the activities of the colleges' complaints inquiry committees and registration committees, in order to ensure they fulfill their duties in the public interest and as mandated by legislation. The Review Board provides a neutral forum for members of the public as well as for health professionals to resolve disputes or seek review of the colleges' decisions.

The Review Board also helps to improve the health care system and serve the public interest in BC by developing and publishing guidelines and recommendations for the purpose of assisting colleges to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair.

The Board...

...Composition

The board consists of one Chair and 15 - 25 members appointed by the Lieutenant Governor in Council.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Alexandor, Michael J.B.	OIC 740/10, December 31, 2010	Member	December 31, 2012
Bennett, Lorianna	OIC 740/10, December 31, 2010	Member	December 31, 2013
Berg, Judith J.	OIC 740/10, December 31, 2010	Member	December 31, 2012
Blane, Rex D.	OIC 138/12, March 8, 2012	Member	December 31, 2014
Clark, D. Marilyn	OIC 740/10, December 31, 2010	Member	December 31, 2012
Doll, Arlene M.	OIC 138/12, March 8, 2012	Member	December 31, 2014

English, Q.C., John Thomas	OIC 597/11, December 31, 2011	Chair	December 31, 2012
Hobbs, David Arthur	OIC 740/10, December 31, 2010	Member	December 31, 2013
Kuhl, Victoria (Vicki)	OIC 740/10, December 31, 2010	Member	December 31, 2012
McDowell, Lori	OIC 740/10, December 31, 2010	Member	December 31, 2012
Morris, Michael J.	OIC 740/10, December 31, 2010	Member	December 31, 2013
Mourton, Maurice R.	OIC 740/10, December 31, 2010	Member	December 31, 2013
O'Fee, John H.	OIC 187/12, March 29, 2012	Member	December 31, 2014
Scott, W. Laurence	OIC 139/12, March 8, 2012	Member	December 31, 2014
Silber, Herbert (Herb) S.	OIC 138/12, March 8, 2012	Member	December 31, 2014
Silversides, Q.C., Donald A.	OIC 740/10, December 31, 2010	Member	December 31, 2013
del Val, Helen Ray	OIC 740/10, December 31, 2010	Member	December 31, 2013

17 current members.

...Mandate

The main purpose of the HPRB is to provide a fair, impartial, accountable and transparent mechanism for the review of decisions of colleges of designated health professions regarding registration, management of complaints, and discipline.

What's Involved

For More Information...

www.hprb.gov.bc.ca

Health Professions Review Board
Suite 900, 747 Fort Street
Victoria BC V8W 2E9

Mailing Address
PO Box 9429 Stn Prov Govt
Victoria BC V8W 9V1

Telephone: 250-953-4956
Facsimile: 250-953-3195
Toll-free telephone number (within BC): 1-888-953-4986

E-mail: hprbinfo@gov.bc.ca

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Health Shared Services BC

Health Shared Services BC finds opportunities for health authorities across the province to improve cost effectiveness and enhance service quality. By working collaboratively on common services, Health Shared Services BC ensures health authorities get the most value for every dollar spent.

The number one priority of our health care system is making sure that patients get the best care possible. Health Shared Services BC is committed to consistently seeking ways to get the most out of every health care dollar in order to maximize resources going to direct patient care.

Health Shared Services BC is a unique initiative for the province. The organization has been designed in a way that enables health authorities to achieve more collectively together than they could independently.

Health Shared Services BC contributes to the Ministry of Health Services' goal of sustaining high quality patient care through more efficient and cost-effective services. Together, ensuring a sustainable, publicly funded health care system.

The Board...

...Composition

The HSSBC Management Board shall be composed of the following individuals and no substitutes or alternates shall be permitted:

(a) the President and CEO from time to time of the Provincial Health Services Authority;
(b) the Chief Executive Officers, from time to time, of each customer;
(c) one Ministry representative designated from time to time by the Minister:
(d) up to two independent individuals recommended by the HSSBC Management Board and designated from time to time by the Minister; and
(e) the Chief Executive Officer of Providence Health Care Society, for as long as that entity remains an affiliate of Vancouver Coastal Health Authority, to have non-voting observer status only.

Click here for biographies of all Members

Current Members			

Name:	By order:	Position:	Expiry:
Leighton, Peter R.	Ministerial Letter Letter, February 1, 2011	Independent Director	January 31, 2014
Longworth, Thomas J.	Ministerial Letter ML 924100, April 24, 2012	Member	April 24, 2015
McKnight, Elaine	Ministerial Letter 919210/919221, February 15, 2012	Ministry Representative	At Pleasure

3 current members.

...Mandate

To establish a province-wide Health Authority Shared Services Organization that will create enhanced value to the health system through the effective and efficient delivery of agreed upon support services.

What's Involved

For More Information...

Health Shared Services BC
700-1380 Burrard Street
VANCOUVER BCÂ Â Â V6Z 2H3

Tel: 604 875-7381

E-mail: contact@hssbc.ca

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Medical Services Commission

Medicare is the cornerstone of Canada's health care system, ensuring that all Canadians, regardless of their financial status, have reasonable access to adequate health care and diagnostic facility services.

In British Columbia, the Medical Services Plan, which covers the cost of care delivered by fee-for-service health care practitioners in the province, is administered by the Medical Services Commission.

The majority of these costs is apportioned to medical doctors by the Medical Services Commission which is composed of representatives of the BC Medical Association, the Government of British Columbia and the beneficiaries of the Medical Services Plan (most citizens of the province).

The Board...

...Composition

The Commission consists of up to nine persons (and their alternates) appointed by the Lieutenant-Governor in Council. Three of these members are nominated by the BC Medical Association; three are nominated on the joint recommendation of the Minister of Health and the BC Medical Association to represent beneficiaries; and three are public servants who represent the Government of British Columbia.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Collins, Carol A.	OIC 72/12, February 16, 2012	Beneficiary Rep	June 30, 2014
Davidson, Heather Anne	OIC 74/12, February 16, 2012	2nd Alternative Government	At Pleasure
Gillespie, Ian A.	Nominated 459/11, October 1, 2011	1st Alternate BCMA	October 1, 2012
Gregory, Brian W.	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Halpenny, Robert	OIC 22/05, January 14, 2005	Government Rep	At Pleasure
Mackenzie, Isobel	OIC 194/11, June 30, 2011	Beneficiary Rep	June 30, 2013

Manning, Nichola S. M.	OIC 74/12, February 16, 2012	1st Alternate Government	At Pleasure
McKenzie, Melanie L.	OIC 194/11, June 30, 2011	Beneficiary Rep	June 30, 2014
Norton, Bryan R.	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Power, Stephanie A.	OIC 74/12, February 16, 2012	3rd Alternate Government	At Pleasure
Ross, Shelley N.	OIC 459/11, October 1, 2011	2nd Alternate BCMA	October 1, 2012
Seckel, Allan P.	OIC 73/12, April 1, 2012	3rd Alternate Member	June 30, 2014
Taylor, Sheila A.	OIC 74/12, February 16, 2012	Government Rep - Deputy Chair	At Pleasure
Thomson, Darrell	OIC 459/11, October 1, 2011	BCMA Rep	October 1, 2012
Vincent, Thomas E.	OIC 240/12, April 19, 2012	Government Rep - Chair	At Pleasure

15 current members.

...Mandate

The Mandate of the Commission is to facilitate the reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facilities, under the Medical Services Plan (MSP). The commission is responsible for the administration and operation of the Medical Services Plan, a health insurance policy for residents of the province, and establishes a schedule for the payment of insured services.

What's Involved

Members are asked to be available for monthly meetings.

For More Information...

Medical Services Commission
Ministry of Health Services
3-1, 1515 Blanshard Street
Victoria, BC V8W 3C8

Tel: 250 952-3073
Fax: 250 952-3131

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Mental Health Review Board

The Mental Health Review Board is an independent, quasi-judicial administrative tribunal established in April 2005 to conduct review panel hearings under the *Mental Health Act*. It is made up of a chair and members appointed by the Minister under the *Act*. The Board conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the *Act*.

The Board...

...Composition

Under the *Act*, the Minister appoints the Chair of the Board and all legal, medical and community members authorized to sit as review panel members and conduct hearings throughout the Province. The Chair of the Board serves full time and the members serve part time.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Ali, Naved A.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Baird, Maureen E.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Bilsbarrow, Jennifer	Minister 77/11, April 3, 2011	Member	April 30, 2013
Boon, John	Minister 77/11, April 3, 2011	Member	April 30, 2014
Borowicz, QC, Frank S.	Minister 353/11, December 31, 2011	Member	December 31, 2013
Bubbs, Joan	Minister 273/11, October 4, 2011	Member	December 31, 2013
Buckley, L. Ralph	Minister 77/11, April 3, 2011	Member	April 30, 2013
Cardinal, Roger J.A.	Minister 252/10, September 7, 2010	Member	December 31, 2012
Cheema, Q.C., Pinder K.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Cherneski, Heather M.	Minister 189/11, July 15, 2011	Member	December 31, 2014
Chow, Kenmau	Minister 189/11, July 15, 2011	Member	December 31, 2014
Daroux, Danielle K.	Minister 211/10, July 9, 2010	Member	December 31, 2012

Deliyannides, Alexandra	Minister 273/11, October 4, 2011	Member	December 31, 2014
Dionne, Michael D.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Dirksen van Schalkwyk, Reinette	Minister 100/10, March 30, 2010	Member	December 31, 2012
Doll, Arlene M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Dowey, Michael	Minister 77/11, April 3, 2011	Member	April 30, 2014
Duffy, Helen P.	Minister 189/11, July 15, 2011	Member	December 31, 2013
Eaves, Derek	Minister 77/11, April 3, 2011	Member	April 30, 2014
Fabriel-Leclerc, Christin	Minister 273/11, October 4, 2011	Member	December 31, 2014
Fairweather, Tanya M.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Gowans, Helen M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Graves, Carl	Minister 77/11, April 3, 2011	Member	April 30, 2014
Gray, Elizabeth R.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Griffiths, Robert A.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Grigg, Harvey M.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Hargreaves, Bob	Minister 77/11, April 3, 2011	Member	April 30, 2013
Higgins, Roger S.	Minister 278/10, October 5, 2010	Member	December 31, 2013
Hodge, Gillian M.	Minister 54/12, February 29, 2012	Member	December 31, 2015
Holan, Jan	Minister 55/11, February 22, 2011	Member	December 31, 2013
Hyatt, Stan L.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Ingram, Marie	Minister 77/11, April 3, 2011	Member	April 30, 2013
Jackson, Nora	Minister 59/12, February 29, 2012	Member	December 31, 2014
Jiwa, Abdulkarim M.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Joly, Guy C.	Minister 59/12, February 29, 2012	Member	December 31, 2015
Kolsteren, Ingrid A.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Lamb, Diane M.	Minister 77/11, April 3, 2011	Member	April 30, 2013
LeRose, Kenneth B.	Minister 55/11, February 22, 2011	Member	December 31, 2013
Leong, Judith M.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Lewis, Thomas G.	Minister 189/11, July 15, 2011	Member	December 31, 2013

Martin, Joseph B.	Minister 211/10, July 9, 2010	Member	December 31, 2012
Massam, John	Minister 77/11, April 3, 2011	Member	April 30, 2013
Maurice, William (Bill)	Minister 77/11, April 3, 2011	Member	April 30, 2014
May, David	Minister 77/11, April 3, 2011	Member	April 30, 2014
McPherson, Kathleen E.	Minister 273/11, October 4, 2011	Member	December 31, 2014
Moore, Tracy Rae	Minister 77/11, April 3, 2011	Member	April 30, 2013
Murray, Alistair Stuart	Minister 77/11, April 3, 2011	Member	April 30, 2014
Naccarato, Saverio (Sam)	Minister 77/11, April 3, 2011	Member	April 30, 2014
Ngan, Elton T.C.	Minister 77/11, April 3, 2011	Member	April 30, 2014
Noone, Joseph	Minister 77/11, April 3, 2011	Member	April 30, 2014
Ostrowski, Q.C., Margaret	Minister 285/09, December 10, 2009	Chair	December 31, 2013
Parfitt, Hugh	Minister 77/11, April 3, 2011	Member	April 30, 2014
Parnell, Peter	Minister 77/11, April 3, 2011	Member	April 30, 2013
Pfeifer, Mary-Ann A.	Minister 77/11, April 3, 2011	Member	April 30, 2013
Pfliger, Jennifer	Minister 77/11, April 3, 2011	Member	April 30, 2013
Plenert, Wayne N.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Pope, Q.C., Dale B.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Preston, June C.	Minister 59/12, February 29, 2012	Member	December 31, 2014
Richardson, J.A. (Gus)	Minister 77/11, April 3, 2011	Member	April 30, 2013
Rogers-Rainey, Tanya	Minister 77/11, April 3, 2011	Member	April 30, 2013
Sahota, Manmohan	Minister 273/11, October 4, 2011	Member	December 31, 2014
Schieldrop, Peter	Minister 77/11, April 3, 2011	Member	April 30, 2014
Smerychynski, Linda J.	Minister 77/11, April 3, 2011	Member	April 30, 2013
Soroka, Allen H.	Minister 273/11, October 4, 2011	Member	December 31, 2013
Stilling, Wayne	Minister 273/11, October 4, 2011	Member	December 31, 2013
Symonds, Vance Brian	Minister 189/11, July 15, 2011	Member	December 31, 2013
Tapper, Christopher Mark	Minister 77/11, April 3, 2011	Member	April 30, 2014
Tomchenko, Oleg H.	Minister 278/10, October 5, 2010	Member	December 31, 2013
Uhlmann, Ralph P.	Minister 189/11, July 15, 2011	Member	December 31, 2014
Waddington, Sandra J.	Minister 54/12, February 29, 2012	Member	December 31, 2014
Walters, Sandra	Minister 189/11, July 15, 2011	Member	December 31, 2013
Warner, Q.C., Peter D.	Minister 100/10, March 30, 2010	Member	December 31, 2012

Westwood, Kevin Ralph	Minister 273/11, October 4, 2011	Member	December 31, 2013
Williams, Laurie	Minister 77/11, April 3, 2011	Member	April 30, 2013
Williams, Tiina P.	Minister 189/11, July 15, 2011	Member	December 31, 2013
Wong, Kum C.	Minister 273/11, October 4, 2011	Member	December 31, 2014
Wong, Lisa M.	Minister 55/11, February 22, 2011	Member	December 31, 2013

77 current members.

...Mandate

The Board has jurisdiction to conduct hearings and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the *Mental Health Act*.

What's Involved

Board members are scheduled for review panel hearings within statutory time limits of either 14 or 28 days from when applications are received. They typically need to set aside a half-day or full day to conduct one or two hearings at a nearby mental health facility. They may sometimes be asked to travel or accept a case assignment on exceptionally short notice where necessary to provide a hearing within the statutory time limit.

For More Information...

Mental Health Review Board
#302 - 960 Quayside Drive
New Westminster, BC V3M 6G2

Tel: 604 660-2325
Fax: 604 660-2403

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Patient Care Quality Review Board - Fraser

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Fraser Patient Care Quality Review Board is cross-appointed to the **Vancouver Coastal Patient Care Quality Review Board**, and the **Provincial Health Services Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 256/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 256/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 298/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 256/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 256/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 298/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC Â V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Interior

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Fairey, Randall N.	Minister 297/10, October 15, 2010	Member	October 15, 2012
Horning, Donna A.	Minister 70/12, March 12, 2012	Member	March 31, 2014
Humphries, Thomas R.	Minister 257/11, October 15, 2011	Member	October 15, 2013
Morgan, Gloria A.	Minister 297/10, October 15, 2010	Member	October 15, 2012
Ross, Robert J.	Minister 83/12, March 25, 2012	Member	March 31, 2014
Sharman, Roger C.	Minister 257/11, October 15, 2011	Chair	October 15, 2014

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board

PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Northern

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 50/12, February 20, 2012	Member	March 31, 2014
Dittmar, Lorna E.	Minister 299/10, October 15, 2010	Member	October 15, 2012
MacRitchie, W. Elizabeth	Minister 191/11, July 15, 2011	Member	October 15, 2012
Norton, William E.	Minister 261/11, October 15, 2011	Chair	October 15, 2014
Read, Allison A.	Minister 260/11, September 14, 2011	Member	October 15, 2012

5 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Provincial Health Services

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Provincial Health Services Patient Care Quality Review Board is cross-appointed to the **Vancouver Coastal Patient Care Quality Review Board**, and the **Fraser Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 255/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 255/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 300/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 255/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 255/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 3001/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to

improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Vancouver Coastal

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Vancouver Coastal Patient Care Quality Review Board is cross-appointed to the **Fraser Patient Care Quality Review Board**, and the **Provincial Health Services Patient Care Quality Review Board**.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Chritchley, John (Jack) H.	Minister 254/11, October 15, 2011	Chair	October 15, 2014
Gilbert, John H.V.	Minister 254/11, October 15, 2011	Member	October 15, 2013
Holmes, Robert D.	Minister 301/10, October 15, 2010	Member	October 15, 2012
Virji-Babul, Naznin	Minister 254/11, October 15, 2011	Member	October 15, 2013
Volker, Janis A.	Minister 254/11, October 15, 2011	Member	October 15, 2013
Wilking, N. Sandra	Minister 301/10, October 15, 2010	Member	October 15, 2012

6 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Patient Care Quality Review Board - Vancouver Island

The *Patient Care Quality Review Board Act* requires the Minister to establish Patient Care Quality Review Boards in each health authority region and the Provincial Health Services Authority.

The Board...

...Composition

Each Patient Care Quality Review Board will consist of a member appointed by the Minister and designated by the Minister as the Chair, and other members appointed by the Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Beamish, R. Ann	Minister 288/11, October 20, 2011	Member	October 15, 2013
Patterson, Michael F.	Minister 302/10, October 15, 2010	Member	October 15, 2012
Swift, Q.C., Richard J.	Minister 258/11, October 15, 2011	Chair	October 15, 2014
Thomson, Linda J.A.	Minister 258/11, October 15, 2011	Member	October 15, 2014

4 current members.

...Mandate

The purposes of the Patient Care Quality Review Boards are to serve as an independent appeal mechanism for care quality complaints with a process that is clear, consistent, transparent and accountable, and to identify trends related to patient complaints and make recommendations to improve patient care quality.

For More Information...

Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9V1

Tel: 1-866-952-2448
Fax: 250 952-2428

E-mail: contact@patientcarequalityreviewboard.ca

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Professional College - College of Chiropractors of British Columbia

Chiropractic is the branch of the healing arts concerned with the restoration and maintenance of health through adjustment by hand of the human body's skeletal articulations, especially the spinal column.

The College of Chiropractors of BC is the professional body responsible for the registration of practitioners of chiropractic in the Province.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of eight professional representatives and four public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bucher, Robert B.	Minister 289/10, December 31, 2010	Public/Lay Member	December 31, 2013
Hall, Derek A.	Minister 159/12, September 1, 2012	Public/Lay Member	September 1, 2015
Kellner, Douglas K.	Minister 159/12, September 1, 2012	Public/Lay Member	September 1, 2015
Kesteloo, Karen L.	Minister 42/12, February 20, 2012	Public/Lay Member	March 31, 2014

4 current members.

...Mandate

The Board governs the affairs of the College and establishes the qualifications of persons to be admitted to and registered with the College of Chiropractors of BC. It makes rules for the discipline and control of chiropractors, providing for the imposition of sanctions, including suspension or cancellation of registration. It makes rules regarding examinations and registration, including fees and the

appointment of the examining board, and may make rules regarding continuing education and liability insurance.

What's Involved

For More Information...

College of Chiropractors of British Columbia
#125-3751 Shell Road
RICHMOND BC V6X 2W7

Tel: 604 270-1332
Fax: 604 278-0093

E-mail: registrar@bcchiro.com

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Professional College - College of Dental Hygienists of British Columbia

Dental hygienists are the providers of primary dental care such as cleaning, fluoride treatments and preventative maintenance measures. They may be employed by clinics or by dental practitioners in private practice as part of a dental health care team.

The College of Dental Hygienists is responsible for the registration of professional dental hygienists practising in British Columbia.

The Board...

...Composition

The board consists of nine members, six of whom are registrants of the college and are elected by registrants of the college (non-BRDO), and three of whom are appointed by the Minister Responsible (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Logan, Kim J. C.	Minister 55/12, February 23, 2012	Public/Lay Member	March 31, 2014
McPhail, Tara	Minister 55/12, February 28, 2012	Public/Lay Member	February 28, 2015
Smith, Paul W.	Minister 55/12, February 28, 2012	Public/Lay Member	February 28, 2015

3 current members.

...Mandate

The purpose of the Board is to regulate the standards of practice for the profession of dental hygiene.

What's Involved

Board members must attend three meetings per year, with each meeting lasting up to two days. Members will also be asked to serve on committees or panels of the board and can expect to spend an additional five to seven days per year on committee work.

For More Information...

College of Dental Hygienists of BC
219 Yarrow Building - 645 Fort Street
Victoria, BC V8W 1G2

Tel: 250 383-4101
Fax: 250 383-4144

E-mail: cdhbc@cdhbc.com

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Professional College - College of Dental Surgeons of British Columbia

The College of Dental Surgeons of British Columbia registers, licenses and regulates dentists and certified dental assistants in the public interest.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of 12 professional representatives and six public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Crombie, Melanie M.	Minister 272/11, October 6, 2011	Public/Lay Member	October 1, 2014
De Vita, Dan C.	Minister 31/09, April 3, 2009	Public/Lay Member	October 1, 2015
Johal, Julie J.	Minister 330/11, November 30, 2011	Public/Lay Member	November 30, 2013
Lemon, Richard	Minister 31/09, April 3, 2009	Public/Lay Member	October 1, 2015
Pusey, David	Minister 330/11, November 30, 2011	Public/Lay Member	November 30, 2013
Soda, Anthony L.	Minister 330/11, October 19, 2011	Public/Lay Member	October 1, 2013

6 current members.

...Mandate

The College of Dental Surgeons of BC assures British Columbians of professional standards of oral health care, ethics and competence by regulating dentistry in a fair and reasonable manner.

We fulfill our mission statement by setting requirements to practice; establishing, monitoring and enforcing standards of conduct and care; and where necessary disciplining registrants; as well as monitoring the continuing education of more than 3,170 dentists and over 6,500 CDAs working in BC.

What's Involved

For More Information...

Professional College - College of Dental Surgeons of British Columbia
500 - 1765 8th Avenue West
VANCOUVER BC V6J 5C6

Tel: 604 736-3621
Fax: 604 734-9448

E-mail: info@cdsbc.org

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Professional College - College of Dental Technicians of British Columbia

Dental technicians work on the referral of dentists in the construction of crowns, bridges dentures and other oral appliances.

The College of Dental Technicians is the professional body responsible for the accreditation of dental technicians in British Columbia.

The Board...

...Composition

The College's board is made up of five elected Dental Technicians (non-BRDO), one elected Dental Technician Assistant (non-BRDO), and three government appointed public members (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Grigg, Harvey M.	Minister 82/12, May 1, 2012	Public/Lay Member	May 30, 2014
Minichiello, Diane B.	Minister 085/10, May 16, 2010	Public/Lay Member	September 30, 2013

2 current members.

...Mandate

The Council's mandate is to serve and protect the public, and to exercise its powers and discharge its responsibilities under all enactments in the public interest. The Council supervises the education of dental technicians and may appoint an examining committee. The Council registers qualified applicants, issues certificates of registration, holds disciplinary hearings and may impose sanctions including suspension or cancellation of registration. The Council may also make rules respecting registration, continuing education, examinations, fees, specialization and advertising.

What's Involved

The Council meets at least six times per year. Members will be asked to sit on committees or panels of the Council, with varying degrees of time-commitment.

For More Information...

College of Dental Technicians of BC
400 - 1727 West Broadway
Vancouver, BC V6J 4W6

Tel: 604 736-4776
Fax: 604 734-4779

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Professional College - College of Denturists of British Columbia

Denturists work with patients without referrals from a dentist for the construction of dentures.

The College of Denturists is the body responsible for the regulation of the profession and for governing the licensing and accreditation of denturists in British Columbia.

The Board...

...Composition

The board consists of six elected registrants (non-BRDO) and three lay members appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Bains, Jag S.	Minister 14/12, January 12, 2012	Public/Lay Member	December 31, 2012
Gardner, Pamela J.	Minister 088/10, March 31, 2010	Public/Lay Member	September 30, 2013
Harden, Deborah J.	Minister 112/11, April 27, 2011	Public/Lay Member	March 31, 2014

3 current members.

...Mandate

The Council supervises the education of denturists and may appoint an examining committee. The Council registers qualified applicants, issues certificates of registration, holds disciplinary hearings and may impose sanctions including suspension or cancellation of registration. The Council may also make rules respecting registration, continuing education, examinations, fees, specialization and advertising.

What's Involved

The Council five times per year. Members will be asked to sit on committees or panels of the board, with varying degrees of time-commitment.

For More Information...

College of Denturists of British Columbia
305 - 321 Sixth St.
New Westminster, BC V3L 3A7

Tel: 604 515-0533
Fax: 604 515-0534

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Professional College - College of Dietitians of British Columbia

The College of Dietitians of British Columbia is the regulatory body established to superintend the practice of dietetics. The College's primary function will be to register dietitians to practise in BC, establish standards of practice and deal with complaints about Dietitians.

The Board...

...Composition

The board consists of six elected registrants (non-BRDO) and three lay members appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Kershaw, Adrian	Minister 262/11, October 31, 2011	Public/Lay Member	October 31, 2012
Pagely, Buncy	Minister 43/12, March 31, 2012	Public/Lay Member	March 31, 2015
Stephenson, Diana L.	Minister 111/11, April 27, 2011	Public/Lay Member	March 31, 2013

3 current members.

...Mandate

The College's mandate is to protect the public interest under the *Health Professions Act* and to fully administer the regulation of dietitians in the Province.

What's Involved

Members will be expected to sit on the Council's committees. The workload and meeting times of the committees will vary.

For More Information...
The College of Dietitians of British Columbia
103 - 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Tel: 604 736-2016
Fax: 604 736-2018

E-mail: info@collegeofdietitiansbc.org

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Professional College - College of Licensed Practical Nurses of British Columbia

The College of Licensed Practical Nurses of British Columbia is the regulatory body established to govern the practice of licensed practical nursing.

The Board...

...Composition

The College Board is comprised of both elected and appointed members.

- Eight directors (non-BRDO) represent the five electoral districts of the CLPNBC and are elected by the registrants in their districts.
- Four public representatives (BRDO) are appointed by the provincial government. The *Health Professions Act* requires that one-third of all board members be public representatives.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Khakzad, Pirouz	Minister 332/11, December 2, 2011	Public/Lay Member	September 30, 2014
Spina, Margaret L.	Minister 291/10, October 18, 2010	Public/Lay Member	September 30, 2013

2 current members.

...Mandate

The College is responsible for the licensing of licensed practical nurses in British Columbia. Additionally, the Council has the authority of general supervision of the examinations and schools for training practical nurses throughout the Province.

What's Involved

Members should be prepared to meet at least once per month; additional meetings may be scheduled as required. Members may also be asked to sit on subcommittees or panels of the council.

For More Information...

College of Licensed Practical Nurses of British Columbia
260-3480 Gilmore Way
Burnaby, BC V5G 4Y1

Tel: 778 373-3100
Toll Free: 1 877 373-2201
Fax: 604 660-3102

E-mail: info@clpnbc.org

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Professional College - College of Massage Therapists of British Columbia

The College of Massage Therapists of British Columbia is the regulatory body for massage therapy in British Columbia.

It is the duty of the College at all times:

- To serve and protect the public.
- To exercise its powers and discharge its responsibilities under all enactments in the public interest.

The Board...

...Composition

At least one-third of the Council consists of public representatives appointed by the Minister Responsible to represent the public interest. The Board shall be composed of six elected board members (non-BRDO) and no less than three public representatives (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Crawford, W. David	Minister 92/12, March 30, 2012	Public/Lay Member	December 31, 2014
Darnell, Rebecca	Minister 292/10, December 31, 2010	Public/Lay Member	December 31, 2012
Gulamhusein, Naseem L.	Minister 44/12, February 20, 2012	Public/Lay Member	March 31, 2014
Harris, B. Lynne	Minister 166/12, August 1, 2012	Public/Lay Member	August 1, 2014
Waithman, Marilynne	Minister 25/12, February 1, 2012	Public/Lay Member	March 31, 2014

5 current members.

...Mandate

The College of Massage Therapists of BC serves and protects the public by regulating the profession

of massage therapy in BC in accordance with the duties and objects set out in the *Health Professions Act*. We believe in personal integrity, administrative fairness and professional accountability.

What's Involved

Council members are required to attend ten meetings per year. In addition, all members will be asked to served on committees with varying degrees of time-commitment.

For More Information...

College of Massage Therapists of British Columbia
103 - 1089 West Broadway
Vancouver, BC V6H 1E5

Tel: 604 736-3404
Fax: 604 736-6500

E-mail office@cmtbc.bc.ca

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Professional College - College of Midwives of British Columbia

Registered midwives in British Columbia provide primary care to healthy pregnant women and their newborn babies from early pregnancy, throughout labour and birth, and up to six weeks postpartum. Individuals who wish to practice midwifery in BC must have appropriate education and training and pass examinations for registration with the College, which was established as the regulatory body for midwives under the *Health Professions Act*.

The Board...

...Composition

The College is comprised of six elected registered midwife members (non-BRDO) and three appointed public members.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Blais, Pauline	Minister 187/11, July 31, 2011	Public/Lay Member	July 31, 2013
Masini Pieralli, Laura S.	Minister 187/11, July 31, 2011	Public/Lay Member	July 31, 2014

2 current members.

...Mandate

The College's mandate is to serve and protect the public interest by regulating midwifery practice in accordance with the *Health Professions Act* and the College's bylaws. The goal of the College is to register qualified, competent midwives to provide safe, high-quality care to women and their families in the province of British Columbia.

The College has the following duties and objectives:

- to set the standards of education and qualifications for registration;
- to examine candidates for registration, assess competency and register qualified candidates;
- to set the standards of practice, and to monitor and enforce them;
- to monitor the continuing competency of registrants, and;
- to establish a program to prevent professional misconduct of a sexual nature.

What's Involved

Council members are required to attend four board meeting per year on a quarterly basis, and to serve on at least two committees. Committee work involves a time commitment of up to one day each month.

For More Information...

College of Midwives of BC
Suite 210 - 1789 West 7th Ave
Vancouver, BC V6J 4S6

Tel: 604 742-2234
Fax: 604 730-8908

E-mail: admin@cmbc.bc.ca

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Professional College - College of Naturopathic Physicians of British Columbia

Naturopathic medicine is medicine that treats the underlying nature or cause of a disease. It is the art of healing by supporting the natural healing processes of the patient and removing any impediment to the healing process; the prevention, diagnosis and treatment of physical and mental diseases, disorders and conditions; and the promotion of good health using not only natural methods but methods which support or enhance the patient's overall health.

The Board...

...Composition

The Council consists of eight members. Four of these are elected by members of the College of Naturopathic Physicians of British Columbia (non-BRDO) and the remainder are appointed by the Minister Responsible to represent the public interest.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Barnaby, Wesley L.	Minister 158/12, July 31, 2012	Public/Lay Member	July 31, 2015
Bechard, Gary M.	Minister 329/11, December 2, 2011	Public/Lay Member	September 30, 2013
Manning, Mary Doris	Minister 158/12, July 31, 2012	Public/Lay Member	July 31, 2015

3 current members.

...Mandate

The Council makes rules governing the education, licensing and conduct of naturopathic physicians practising in British Columbia and administers the affairs of the Association of Naturopathic Physicians of British Columbia.

What's Involved

The Council meets once per month. Members must be available for an additional one day per month to participate in board conference calls.

Members will be expected to attend the annual general meeting and to appear at special events and

conferences as they relate to the profession.

For More Information...

College of Naturopathic Physicians of BC
1698 West 6th Avenue
Vancouver, BC V6J 5G4

Tel: 604 688-8236
Fax: 604 688-8476

E-mail: office@cnpbc.bc.ca

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Professional College - College of Occupational Therapists of British Columbia

The College of Occupational Therapists is the professional regulatory body, designated under the *Health Professions Act*, overseeing professional Occupational Therapists in BC.

The Board...

...Composition

The Council consists of nine persons, including three lay members appointed by the Responsible Minister to represent the public interest. The remaining members are elected by and from the professional registrants of the College (non-BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Baker, Sherry	Minister 017/11, January 31, 2011	Public/Lay Member	January 31, 2014
Carvalho, Vila Nova	Minister 017/11, January 31, 2011	Public/Lay Member	January 31, 2014
Williams, Carol Ann	Minister 028/10, January 31, 2010	Public/Lay Member	January 31, 2013

3 current members.

...Mandate

The College of Occupational Therapists is the regulatory body responsible for the registration and licensing of occupational therapy practitioners in British Columbia.

The Council makes rules respecting:

- the management of the business and property of the College;
- the maintenance of a register of occupational therapists;
- the holding of examinations; and,
- fees.

What's Involved

Members should be prepared to attend at least four meetings per year, including the Annual General Meeting. Members may be asked to sit on disciplinary committees or other panels of the Council.

For More Information...

College of Occupational Therapists of BC
219 Yarrow Building
645 Fort Street
Victoria, BC V8W 1G2

Tel: 250 386-6822
Fax: 250 383-4144

E-mail: info@cotbc.org

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Professional College - College of Opticians of British Columbia

Opticians are professionals skilled in the precision grinding of eyeglasses and the fitting of contact lenses to persons requiring optical prescriptions. The College of Opticians (COBC) is the professional organization responsible for the registration of opticians and contact lens-fitters in BC.

The Board...

...Composition

As a self-regulating profession, the COBC is governed by a Board of Directors comprised of elected and appointed members. Of the 10 board members, six are elected from the profession (non-BRDO) and four are appointed by the Minister Responsible (BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Virk, Dalminder (Del) S.	Minister 145/12, June 29, 2012	Public/Lay Member	June 30, 2014
Wood Bernbaum, Lesley	Minister 014/11, January 31, 2011	Public/Lay Member	January 31, 2013

2 current members.

...Mandate

The College is charged, under the *Health Professions Act*, with the duty to serve and protect the public while superintending the profession. The College is also responsible for the registration and licensing of professional opticians and contact lens-fitters practising in British Columbia.

What's Involved

Council meetings are held no less than four times per year. In addition, members will be asked to serve on committees with varying degrees of time-commitment. Board and committee meetings are usually held on weekends and evenings, to accommodate members' work schedules.

For More Information...

College of Opticians of BC
420 - 2025 West Broadway
Vancouver, BC V6J 1Z6

Tel: 604 278-7510
Fax: 604 278-7594

E-mail: reception@cobc.ca

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Professional College - College of Optometrists of British Columbia

Under the *Health Professions Act*, the College of Optometrists of British Columbia is committed to serving and protecting the public interest by guiding the profession of optometry in British Columbia.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of six professional representatives and three public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Buchanan, Barbara E.	Minister 155/12, September 1, 2012	Public/Lay Member	September 1, 2015
MacPherson, David	Minister 155/12, September 1, 2012	Public/Lay Member	September 1, 2015

2 current members.

...Mandate

The Board regulates the practice of optometry in the province through registration of practitioners, investigation of complaints, and maintenance of a hearing and disciplinary process. The Board may make rules concerning the practice of optometry, including the discipline of practitioners and the use of drugs for diagnostic purposes. The Board issues and revokes permits to optometric corporations.

What's Involved

For More Information...

College of Optometrists of British Columbia
1204 - 700 West Pender Street

VANCOUVER BC V6C 1G8

Tel: 604 623-3464
Fax: 604 623-3465

E-mail: optometry_board@telus.net

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Board Resourcing and Development Office

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Professional College - College of Pharmacists of British Columbia

The College of Pharmacists of BC is the regulatory body for pharmacy in British Columbia and is responsible for registering pharmacists and licensing pharmacies throughout the province.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of seven professional representatives and four public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Denton, Penelope (Penny) Ann	Minister 294/10, October 18, 2010	Public/Lay Member	October 1, 2012
Gustavson, Kris J.	Minister 188/11, July 15, 2011	Public/Lay Member	October 1, 2012
Scholtens, John J.	Minister 305/10, October 21, 2010	Public/Lay Member	October 1, 2012
Slater, Jeff	Minister 305/11, November 17, 2011	Public/Lay Member	October 1, 2013

4 current members.

...Mandate

To ensure British Columbia pharmacists provide safe and effective pharmacy care to help people achieve better health.

What's Involved

For More Information...

Professional College - College of Pharmacists of British Columbia
200 - 1765 8th Avenue West
VANCOUVER BC V6J 5C6

Tel: 604 733-2440
Fax: 604 733-2493

E-mail: Marshall.Moleschi@bcpharmacists.org

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Professional College - College of Physical Therapists of British Columbia

The College of Physical Therapists of British Columbia (CPTBC) is a not-for-profit organization responsible for regulating the practice of physical therapists in the public interest.

CPTBC is a regulatory organization that operates within the legislative framework provided by the *Health Professions Act*.

The College sets standards for entry into the profession, registers physical therapists, sets and enforces a set of rules that registrants must follow and develops programs to promote the highest standards of physical therapy practice.

The CPTBC also investigates complaints and disciplines physical therapists who have been found guilty of professional misconduct or incompetence.

The Board...

...Composition

The College consists of nine members. Six members (non-BRDO) are elected physical therapists and three members are public representatives appointed by the Responsible Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Carter, Wendy L.	Minister 45/12, February 20, 2012	Public/Lay Member	May 31, 2014
Lam, Michael Chi Chiu	Minister 118/11, May 31, 2011	Public/Lay Member	May 31, 2014
Tevington, Marilyn J.	Minister 118/11, May 3, 2011	Public/Lay Member	March 31, 2013

3 current members.

...Mandate

CPTBC is mandated by the *Health Professions Act* of British Columbia. This mandate includes:

- the regulation of the practice of the profession;

- the establishment of the entry-to-practice requirements and the registration;
- the assurance of the quality of professional practice;
- the promotion of continuing competence;
- the setting of ethical standards; and,
- the investigation of complaints against its registrants.

What's Involved

The Council meets approximately once every two months. Members will be asked to participate in committees, panels, or both, each of which may have varying degrees of additional time commitment.

For More Information...

College of Physical Therapists of BC
407 - 1755 West Broadway
Vancouver, BC V6J 4S5

Tel: 604 730-9193
Fax: 604 737-6809

E-mail: info@cptbc.org

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Professional College - College of Physicians and Surgeons of British Columbia

The College of Physicians and Surgeons of British Columbia protects the public by establishing and endorsing high standards of medical practice by licensed physicians.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of 10 professional representatives and six public representatives who will hold office until the first election is held under the *Health Professions Act*.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Charvat, Lori	Minister 118/12, September 1, 2012	Public/Lay Member	September 1, 2014
Corfield, Michelle M. A.	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2013
Creed, Walter M.	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2014
Gill, Satvir S.	Minister 118/12, May 8, 2012	Public/Lay Member	May 30, 2014
Jenkinson, Valerie	Minister 245/11, September 1, 2011	Public/Lay Member	September 1, 2013

5 current members.

...Mandate

The College of Physicians and Surgeons of British Columbia (the "College") was established by the Provincial Legislature in 1886 as the licensing and regulatory body for all physicians and surgeons in the province. The College is entrusted with the responsibility to establish, monitor and enforce high standards of qualification and medical practice across the province.

What's Involved

For More Information...

Professional College - College of Physicians and Surgeons of British Columbia
400 - 858 Beatty Street
VANCOUVER BC V6B 1C1

Tel: 604 733-7758
Fax: 604 733-3503

E-mail: droetter@cpsbc.ca

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Board Resourcing and Development Office

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Professional College - College of Podiatric Surgeons of BC

The College of Podiatric Surgeons is working through a transitional implementation period and will assume responsibility for regulating the profession when the current *Podiatrists Act* is repealed on February 1, 2011. Until then, the BC Association of Podiatrists and the Board of Examiners in Podiatry will continue to regulate the profession.

The Board...

...Composition

The Minister Responsible will appoint all members of the first board which will consist of professional representatives and twopublic representatives who will hold office until the first election is held under the *Health Professions Act* which must be held by February 1, 2012.

Following the first election, no fewer than two persons and not less than one-third of the total number of board members must be public representatives appointed by the Minister. The other members must be elected from the registrants of the College.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Awan, Mahmood A.	Minister 144/12, June 29, 2012	Public/Lay Member	June 30, 2014
Shergill, Jagdeep S.	Minister 144/12, June 29, 2012	Public/Lay Member	June 30, 2014

2 current members.

...Mandate

The College of Podiatric Surgeons was established under the *Health Professions Act* on July 1, 2010, to regulate the profession of podiatric medicine.

What's Involved

For More Information...

Professional College - College of Podiatric Surgeons of BC
#617 - 938 Howe Street
VANCOUVER BCÂ Â Â V6Z 1N9

Tel: 604 602-0400
Fax: 604 602-0399

E-mail: bcap@foothealth.ca

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Professional College - College of Psychologists of British Columbia

Psychology is the scientific study of the brain, mind and behaviour, which is useful in treating mental illness and behavioural problems. In order to practice in British Columbia, professional psychologists must be licensed by the BC College of Psychologists.

The Board...

...Composition

Under the *Health Professions Act*, the Board of the college consists of six elected registrants (non-BRDO) of the College and three government appointed public members.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Fellman, Michael	Minister 46/12, February 20, 2012	Public/Lay Member	March 31, 2014
Hynes, Jenelle M.	Minister 364/10, January 31, 2011	Public/Lay Member	January 31, 2013
Readman, J. Dean	Minister 46/12, February 20, 2012	Public/Lay Member	March 31, 2014

3 current members.

...Mandate

The BC College of Psychologists is the regulatory body responsible for the accreditation and licensing of psychology practitioners in British Columbia.

The Council makes rules respecting:

- the management of the business and property of the College;
- the maintenance of a register of psychologists;
- the holding of examinations, and;
- fees.

The Council also determines the bylaws regarding registration, qualifications, discipline, ethics, and

other matters. The Council may, if necessary, take disciplinary action against a registered psychologist.

What's Involved

There is one meeting each month, of approximately five hours in duration. There is also some preparation time involved. Members will be asked to sit on disciplinary committees or other panels of the Board.

For More Information...

College of Psychologists of BC
404 - 1755 West Broadway
Vancouver, BC V6J 4S5

Tel: 604 736-6164
Fax: 604 736-6133

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Professional College - College of Registered Nurses of British Columbia

Nursing in British Columbia has been a self-regulating profession since 1918. Under the *Health Professions Act*, it is the duty of College of Registered Nurses of British Columbia (CRNBC) to protect the public through the regulation of registered nurses, nurse practitioners and licensed graduate nurses.

The Board...

...Composition

The Council consists of 12 members elected by and from registrants of the College (non-BRDO) and six public members appointed by the Responsible Minister.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Anderson, Catherine I.	Minister 156/12, August 31, 2012	Public/Lay Member	August 31, 2014
Cheng, Chilwin C.	Minister 016/11, January 31, 2010	Public/Lay Member	January 31, 2013
Hobrough, Ana-Maria	Minister 156/12, August 31, 2012	Public/Lay Member	August 31, 2015

3 current members.

...Mandate

The mandate of the College is to ensure that registered nurses in British Columbia practice in a manner that serves and protects the public.

What's Involved

Regular meetings are held five times per year. Members are also expected to attend the College's two day Conference for Leaders in late fall and the two day Annual General Meeting in the spring. Members will be asked to sit on committees or panels of the board, with varying degrees of time-commitment.

For More Information...
College of Registered Nurses of BC

2855 Arbutus Street
Vancouver, BC V6J 3Y8

Tel: 604 736-7331
Fax: 604 738-2272

E-mail: info@crnbc.ca

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Professional College - College of Registered Psychiatric Nurses of BC

The College of Registered Psychiatric Nurses of BC is the regulatory body for professional psychiatric nurses in British Columbia.

The Board...

...Composition

The Council consists of nine members. One-third of the Council members are lay members appointed by the Responsible Minister to represent the public interest. The remaining two-thirds are registered psychiatric nurses elected by members of the profession (non-BRDO).

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Anderson, Paul John	Minister 027/10, January 26, 2010	Public/Lay Member	December 20, 2012
Ribeyre, Paul (Ted)	Minister 47/12, February 20, 2012	Public/Lay Member	March 31, 2014
Robinson, Carol E.	Minister 251/10, November 30, 2010	Public/Lay Member	November 30, 2012

3 current members.

...Mandate

The Council may make rules respecting ethics, discipline, duties and the procedure for investigating a complaint against a member of the association. The Council may make bylaws regarding its procedure and the registration of psychiatric nurses.

What's Involved

Regular meetings are held once every three months. Members may also be required to serve on external committees or disciplinary hearings which could intermittently require a greater time commitment. Public members may also be required to serve on the executive committee, which meets more frequently.

For More Information...

College of Registered Psychiatric Nurses of BC
307 - 2502 St John's Street
Port Moody, BC V3H 2B4

Tel: 604 931-5200
Fax: 604 931-5277

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Professional College - Traditional Chinese Medicine Pract and Acupuncturists

The College of Traditional Chinese Medicine Practitioners and Acupuncturists (CTCMA) of British Columbia is the regulatory body established under the *Health Professions Act* to oversee the practice of Traditional Chinese Medicine and Acupuncture in British Columbia.

The Board...

...Composition

The Council consists of six members elected by and from the registrants of the College (non-BRDO) and three lay members appointed by the Minister to represent the general public.

Click here for biographies of all Members

Current Members			
Name:	**By order:**	**Position:**	**Expiry:**
Lee, Bar-Chya	OIC 153/12, June 30, 2012	Public/Lay Member	June 30, 2014
MacLeod, William (Bill) D.	Minister 330/10, December 31, 2010	Public/Lay Member	December 31, 2012
Stewart, Vivienne H.	Minister 330/10, December 31, 2010	Public/Lay Member	December 31, 2012

3 current members.

...Mandate

The Council is charged with regulating standards of practice for the professions of Traditional Chinese Medicine and Acupuncture; it is also responsible for the registration and licensing of professional acupuncturists and practitioners of Traditional Chinese Medicine in British Columbia.

What's Involved

Members should be prepared to meet at least once per month, as well as for additional and subcommittee meetings as required.

For More Information...

College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC
1664 West 8th Avenue

Vancouver, BC V6J 1V4

Tel: 604 738-7100
Fax: 604 738-7171

E-mail: info@ctcma.bc.ca

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Ministry of Health

2012/13 – 2014/15 SERVICE PLAN

February 2012

For more information on the British Columbia Ministry of Health,
see Ministry Contact Information on Page 22 or contact:

Ministry of Health
1515 BLANSHARD STREET
VICTORIA, B.C.
V8W 3C8

or visit our website at:
www.gov.bc.ca/health

Published by the Ministry of Health

Message from the Minister and Accountability Statement

I am pleased to present the *2012/13 – 2014/15 Service Plan* for the Ministry of Health. This plan outlines the strategic priorities and goals for British Columbia's health system over the next three years.

British Columbia's health system has entered a period of change, innovation and renewal. Our strategic focus is on creating better health outcomes for British Columbians through a more efficient, sustainable health system. We are putting families first by supporting British Columbians to become healthy and active, enhancing care in the community and at home, and ensuring a caring hospital environment that supports the needs of patients and families. We are also developing new ways of engaging and communicating with British Columbians about their health care.

Government's investments into health care will continue, with the health budget reaching more than $16 billion in 2012/13. However, health care consumes almost half of government's total budget, and if future increases in the health budget are not carefully controlled, funding for other vital services like transportation and social services will be at risk. We need to take into account the fiscal context of global economic uncertainty and slow economic growth, and find innovative ways to maximize each health dollar. At the same time, we must continue to meet the growing demand for health services and provide safe, effective, appropriate, accessible and patient-centred care to all British Columbians who need it.

We are working to make British Columbia's health system stronger and more sustainable. This means shifting the focus from just treating disease, to preventing disease. Using preventative measures to address chronic diseases such as diabetes, heart disease and some cancers can significantly improve health and avoid related health care costs. We are working with families and key partners like communities and schools to help British Columbians make good lifestyle choices and be as fit and active as possible. For example, in this past year, the Ministry of Health launched the $68.7 million Healthy Families BC strategy and the Smoking Cessation Program to help British Columbians improve their lifestyles. Over the next three years, we want to build on these programs and engage all British Columbians to make more informed choices and set them on the road to better health and better quality of life. That is why on November 25, 2011, the Province signed a statement of intent with ParticipACTION to work towards increasing physical activity levels among British Columbians and serve as a model for other jurisdictions to follow.

British Columbia's health system seeks to provide the majority of health services and care in communities and homes across the province. By reducing the need for emergency and hospital services, we aim to help people live longer, healthier lives at home. We are striving to achieve this by working to provide all British Columbians with a family doctor; supporting the partnership between health care providers and patients; and empowering patients through initiatives like chronic disease self-management training, home-based dialysis, flexible care models and advance care planning.

The province's fastest growing segment of our population is over 75 years old – with one-sixth of British Columbians over the age of 65. Given the changing needs and expectations of our aging population, we will continue to modernize and improve care options and supports for seniors.

Our recent action plan to improve care for B.C. seniors outlines the steps we are taking to create sustainable and lasting improvements to better serve the needs of seniors across the province. The action plan will see the establishment of an Office of the Seniors' advocate and a provincial phone line to ensure seniors and families can report concerns and complaints and have them resolved in a timely manner. We recognize older people have a right to live in safety, free from abuse and neglect, and the plan commits to developing a provincial elder abuse prevention strategy. Other actions include: Providing local governments with the funding, tools and supports to create age-friendly environments that allow seniors to actively participate in their communities; and updating the SeniorsBC.ca website and BC Seniors' Guide to ensure seniors have easy access to current information on available programs and services across the province.

We will continue to ensure that safe, high quality care is delivered in hospitals to support the needs of patients and their families. For example, initiatives such as the implementation of evidence-based clinical care guidelines will further spread best practices across the province and ensure improved health outcomes for patients.

Finally, a key enabler of quality and sustainability in the health system is our drive to improve innovation, productivity and efficiency. Over the next three years, initiatives such as the BC Services Card and the implementation of a province-wide electronic health record system will help to transform the health system and further the development of secure technology-enabled functions and services for both patients and health care providers, while improving patient safety and access.

The *Ministry of Health 2012/13 – 2014/15 Service Plan* was prepared under my direction in accordance with the *Budget Transparency and Accountability Act*. I am accountable for the basis on which the plan has been prepared.

Honourable Michael de Jong, Q.C.
Minister of Health
February 21, 2012

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Purpose of the Ministry

The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, cost effective and timely health services are available for all British Columbians. The British Columbia health system is one of our most valued social programs – virtually every person in the province will access some level of health care or health service during their lives.

The Ministry works with health authorities, health care providers, agencies and other organizations to guide and enhance the Province's health services to ensure that British Columbians are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction and support to health service delivery partners and sets province-wide goals, standards and expectations for health service delivery by health authorities. The Ministry enacts this leadership role through the development of social policy, legislation and professional regulation, through funding decisions, negotiations and bargaining, and through its accountability framework for health authorities and oversight of health professional regulatory bodies.

The Ministry directly manages a number of provincial programs and services. These programs include the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; the BC Vital Statistics Agency, which registers and reports on vital events such as a birth, death or marriage; and HealthLink BC, a confidential health information, advice and health navigation system available by telephone (8-1-1) or online (www.healthlinkbc.ca). HealthLink BC also publishes the BC HealthGuide Handbook, which is available through local pharmacies.

The Province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination and accessibility of services and province-wide health programs. These include the specialized programs and services that are provided through the following agencies: BC Cancer Agency; BC Centre for Disease Control; BC Children's Hospital and Sunny Hill Health Centre for Children; BC Women's Hospital and Health Centre; BC Provincial Renal Agency; BC Transplant; Cardiac Services BC; the Emergency and Health Services Commission, which provides ambulance services across the province and operates BC Bedline, the provincial acute bed management system; BC Mental Health Addiction Services including Riverview Hospital and the Forensic Psychiatric Services Commission; and Perinatal Services BC.

The Ministry monitors the delivery of health services and the health of British Columbia's population on an ongoing basis. These monitoring activities inform the Ministry's strategic planning and policy direction to ensure that the delivery of health services continues to meet the needs of British Columbians now and in the future.

Strategic Context

The health system in British Columbia is a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand.

Although the British Columbia health system effectively meets the majority of the population health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to frail seniors, a rising burden of illness from chronic diseases, mental illness and cancer, and advances in technology and pharmaceuticals driving new costly procedures and treatments. The pressure is compounded by the need for new health service delivery models by health professionals and health care workers, and the need to maintain and improve the health system's physical infrastructure (that is, buildings and equipment). In the current economic climate it is even more important for the health system to find new and creative ways to ensure that the resources available for health services are used effectively and in ways that most benefit the citizens of British Columbia.

The Economic Forecast Council estimates that British Columbia's real GDP grew by 2.2 per cent in 2011 and projects that the rate of real GDP growth will remain at 2.2 per cent in 2012, before increasing to 2.5 per cent in 2013. Risks to British Columbia's economic outlook include a return to recession in the US; the European sovereign debt crisis threatening the stability of global financial markets; slower than anticipated economic growth in Asia dampening demand for BC exports; and a weakening of the US dollar disrupting the financial markets and raising the cost of BC exports abroad.

British Columbia also faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved significantly in several respects over the past few decades, the Aboriginal population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other residents of British Columbia. Government is working with First Nations, Métis and other partners to improve Aboriginal people's health outcomes.

The Aging Population

The seniors' population of British Columbia currently makes up 15 per cent of the total population and is expected to double within the next 20 years, making it one of the fastest growing seniors' populations in Canada.[1] The aging population is a significant driver of demand because the need for health services rises dramatically with age. People over age 65 make up 14 per cent of the British Columbia population, but use 33 per cent of physician services, 48 per cent of acute care services, 49 per cent of PharmaCare expenditures, 74 per cent of home and community care services and 93 per cent of residential care services.[2] There is also an increasing need to provide appropriate

[1] P.E.O.P.L.E. 35, population estimates, BC Stats, Ministry of Labour, Citizens' Services and Open Government. 2012

[2] Planning and Innovation Division, Ministry of Health. Using Medical Services Plan expenditures 2006/07; Acute care inpatient and day surgery workload weighted cases, Discharge Abstract Database (DAD) 2006/07; HCC community services by age group 2005/06 (summed based on average unit costs); Residential care days 2006/07.

care for those with frailty or dementia and to help seniors stay healthy, independent and in the community for as long as possible.

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, asthma and some cancers. People with chronic conditions represent approximately 38 per cent of the British Columbia population and consume approximately 80 per cent of the combined physician payment, PharmaCare and acute (hospital) care budgets.[3] Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions could increase 58 per cent over the next 25 years[4] and be a significant driver of demand for health services. Chronic diseases can be prevented or delayed by addressing key risk factors including physical inactivity, unhealthy eating, obesity, alcohol consumption and tobacco use.

Advances in Technology and Pharmaceuticals

New treatment and technology development over the past 10 years has included less invasive surgery, increased use of diagnostic imaging and the introduction of new biological and other drug therapies that have made health care more efficient and effective, but has also led to a significant increase in demand for products and services. For example, the expansion of technology has seen the number of CT exams increase by approximately 100 per cent and the number of MRI exams increase by almost 170 per cent in the province since 2001.[5] In addition, new surgical techniques and equipment have contributed to the expanded use of joint replacement procedures. In British Columbia, the number of hip replacements has increased by 102 per cent and the number of knee replacements by 180 per cent over the past decade.[6]

Health Resources and Health System Infrastructure

Although attrition rates have recently decreased, looming retirements in the health sector workforce, combined with the rising demand for services, are still key challenges that will impact the Province's ability to maintain an adequate supply and mix of health professionals and health care workers. Planning for, and ensuring that we have the required number of qualified health care providers entering the workforce is still important. However, we also need to continue focusing on redesigning health service delivery models so that we are fully leveraging the skill sets of professionals, including creating and supporting integrated health care teams. Through building and maintaining healthy, supportive workplaces that enhance working and learning conditions, we have the opportunity to attract and retain the workforce we need to provide high quality services while ensuring we are flexible enough to adapt to the changing needs of the population as we move forward.

Another challenge in delivering health services is the need to maintain and improve the health system's physical infrastructure. The health system is faced with the continuous need to update or expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to British Columbians.

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[3] Discharge Abstract Database (DAD), Medical Services Plan and PharmaCare data 2006/07.

[4] Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis*, March 2007, (2007-064). As cited in Primary Health Care Charter: A collaborative approach (2007), Ministry of Health.

[5] HAMIS/OASIS, Management Information Branch, Planning and Innovation Division, Ministry of Health. As of October 12, 2011.

[6] Surgical Patient Registry, MoH, http://www.health.gov.bc.ca/swt/faces/PriorityAreas.jsp. Accessed Jan 13, 2012.

Goals, Objectives, Strategies and Performance Measures

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

Objective 1.1: Individuals are supported in their efforts to maintain and improve their health through health promotion and disease prevention.

British Columbians are, in general, among the healthiest people in the world. We want to support the excellent health status of the majority of British Columbians while also helping those who do not enjoy good health, or who are at risk of diminishing health from factors such as poor diet, obesity, physical inactivity, injuries, tobacco use and problematic substance use. We will help people make healthy lifestyle choices by providing more tools, choices and supports for people to invest in their health to prevent or delay the onset of illness and injury. We will also enhance prevention programs and collaborate with other sectors to promote health as a valued outcome of policies and programs in order to make long term sustainable changes for improved health across British Columbia.

Strategies

- Work with health authorities, family doctors, primary care providers, community partners and others to advance the health of women and children through comprehensive and effective programs and services.
- Support communities, including schools, workplaces and municipalities, to strengthen healthy living opportunities with a focus on healthy eating, physical activity, reduced salt and sugary drink consumption, tobacco reduction and responsible alcohol use in order to reduce childhood obesity and the prevalence of chronic disease.
- Support families and individuals to invest in their own health through programs and incentives that lead to healthy lifestyle choices.
- Provide supports for older people and frail seniors, including supports to prevent falls and injuries, and to promote independence.
- Improve health outcomes for Aboriginal people and communities and provide culturally safe health services to all Aboriginal people in British Columbia by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

- Work with Tripartite partners to implement the British Columbia Tripartite Framework Agreement on First Nation Health Governance including supporting the creation of a new First Nations health governing body with strong linkages to the provincial health system.
- Protect the health of families and individuals, and support healthy communities through policies and programs such as food safety and drinking water quality practices.

Performance Measure 1: Healthy communities.

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of communities that have completed healthy living strategic plans.	0%[1]	25%	30%	35%

Data Source: Survey, ActNow BC Branch, Population and Public Health Division, Ministry of Health, 2011.

[1] Baseline reflects anticipated changes to the current programs.

Discussion

This performance measure focuses on the number of communities out of a total of 160 communities in British Columbia that have developed healthy living strategic plans for 2010/11 and beyond. Community efforts to support healthy living through planning, policy, built environments and other mechanisms are critical to engaging individuals where they live, work and play. Sustained community level actions will decrease the number of British Columbians who develop chronic diseases. The Ministry is advising communities on comprehensive healthy living plans.

Goal 2: British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

Objective 2.1: Providing a system of community based health care and support services built around attachment to a family doctor and an extended health care team with links to local community services.

As British Columbia's population ages and the incidence of chronic disease increases, the demand for health services is increasing and changing. An integrated system of primary and community based health care will provide continuity of care as one's health needs change and will improve care for all patients, but particularly for those with more complex needs such as people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth and the frail senior population. Evidence suggests that primary and community based health care are best suited to provide care to these populations and can play a critical role in improving health and reducing the need for emergency department visits and hospitalizations. Increasing access to family doctors, and

coordinating and linking family doctors to other community services such as home health care and community mental health care, will improve the quality and experience of care for patients and better support their families and caregivers.

Strategies

- Promote health service redesign, the use of integrated health care teams, coordination between health care providers, improved access to family doctors and more responsive care in community settings for frail seniors, patients with chronic diseases, and people with mental health and substance use conditions to improve health outcomes and reduce the need to access care through emergency departments and hospitals, and delay the need for residential care.
- Implement priority strategies for community based health service redesign, including care management practice and actions for people with dementia and those requiring end-of-life care.
- Promote the patient attachment initiative to provide every citizen of British Columbia the opportunity to have a family doctor as a first point of contact for care that is comprehensive, accessible, coordinated and continuous.
- Engage with patients, families, caregivers and community organizations to ensure voice, choice and representation in individual care planning and health service redesign.
- Implement *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use* by working with ministries, health authorities and other partners to ensure alignment with the plan's focus on prevention, early intervention, appropriate treatment and sustainability.
- Use a multidisciplinary approach to improve medication management to reduce adverse effects arising from the use of multiple medications by a patient.

Performance Measure 2: Chronic disease management.

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of general practitioner physicians providing chronic disease management.	89%	90%	90%[1]	95%

Data Source: Medical Services Plan, Management Information Branch, Planning and Innovation Division, Ministry of Health, 2011. Annual data includes the physicians billing incentive fee items claimed from MSP and paid to September 30th of the following year for diabetes, congestive heart failure, hypertension, chronic obstructive pulmonary disease and complex care management.

[1] The target for 2013/14 has been adjusted from the 95 per cent target used in the *Revised 2011/12 – 2013/14 Service Plan* to account for inherent challenges in engaging the final 10 per cent of general practitioner physicians in chronic disease management.

Discussion

This performance measure focuses on the number of general practitioner physicians (family doctors) providing comprehensive chronic disease management for people with diabetes, congestive heart failure, hypertension and chronic obstructive pulmonary disease. Proactive management of chronic

diseases can improve the quality of life for people with chronic conditions and reduce complications, emergency department visits, hospitalizations, some surgeries and repeated diagnostic testing. Accordingly, the Ministry is working with family doctors to maintain and expand the number providing proactive chronic disease management to their patients. Importantly, there is a concurrent focus on increasing the provision of comprehensive chronic disease management overall to more people in British Columbia who have an identified need for this type of support. Engaging a significant number of family doctors and providing associated practice supports are key steps toward improving care and associated health outcomes for all patients with chronic diseases.

Performance Measure 3: Chronic disease hospital admissions.

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people under 75 years with a chronic disease admitted to hospital (per 100,000 people).	265	235	225	215

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health; P.E.O.P.L.E. 35, population estimates, BC Stats, Ministry of Labour, Citizens' Services and Open Government; 2011

Discussion

This performance measure tracks the number of people with selected chronic diseases such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic diseases need the expertise and support of family doctors and other health care providers to manage their disease in the community in order to maintain functioning and reduce complications that will require more medical care. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which help control the costs of health care. As part of a larger initiative of strengthening community based health care and support services, family doctors, home health care providers and other health care professionals are working to provide better care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home health care and support for seniors.

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of people aged 75+ years receiving home health care and support.	15.6%	16.5%	17%	17.5%

Data Source: P.E.O.P.L.E. 35, population estimates, BC Stats, Ministry of Labour, Citizens' Services and Open Government; Continuing Care Data Warehouse, Management Information Branch, Planning and Innovation Division, Ministry of Health (A small amount of baseline data is currently unavailable due to the transition to new reporting mechanisms); Home and Community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management Information Branch, Planning and Innovation Division, Ministry of Health; 2011

Discussion

This performance measure tracks the per cent of seniors (aged 75+ years) who receive home health care such as home nursing and rehabilitative care, clinical social work, light housekeeping, assisted living and adult day programs. While the majority of seniors experience healthy aging at home, there is a growing need for community care options to support those who can no longer live independently. This support helps people manage chronic disease and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community based health care and support services, the Ministry is expanding home health services and ensuring that seniors at high risk are a priority in the provision of care. This focus, combined with the use of new technology for monitoring health at home and supporting caregivers, can significantly improve health outcomes for seniors.

Goal 3: British Columbians have access to high quality hospital services when needed.

Objective 3.1: Acute care services are accessible, effective and efficient.

While the majority of health needs can be met through primary and community based health care, the citizens of British Columbia also require timely access to safe and appropriate hospital services that support the needs of patients and their families.

Strategies

- Continue patient-focused funding to provide appropriate incentives to encourage increased access, efficiency as well as clinical and service excellence across the health system, including incentives to support care in communities.
- Expand the clinical care management system to improve the quality, safety and consistency of key clinical care services.
- Expand employment opportunities for local paramedics, in turn enhancing the level of support for the delivery of ambulance services in rural and remote communities.
- Improve access to diagnostic imaging services such as MRI and CT exams by working with health authorities to improve efficiency and appropriateness.
- Continue to provide excellent cancer treatment through the BC Cancer Agency, including opening a new full service cancer centre in Prince George in 2012.

Performance Measure 5: Access to surgery.

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of non- emergency surgeries completed within the benchmark wait time.	72.1%[1]	75%[2]	80%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Planning and Innovation Division, Ministry of Health, 2011. Includes all surgeries other than C-sections that have a priority code for patients aged 17+ years.

[1] Baseline is for surgeries completed from April 1, 2011 to November 30, 2011.

[2] Target per cents are for surgeries completed in the fiscal year.

Discussion

In the last several years, British Columbia's health system has successfully reduced wait times for cataract, hip and knee joint replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding, combined with continuous effort to foster innovation and efficiency in British Columbia's hospitals, will improve the timeliness of patients' access to an expanding range of surgical procedures. The Patient Prioritization Initiative is one of these innovations, a first in Canada, allowing surgeons to monitor patients' wait times in five priority levels. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times associated with each priority level. As patient prioritization is a new approach and there are people without a prioritization code already waiting for surgery, the target for 2012/13 will allow for a 'catch up' period, after which the per cent of surgeries completed within the benchmark is expected to increase by 5% each year.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

Objective 4.1: Optimize supply and mix of health human resources, information management, technology and infrastructure in service delivery.

A high performing health system is one that uses its resources in the best way possible to improve health outcomes for patients and the broader population. To be sustainable, we must ensure that the health system has enough of, and the right mix of health professionals to provide the services that will meet British Columbians' needs now and in the future. We must also ensure that health care providers are appropriately supported by information management systems, technologies and the physical infrastructure to deliver high quality services as efficiently as possible.

Strategies

- Support health service redesign and an affordable, sustainable health system by ensuring that British Columbia has the required supply of health care providers and that their skills are being used effectively.
- Strengthen and align performance assessment processes and systems for medical professionals, including licensure, credentialing, privileging, and monitoring, in order to improve public confidence in the quality of care provided in British Columbia.
- Transform the BC CareCard to include photo identification and computer chip technology as a first move to a new secure BC Services Card that will support cross-government services in the future.
- Expand the implementation and adoption of eHealth systems to enable patient health information to be securely stored and shared electronically by authorized users. This will enable the availability of timely clinical information such as laboratory test results and patient medication histories to support health care providers in decision making and improving patient care.
- Expand Telehealth to improve rural and Aboriginal communities' access to health services and specialists.
- Provide citizens with a more comprehensive understanding of the health system through public access to more health information and data as part of the provincial DataBC initiative.

Performance Measure 6: Electronic medical record system implementation.

Performance Measure	2009/10 Baseline	2011/12 Forecast	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of physicians implementing electronic medical record systems.	41%	55%	65%[1]	75%[1]	Maintain at or above 75%[2]

Data Source: Health Sector IM/IT Division, Ministry of Health, 2011. Measured through physician enrolment in a voluntary program to promote adoption of electronic medical record (EMR) systems. An estimated 5,000 physicians have a clinical requirement for an EMR system and would be eligible for this program.

[1] Targets for 2012/13 and 2013/14 have been adjusted from the targets used in the *Revised 2011/12 – 2013/14 Service Plan* to reflect the slowing rate at which physicians are adopting EMR systems as compared to the initial years of the program when uptake was more immediate.

[2] The target of 75 per cent of physicians implementing EMR systems recognizes that some physicians will not implement an EMR system due to the nature or location of their practice such as those working primarily in hospitals and having access to an EMR system already in place.

Discussion

Electronic medical record systems (EMRs) are replacing today's largely paper-based patient charts and will help improve the overall sustainability of British Columbia's health system. In busy physician offices, where volumes of paper files from multiple sources must be managed on a daily basis, EMRs help with organization, accuracy and completeness of patient records. EMRs also make critical clinical information about patients more accessible to physicians and their health care staff.

Provincial clinical guidelines for the management of chronic diseases and clinical supports such as alerts and recall notices based on these guidelines are embedded within EMRs contributing to quality of care. When integrated with other eHealth systems, EMRs will also have access to laboratory and drug information, reducing unnecessary clinical tests and adverse drug interactions, both of which support patient safety and reduce health care costs.

Objective 4.2: Drive efficiency and innovation to ensure sustainability of the publicly funded health system.

We are committed to efficiently managing the health system to ensure resources are spent where they will have the best health outcome. We must continually drive improvement in innovation, productivity and efficiency to ensure that our publicly funded health system is affordable and effective for the citizens of British Columbia.

Strategies

- Drive process improvements such as Lean Design principles across the health system, which eliminates waste, improves services to patients and improves the quality, productivity and efficiency of health care processes.
- Implement a provincial evidence informed decision making process for the introduction of new health technologies and drugs to improve health outcomes and manage health care costs.
- Continue consolidation of corporate, clinical support and administrative functions to achieve savings, efficiencies and quality improvements across the Lower Mainland health authorities and expand this initiative provincially. In addition, maximize efficiencies through Health Shared Services BC development of a Canadian purchasing alliance for public sector procurement of medical supplies and equipment.
- Continue to develop structured performance monitoring tools and performance management practices, and improve the availability of quality data and analysis to assist clinical and management decision making and optimize health expenditures.
- Communicate the strategy for sustainable health care to the citizens of British Columbia by using an interactive media approach, including an online forum for more direct, open and meaningful dialogue about the health system.

Resource Summary

Core Business Area	2011/12 Restated Estimates[1]	2012/13 Estimates	2013/14 Plan	2014/15 Plan
Operating Expenses ($000)				
Health Programs				
Regional Services	10,561,534	10,858,769	11,286,809	11,651,528
Medical Services Plan	3,796,811	3,894,537	4,026,739	4,120,496
PharmaCare	1,139,722	1,185,330	1,229,208	1,266,429
Health Benefits Operations	34,410	35,123	35,560	36,005
HealthLink BC	33,322	34,741	34,741	34,741
Vital Statistics	6,734	6,863	7,000	7,140
Recoveries from Health Special Account Services	(147,250)	(147,250)	(147,250)	(147,250)
Executive and Support Services	160,391	164,754	164,756	164,756
Health Special Account	147,250	147,250	147,250	147,250
Total	**15,732,924**	**16,180,117**	**16,784,813**	**17,281,095**
Ministry Capital Expenditures (Consolidated Revenue Fund) ($000)				
Executive and Support Services	31,207	16,614	277	255
Total Capital Expenditures	**31,207**	**16,614**	**277**	**255**
Capital Grants ($000)				
Health Facilities	463,255	437,838	394,652	415,125
Total Capital Grants	**463,255**	**437,838**	**394,652**	**415,125**

1 For comparative purposes, amounts shown for 2011/12 have been restated to be consistent with the presentation of the *2012/13 Estimates*.

Health Authority Income Statement Resource Summary

As required under the *Budget Transparency and Accountability Act*, British Columbia's six health authorities are included in the government reporting entity. The health authorities have been primary service delivery organizations for the public health sector for several years and many of the performance measures and targets included in the *Ministry of Health 2012/13 – 2014/15 Service Plan* are related to services delivered by the health authorities. The majority of the health authorities' revenue and a substantial portion of the funding for capital acquisitions are provided by the Province in the form of transfers from the Ministry's operating and capital budgets.

Health Authorities and Hospital Societies	2011/12 Forecast	2012/13 Budget	2013/14 Plan	2014/15 Plan
Combined Income Statement ($000)				
Total Revenue[1]	12,108,000	12,431,000	12,835,000	13,139,000
Total Expense[2]	12,092,000	12,431,000	12,835,000	13,139,000
Net Results[3,4]	16,000	0	0	0

[1] Revenue: Includes Provincial revenue from the Ministry of Health, plus revenues from the federal government, co-payments (which are client contributions for accommodation in care facilities), fees and licenses and other revenues.

[2] Expense: Provides for a range of health care services, including primary care and public health programs, acute care and tertiary services, mental health services, home care and home support, assisted living and residential care.

[3] 2011/12 Net Results: The forecast surplus of $16 million is made up of $5 million surplus from Interior Health Authority, $2 million surplus from Vancouver Coastal Health Authority, and $9 million surplus from Vancouver Island Health Authority.

[4] The 2011/12 forecast is based on third-quarter board-approved information provided by the health authorities and hospital societies.

Major Capital Projects

Capital investment ensures the province's health infrastructure is maintained and expanded to meet the growing population and its need for health services. The health sector invests in health facilities such as hospitals, clinics and residential and complex care buildings. Capital investment is also made in medical equipment, including CT scanners, MRIs, laboratory systems and surgical equipment. In addition, investments in information technology and information management systems improve service quality and efficiency, and increase access to services, particularly in rural areas.

The Province's six health authorities and the Ministry collaborate on financial and infrastructure planning to ensure capital investments in the health system are strategic and cost effective. Recognizing the significant cost and long lifespan of most capital investments – both in acquisition and use – the Ministry and health authorities maintain three-year capital expenditure plans, aligned with other health sector planning. This planning horizon enables the Ministry to better anticipate future demand for health services, resulting from a growing and aging population and medical and technological innovations, and to plan and prioritize long term capital investments.

Major capital projects currently underway include:

- **Kelowna and Vernon Hospitals Project**

The Kelowna and Vernon Hospitals project consists of a patient care tower for an expanded emergency department and consolidated outpatient services, and academic space for the University of British Columbia (UBC) medical school's new Southern Medical Program at Kelowna General Hospital and a new patient care tower at Vernon Jubilee Hospital for a total cost of $433 million. The Vernon Jubilee Hospital expansion opened for patients on schedule in 2011 and the Kelowna General Hospital expansion will open in 2012.

The new patient care tower, the Centennial Building, at Kelowna General Hospital will include a new building at the hospital to accommodate ambulatory/outpatient services in a single location, quadruple the size of the emergency department and include two shelled floors for future inpatient bed capacity. The project is expected to decrease congestion in the emergency department, increase surgical capacity and improve patient flow throughout the hospital. In addition to the patient care tower, a new stand-alone facility was constructed to accommodate the Southern Medical Program and a new parkade.

The new patient care tower, the Polson Tower, at Vernon Jubilee Hospital includes a new facility for emergency, ambulatory care, operating rooms and intensive care. The project is expected to decrease congestion in the emergency department and expand the capacity of current diagnostic and treatment programs. The building also includes two shelled floors for future inpatient bed capacity.

For more information on the Kelowna and Vernon Hospitals project, please see the website at www.partnershipsbc.ca/files/project-ih.html.

- **Fort St. John Hospital and Residential Care Facility**

The new hospital will be the centre for health care delivery to Aboriginal people and remote communities in northeastern British Columbia and will provide a range of health services that take advantage of telecommunication and telehealth applications, reducing the need for patients to travel to receive care. The 55-bed facility will address wait times and emergency room congestion, and will provide access to modern ambulatory care. It will include emergency, diagnostic, treatment and patient care services and will provide for expansion of health services. The hospital will also be the centre for the UBC Medical School's Northern Medical Program in northeastern British Columbia. The project also includes a new 123-bed residential care facility co-located with the hospital, generating operational efficiencies and opportunities to share health human resources that are scarce in the region. The total project cost is estimated at $298 million and is planned for completion in 2012.

For more information on the new regional hospital in Fort St. John, please see the website at www.health.gov.bc.ca/library/publications/year/2008/FSJ_Capital_Project_Plan_March_2008.pdf.

- **BC Cancer Centre for the North, Prince George**

As part of the Northern Cancer Control Strategy, the BC Cancer Centre for the North will accommodate two linear accelerators and other equipment, treatment rooms and patient areas. An addition and renovations to the University Hospital of Northern BC (Prince George) will accommodate a new six-bed oncology unit, an expansion of pathology, laboratory and diagnostic imaging services, and additional administrative spaces to support the impact of new BC Cancer

Agency services in the north. The Northern Cancer Control Strategy will include renovations and enhancements to up to 11 Northern Health Authority sites in communities outside of Prince George and acquisition of new equipment and information technology to accommodate expansion of community cancer clinics. The estimated capital cost associated with the strategy is $106 million and project completion is planned for 2012.

For more information on the Northern Cancer Control Strategy, please see the website at: www.health.gov.bc.ca/library/publications/year/2008/NorthernCancerCentreProjectPlan.pdf.

- **Surrey Memorial Hospital Critical Care Tower**

The new building will include a new emergency department that is five times larger than the existing department. The new emergency area will include specialized units for mental health, geriatric care, a separate children's emergency area, an enhanced minor treatment unit and an improved area for acute patients. The multi-storey facility will also include a perinatal centre incorporating 48 neonatal intensive care unit beds needed to treat premature infants and newborns in critical distress. The maternity department will be expanded and 13 new obstetric beds will be added. The project will also include additional inpatient beds thereby increasing the inpatient bed capacity at Surrey Memorial Hospital by 30 per cent. An expanded adult intensive care unit will help meet the acute care needs of Surrey, and will play a crucial role in decreasing emergency room congestion. Additional academic space will be created to support the growing partnership between Fraser Health and the UBC medical school. A new rooftop helipad will be located on the top of the new tower. The capital cost of the project is estimated at $512 million. Construction on the new tower began in 2011. The new emergency department will be open to patients in 2013, with final construction of the critical care tower to be completed in 2014.

For more information on the Surrey Memorial Hospital Critical Care Tower, please see the website at www.fraserhealth.ca/about_us/building_for_better_health/surrey_memorial_hospital.

- **Interior Heart and Surgical Centre, Kelowna**

The Interior Heart and Surgical Centre project will include a new, state-of-the-art general operating suite, inpatient surgical unit, and a new laboratory to replace aging facilities currently in use at Kelowna General Hospital. A new 12,970-square-metre (139,590-square-foot) building will be constructed to house the Interior Heart and Surgical Centre and will be built on the site of the existing Pandosy building. The programs currently housed at Pandosy will be relocated to the new patient care tower and a new clinical support building. The existing surgical suite will be relocated to the new Interior Heart and Surgical Centre and will include room for future expansion of surgical services and support services for the cardiac program such as central sterilization services. The surgical suite will be fully integrated with the cardiac revascularization program. The new buildings will be designed to Leadership in Energy and Environmental Design (LEED) Gold standards, and will maximize interior and exterior wood construction. The Interior Heart and Surgical Centre will be completed by 2016 with final renovations to other areas of the hospital completed by 2017. The cost of the project is estimated at $393 million.

For more information on the Interior Heart and Surgical Centre, please see the website at www.buildingpatientcare.ca/interior-heart-and-surgical-centre-project.

- **Children's and Women's Hospital Redevelopment**

The redevelopment of BC Children's Hospital and BC Women's Hospital, both agencies of the Provincial Health Services Authority, will be completed in three phases. The first phase will include opening three additional neonatal intensive care unit (NICU) beds at BC Women's Hospital to help care for the province's most vulnerable patients. Those additional beds will become part of the provincial network of NICU beds. First phase work at BC Children's Hospital and the Shaughnessy Building includes site preparations for the new hospital, construction of additional academic space for UBC, and construction of a new clinical support building and a free-standing child day-care centre. Phase one is expected to cost $91 million. The second and third phases of the project will include the construction of the new BC Children's Hospital and renovations and expansion of BC Women's Hospital. The total project cost for all phases must still be finalized, but is estimated to be approximately $682 million.

For more information on the Children's and Women's Hospital Redevelopment project, please see the website at www.health.gov.bc.ca/library/publications/year/2010/BCCW-CapitalProjectPlan.pdf.

Appendix

Ministry Contact Information

Ministry of Health www.gov.bc.ca/health
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Victoria, British Columbia V8W 3C8
Toll-free in B.C.: 1-800-465-4911
In Victoria, B.C.: 250-952-1742
Email: hlth.health@gov.bc.ca

Medical Services Plan (Health Insurance BC) www.hibc.gov.bc.ca
PO Box 9035 Stn Prov Govt
Victoria, British Columbia V8W 9E3
Toll-free in B.C.: 1-800-663-7100
In Vancouver, B.C.: 604-683-7151

PharmaCare (Health Insurance BC) www.hibc.gov.bc.ca
PO Box 9655 Stn Prov Govt
Victoria, British Columbia V8W 9P2
Toll-free in B.C.: 1-800-663-7100
In Vancouver, B.C.: 604-683-7151

HealthLink BC www.healthlinkbc.ca
Toll-free in B.C.: 8-1-1
In Vancouver, B.C.: 604-215-8110
TTY (Deaf and Hearing-Impaired Assistance): 7-1-1

Health and Seniors Information Line www.seniorsbc.ca
Toll-free in B.C.: 1-800-465-4911
In Victoria, B.C.: 250-952-1742

Healthy Families BC www.healthyfamiliesbc.ca

Patient Care Quality Review Boards www.patientcarequalityreviewboard.ca
PO Box 9643
Victoria, British Columbia V8W 9P1
Toll-free in B.C.: 1-866-952-2448
Email: contact@patientcarequalityreviewboard.ca

Office of the Provincial Health Officer www.health.gov.bc.ca/pho
4th Floor, 1515 Blanshard Street
Victoria, British Columbia V8W 3C8
In Victoria, B.C.: 250-952-1330

Vital Statistics Agency www.vs.gov.bc.ca
PO Box 9657 Stn Prov Govt
Victoria, British Columbia V8W 9P3
Toll-free in B.C.: 1-888-876-1633
In Victoria, B.C.: 250-952-2681
Office – Victoria, B.C. (818 Fort Street, Victoria, B.C., V8W 1H8, 250-952-2681)
Office – Vancouver, B.C. (Room 250, 605 Robson Street, Vancouver, B.C., V6B 5J3, 604-660-2937)
Office – Kelowna, B.C. (Room 101, 1475 Ellis Street, Kelowna, B.C., V1Y 2A3, 250-712-7562)

Hyperlinks to Additional Information

Vancouver Coastal Health Authority www.vch.ca

Vancouver Island Health Authority www.viha.ca

Interior Health Authority www.interiorhealth.ca

Fraser Health Authority www.fraserhealth.ca

Northern Health Authority www.northernhealth.ca

Provincial Health Services Authority www.phsa.ca

Ministry of Health Transformation and Technology Plan

2012/13 Update

4 November 2011

BRITISH COLUMBIA
The Best Place on Earth

Ministry of Health

Table of Contents

Introduction

The purpose of this document is to update the 2011/12 *Health Sector Transformation and Technology Plan* for fiscal year, 2012/13, in accordance with the general and ministry-specific instructions issued by the Ministry of Labour, Citizens' Services and Open Government on 8 July 2011.

For brevity, this update does not repeat the full contents of the 2011/12 plan and, as such, should be read as a 'companion' to that earlier plan.

While this is a Ministry of Health plan, it also must be understood to affect the broader health sector, as all ministry initiatives will have outcomes across the British Columbia health system.

This document is structured in two parts to align with the two main areas of requested response defined in the instructions for 2012/13 Transformation and Technology (T&T) submissions. They are[1]:

1. Refinement and updates to sector[2] vision, business context and alignment with strategic shifts.
2. Alignment and action for the four priority provincial initiatives: Open Data, Open Information, Internet Strategy and Leading Workplace Strategies.

This year's T&T submission comprises narrative updates within this document, regarding the progress of particular aspects of the 2011/12 *Health Sector Transformation and Technology Plan*, and the separate completion and submission of provincial templates, as follows:

- Application Health Check template (an inventory workbook), "*to enable sectors and corporate government (Treasury Board Staff, DMCTT, OCIO, and SSBC) to understand and strategically plan the future requirements of our IM/IT systems*"[3].
- Open Information template, to provide information about the routine release of ministry information and information released in response to access requests made under FOIPPA, along with a plan to move to more proactive disclosure of information.
- Data Inventory template, to describe Ministry of Health data holdings. **Note**[4]: For the size of Health data holdings, the ministry is addressing the inventory within its *Open Data Implementation Plan*, submitted as an addendum to this main T&T submission document.
- Web Properties Inventory template, to provide information about existing ministry web properties and their management as a foundation for the separately submitted, companion narrative, the *Ministry of Health Internet Strategy.*

Where separate templates are submitted, this document references their key findings. Where a new topic-focused plan or strategy is developed separately to fulfil T&T requirements, they are also

[1] *Transformation and Technology Planning Instructions FY 2012 – 2013*. Labour, Citizens' Services and Open Government. 8 July 2011; page 7.
[2] "Sector" in context of T&T planning is the Ministry of Health alone; other government sectors encompass upwards of five ministries together.
[3] Page 17, T&T General Instructions.
[4] Page 9, T&T General instructions note: *If this* [completion of the data inventory] *is not possible within this year's planning window, ministries will need to define a plan to inventory their data, including milestone dates and key responsibilities.*

discussed herein, such that this document will serve as an overview of the full Ministry of Health 2012/13 T&T submission due for 4 November 2011.

Planning Network

Early in 2011, the ministry established a Planning Network and SharePoint site to support the annual development of the T&T plan. The network acts as a 'one-window', connecting program area planning contacts for expedited information-sharing, across-program consultation and coordination with other planning activities. Its establishment was primarily to get ahead of some of the pressures in developing the 2012/13 plan by providing a channel to quickly share planning instructions, gather program-specific information, and to ask and answer planning questions as they came up.

To move quickly, the network is a relatively small group with members in positions with knowledge representative of their division's programs, such that they can respond in most cases without the time of sending on to another.

The network was the primary channel for coordinating the ministry's 2012/13 T&T submission, and for expediting the Health Executive Committee's review of this update and its companion plans, strategies and templates.

Part 1: Vision, Business Context and Strategic Shift Alignments

The purpose of this section is to build "*on last year's plans and based on direction from DMCTT[5], sectors should revisit and/or update their vision and business context and reflect any progress or changes to their transformational priorities*" (page 8, General Instructions). In addition, there are five corporate priorities, identified in the ministry-specific T&T instructions, for which the ministry is to provide "*quality*" in its T&T plan "*as measured by demonstrated progress by March 2012 on five specific deliverables*"[6] The five specific deliverables are (to quote):

1. *Contribute new data holdings to DataBC.*
2. *Inventory the ministry's web presence and management framework, and provide a strategy to rationalize their web properties and render its web presence more citizen-centric and service focused.*
3. *Identify strategies to fast track the implementation of smart cards.*
4. *Complete health care card technical card design and return to Treasury Board with detailed project costing.*
5. *Develop and make available to the public a Health Service Location I-phone Application.*

Progress on the above DMCTT priorities is addressed within this section, along with refinements and updates specific to the ministry's Transformation Vision, Business Context and Transformation Priorities.

Transformation Vision

This section is to "*identify any changes to the vision over the past year due to changing environments, conditions or priorities. Additionally, this section will provide information on how ministries are planning to make progress on foundational transformational initiatives, and other ministry or sector-specific priorities*" (pg. 7, General Instructions).

The 2011/12 Ministry of Health vision for health sector transformation was:

> *Health services are accessible, when and where they are needed, to support personal health, health care decision making, and health system sustainability.*

Refinement for 2012/13

> *The health sector maximizes the opportunity presented by rapidly advancing technology to drive quality, efficiency and sustainability.*

Realization of the ministry's transformation vision and service plan goals continues through its progress on the fifteen key result areas, which comprise the ministry's strategic Innovation and Change Agenda (Appendix A), and discussed in the following Business Context section, along with *Progress in Support of the Innovation and Change Agenda* and examples of technology-leveraging.

[5] Deputy Ministers Committee on Transformation and Technology
[6] Memorandum. John Dyble, Deputy Minister to the Premier, to All Deputy Ministers, 16 June 2011.

Business Context

This section is to "*provide information on how ministries are planning to make progress on foundational transformational initiatives and other ministry or sector-specific priorities*" (pg. 7, General Instructions).

Families First

Translating the transformation vision into the ministry's business context is about enabling a different conversation with citizens about health. It is to empower citizens to become more engaged with the health system and to have ministry programs adopt a 'Families First' attitude, or *lens*, across the health system and its services. The following lists a sample of 'Families First' initiatives, programs and activities in the health sector.

Families First

Keeping your Family Healthy	Providing Care in your Community and at Home	Improving your Hospital Experience
Healthy Eating Initiatives ▪ Sodium and Sugary Drink Reduction Program ▪ School Fruit and Vegetable Program Tobacco Reduction Programs	Physician Attachment Initiative (GP4Me), reinventing the family doctor. Integrated Primary and Community Care Initiative Choice in supports for Independent Living Home Care and Community Supports for Seniors	Clinical Care Guidelines Improving both Patient and Family experience Hospice care Improving the quality of care

A different conversation with citizens about health care

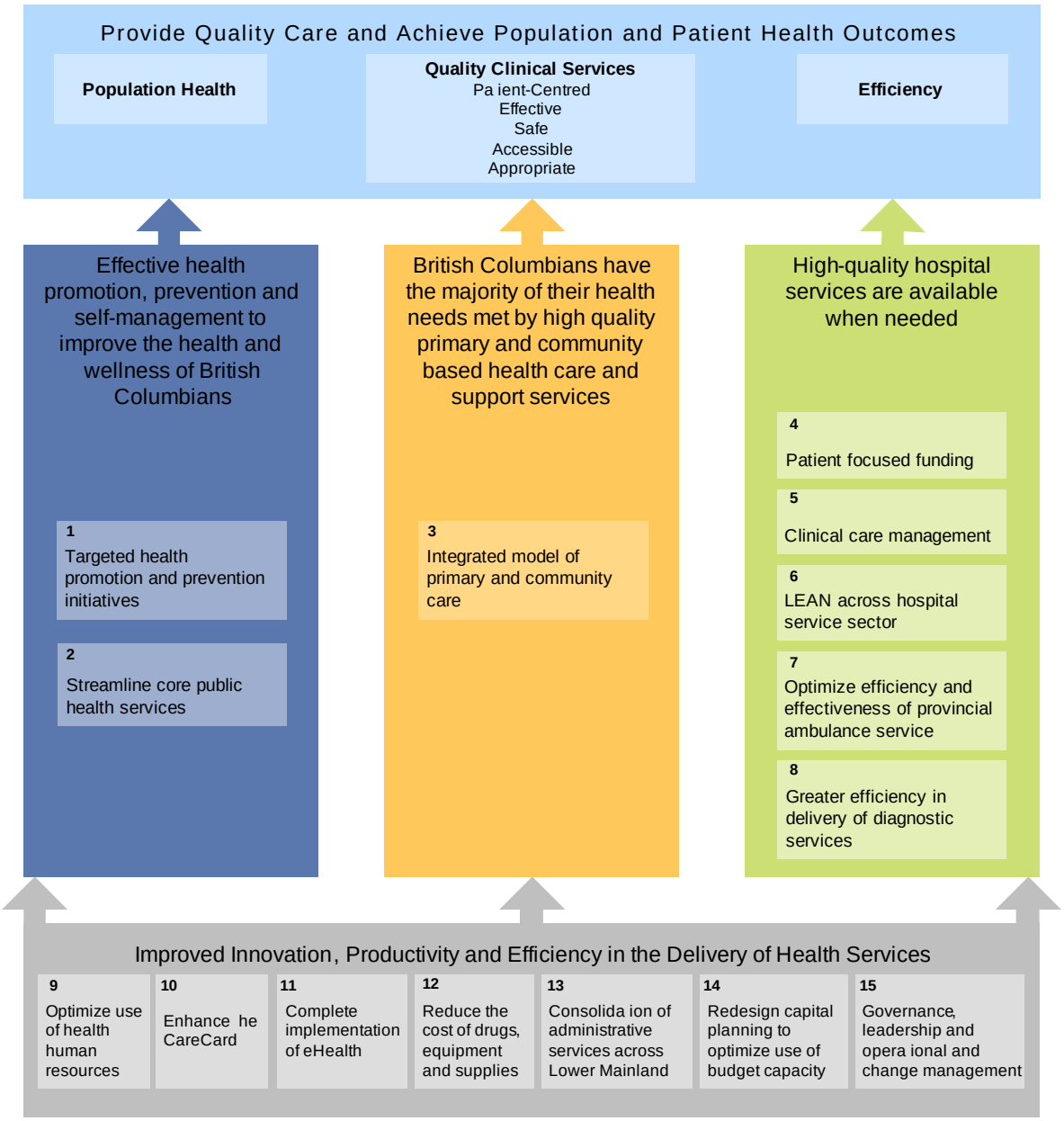
COURAGE CURIOSITY SERVICE ACCOUNTABILITY PASSION TEAMWORK

It is imperative that citizens be empowered to participate in and make informed judgements about their health system. Supported with health information—through open information, open data, the internet strategy and other transformational initiatives—citizens can better judge that the health system is adapting to meet changing needs and expectations. The accelerating pace of change and necessary adaptation to dynamic environments, both of the economy and new technologies, require an engaged, responsible citizenry and a health system that responds to achieve health sector goals and deliver intended health outcomes. To be successful, this challenge takes best advantage of the technologies and tools that will facilitate citizen dialogue and support business innovations across the sector.

The overarching attitude of placing Families First touches all aspects of the ministry's Innovation and Change Agenda.

Innovation and Change Agenda

Ministry program areas continue to work collaboratively to ensure citizens are supported in their efforts to maintain or improve their health. This collaboration is pursued relative to four strategic themes and the fifteen key result areas (KRA) described in the ministry's Innovation and Change Agenda and Health Sector Strategy map (Appendix A). The following is a distillation.



The priority of the Innovation and Change Agenda remains for and beyond 2012/13, along with technology-leveraging to help achieve ministry transformation and KRA goals.

Examples of Technology-Leveraging to Achieve Transformation Goals

While ministry KRA teams are working to transform the health system—and not all transformation activities are technology-focused or necessarily dependent on adopting new technologies—the following list identifies some Health initiatives that are taking advantage of technology to achieve intended outcomes.

1. *Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.*

   Goal: Providing education, support and self management programs will improve population health by focusing on healthy lifestyles and targeting high-risk situations and behaviours, particularly in groups with lower health status.

   Examples of technology-leveraging:

   - Launched the *BC Smoking Cessation Program*, leveraging HealthLink BC's technology infrastructure and 8-1-1 service. Citizens, who have Medical Services Plan (MSP) coverage and wish to quit smoking, register through 8-1-1 to obtain a program reference number. Prescription smoking cessation drugs are covered as benefits under PharmaCare, and non-prescription nicotine replacement therapy products, such as nicotine gum and patches, are provided at no cost, either by mail or at their local community pharmacy. Through HealthLink 8-1-1, citizens also have access to a variety of health-related information and referrals, including the BC stop smoking line, QuitNow Services. See: http://www.health.gov.bc.ca/pharmacare/stop-smoking/ http://www.healthlinkbc.ca/smoking-cessation.stm.
   - Commenced implementation of the *Provincial Restaurant Program*, which will provide nutrition information at the point of ordering in BC restaurants.
   - Introduced new citizen-focused and citizen-engaging *Healthy Families* web site: http://www.healthyfamiliesbc.ca/
   - Introduced the *Sodium and Sugary Drink Reduction Strategy*, including new health eating policies, guidelines, public awareness campaigns and education programs. http://www.healthyfamiliesbc.ca/healthy-eating-sugary-drinks.php
   - Expanded and enhanced the Dietitian services available through HealthLink BC. http://www.healthlinkbc.ca/dietitian/
   - Completed the *Healthy Schools* portal, available on-line at: http://www.actnowbc.ca/healthy_living_tip_sheets/healthy_schools

- Introduced the *Medication Review Program* in community pharmacies with support from PharmaNet claim processing. This program allows patients to request a review of their medication regimen for solving medication management issues. See the following Frequently Asked Questions, and Policies, Procedures and Guidelines for Pharmacists.
  http://www.health.gov.bc.ca/pharmacare/pdf/mrs-faq.pdf
  http://www.health.gov.bc.ca/pharmacare/pdf/medrevguide.pdf
- Launched the *Prescription for Health* program in May 2011 to help physicians assess and make long-term care plans for patients who may be at risk of health complications, such as with chronic diseases. Online public resources are available at: http://www.healthyfamiliesbc.ca/healthy-lifestyles-prescription-for-health.php
- Partnered (funding and leadership support) with the Canadian Mental Health Association, BC Division, to provide provincial access to the *Bounce Back: Reclaim Your Health* initiative. This cognitive behaviour informed DVD and telephone coaching program helps adults experiencing symptoms of depression and anxiety. It is available in English and Chinese. Information can be found at http://www.cmha.bc.ca/bounceback
- Through a provincial cross-stakeholder partnership, provided funding and strategic leadership to offer the *First Link* initiative through the Alzheimer Society. This program provides early intervention service designed to connect to individuals newly diagnosed with dementia and their caregivers to education programs, support groups, and referrals to other community and health care services. Online information and resources are available at: http://www.alzheimerbc.org/We-Can-Help/First-Link.aspx
- Partnered with the Impact Health Improvement Action Society of British Columbia (ImpactBC) by providing provincial leadership and funding support for Patients as Partner activities, including the Patient Voices Network, patient journey mapping, peer coaching for lifestyle supports, continuing General Practice Services Committee (GPSC) Practice Support Program (PSP) support and quality improvement work. Further information is available at: http://www.impactbc.ca/
- Partnered with the University of British Columbia (UBC), Faculty of Medicine's *Intercultural Online Network* (iCON) to provide funding, strategic collaboration and leadership support as well as participation. The iCON provides culturally relevant, linguistically appropriate, trusted health information on chronic disease management to BC's multicultural population through public forums and UBC eHealth strategies. Information on the program and links to public forums are available at

http://www.iconproject.org . As part of iCON, the ministry also collaborated with the Canadian Health Research Foundation (CHSRF), ImpactBC, the Patients Voice Network, and Fraser Health on the project, *Your Voice Counts: Training patients to be effective partners in health system redesign.* Training content is being developed in English, Punjabi and Chinese to be presented either face-to-face or online. http://ehealth.med.ubc.ca/projects/your-voice-counts/

2. *British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.*

Goal: High quality primary and community based health services that provide proactive integrated care and reduce the population's need for hospital or other institutional services.

Examples of technology-leveraging:

- Continued to implement electronic medical record (EMR) systems into physician offices, in collaboration with the Physician Information Technology Office and as part of the BC eHealth initiative. EMR systems help integrate patients' clinical information between care settings, among other benefits to patients, physicians and the health system. http://www.health.gov.bc.ca/ehealth/emr.html
- Increased patient registrations to 1000 on the *Patient Voice Network* (PVN). The PVN is a collaboration with ImpactBC to support Patients as Partners' work across BC. The PVN is a mechanism to recruit, train and support patients and their caregivers to participate in suggesting changes that may benefit the health care system. There is an online, virtual network of interested patients, who receive updates and complete surveys to inform improvement work. Trained patient experts sit on working group committees and participate in focus groups and other processes to help ensure the patient voice is heard[7]. PVN members are supported through a website, Facebook and Twitter at:
  - http://www.patientvoices.ca/
  - http://www.facebook.com/pages/Patient-Voices-Network/193358687356916?q=facebook
  - http://twitter.com/#!/patientvoices?q=twitter

[7] Patient as Partners, Nothing about me without me! First Annual Report, April 2011. http://www.chsrf.ca/Libraries/Researcher_on_Call/PasP_AnnualReport_Final.sflb.ashx

- Continued to provide up-to-date information, via the *General Practice Services Committee* website (www.gpscbc.ca), on GPSC funding initiatives and billing guides for family physicians who provide full service family practice. The GPSC is a ministry partnership with the British Columbia Medical Association and also maintains a website (www.divisionsbc.ca) that provides up-to-date information on Divisions of Family Practice and mechanism by which Divisions of Family Practice can share information.

- Completed three of the four phases of the Community Healthcare and Resource Directory (CHARD). The final phase will be completed in March 2012. The CHARD was built by HealthLink BC and the GPSC. The directory supports family practitioners, their office staff, and some health authority and specialist physician users by providing detailed referral information on practitioners and services available in BC.
  CHARD Information includes:
  - detailed descriptions of the services offered;
  - contact information, along with maps and hours of operation;
  - up-to-date referral forms;
  - patient referral criteria (inclusion/exclusion criteria for specialist referrals based on, e.g., age, diagnoses, geographic locations);
  - instructions for patients preparing for appointments; and,
  - practitioners' specialties and fee structures.

  Providing this information at the time of referral increases the efficiency and appropriateness of patient referrals. http://info.chardbc.ca/about.asp

3. High-quality hospital services are available when needed.

Goal: High quality and accessible hospital services provide effective and appropriate care for patients.

Examples of technology-leveraging:

- Continued promotion of lean management methods in the health authorities, including options for the development and implementation of a central website, which could potentially include an inventory of learning programs, health authority curricula and 'lean' improvement tools. A community of practice implementation plan is complete, with the content and structure of the proposed website yet to be determined.

- Continued development toward implementation of the Diagnostic Imaging Wait Time Tracking Tool, a 2011/12 capital project, the purpose of which is to identify and develop an information management system for the efficient collection and reporting of medical imaging wait times.

4. Improved innovation, productivity and efficiency in the delivery of health services.

Goal: Driving productivity and efficiencies across the system ensures sustainability.

Examples of technology-leveraging:

- Continued development of the new BC Services Card (KRA #10), the vision of which is to replace the existing Health CareCard identity credential with one that offers enhanced identity features and uses the new card as a key enabler of a strategy to increase patient safety. See this document's section, *Progress on Transformation Priorities*, for an update on this transformation priority.
- Continued implementation of the eHealth initiative and its electronic health record (EHR) solutions. See this document's section, *Progress on Transformation Priorities*, for an update on this transformation priority.
- Commenced implementation of a centralized booking solution for Lower Mainland Health Information Management services.
- Commenced modernization of the physician contract management and payment system in the Alternative Payment Program.
- Continued development of a provincial telepathology network as part of the transformation of laboratory services in BC.

The building blocks of technology continue to support the strategic direction of the ministry's Innovation and Change Agenda and extend across the spectrum of ministry business and health system transformation.

Progress on Strategic Shift Transformation Priorities

There are five transformation priorities identified in the 2011/12 T&T Plan and, for 2012/13, five government corporate priorities specifically for the ministry with respect to this 2012/13 T&T Plan Update. Because there is overlap in the priorities, the ten combine to six transformation priorities. The table below identifies how they overlap and where each is addressed in this document.

Transformation Priorities With Section Location In this 2012/13 T&T Plan Update	Government's Ministry-Specific Transformation Priorities for 2012/13 (quotes, not in original order)	Transformation Priorities from the 2011/12 T&T Plan
1. BC Services Card ▪ addressed in this section of Part 1, immediately following.	1. *Identify strategies to fast track the implementation of smart cards.*	1. Smart CareCard
	2. *Complete health care card technical card design and return to Treasury Board with detailed project costing.*	
2. Health Services Locator iPhone Application ▪ addressed in this section	3. *Develop and make available to the public a Health Service Location iPhone Application.*	
3. eHealth Implementation ▪ addressed in this section		2. eHealth Implementation
4. Home Health Monitoring ▪ addressed in this section		3. Home Health Monitoring
5. Open Data[8] ▪ addressed in the Open Data section of Part 2.	4. *Contribute new data holdings to DataBC.*	
6. Internet Strategy[8] ▪ addressed in the Internet Strategy section of Part 2	5. *Inventory the ministry's web presence and management framework, and provide a strategy to rationalize their web properties and render its web presence more citizen-centric and service focused.*	4. Citizens' Access
		5. Health Promotion and Prevention Social Media

[8] Open Data, Open Information, Internet Strategy and Leading Workplace Strategies are new Corporate Priorities and the focus of Part 2. This topics required focused discussion and have related template completions and strategy submissions with this T&T Plan Update.

BC Services Card (also known as the Health CareCard or 'smart card' project)

Two of the five ministry-specific transformation priorities and DMCTT performance measures are:

- *Identify strategies to fast track the implementation of smart card* ; and,
- *Complete health care card technical card design and return to Treasury Board with detailed project costing.*

The BC Services Card was also identified in the 2011/12 T&T plan as a ministry transformation priority and continues in this 2012/13 T&T Plan Update as a fast-tracked priority, as well as being a key result area (#10) for the ministry: *Improve patient safety and access to records through enhancements to the Health CareCard*. The project will transform the Health CareCard to include photo identification and computer chip technology, as a first move to a new BC Services Card. The card will support cross-government services in the future.

The 2011/12 T&T plan provides a brief description of the project. Also see the separately submitted *BC Services Card Project Charter*, which provides more information and detail to address the above T&T performance measures; the following is a synopsis of progress.

Progress Update

The ministry has worked together with its partners to fast-track the BC Services Card, pushing to complete technical design by March 2012, preparing to issue the first card in November 2012, and distributing non-photo cards to children as part of the accelerated first-phase (Release 1) roll-out. A phased approach to the project has been developed to ensure the highest probability of success while having the least risk. This approach has been developed to ensure:

- Existing business processes are leveraged wherever possible to contain development effort and eliminate duplication, and
- Use of natural renewal cycles and unique re-enrolment opportunities for some groups of citizens to limit cost of implementation.

The project will be achieved through a phased implementation that includes three distinct releases:

Release 1: Issues the first BC Services cards beginning in the fall of 2012 and plans to deliver 1.9 million non-photo and photo cards in the first year of program operation, focusing on MSP enrolment for two main client groups: children under 19 years of age (who do not need to re-enrol but will receive new cards) and those 19-74 years of age who visit an Insurance Corporation of British Columbia (ICBC) Driver Licence Office (DLO) to renew their British Columbia Identification (BCId) or British Columbia Driver Licence (BCDL). Release 1 will also offer a limited number of eligible MSP beneficiaries renewing their licences the opportunity to combine their BCDL and the new BC Services card in a single, combination card. Release 1 also integrates ICBC and Health Insurance British Columbia (HIBC) business processes and system environments required to support the BC Services card program requirements, and standardizes all MSP

beneficiary credentials on a chip-enabled card, produced by the ICBC-administered infrastructure.

Release 2: Builds on the base set by Release 1 and extends issuance of non-photo and photo BC Services cards to additional client groups and expands the set of those qualifying to combine their BCDL and BC Services Card in a single combination card. It also extends the BC Services Card system environment to include the Ministry of Labour, Citizen Services and Open Government, which will provide the infrastructure that enables authentication of health care beneficiaries at provider points of care.

Release 3: Builds on the previous releases and extends non-photo and photo BC Services Card to remaining client groups eligible for health care coverage. It also extends the combined BCDL and BC Services Card to a broader range of clients. Finally, it will begin the phased roll-out of identity assurance and authentication services to health care points of service.

Release 1 development started in September 2011 with deployment anticipated for late 2012. The first new BC Services Card will be issued starting November 2012. Releases 2 and 3 will be deployed in the fall of 2013 and 2014 respectively. By the fall of 2013, 1.9 million new cards will have been issued with over 945,000 British Columbians identity-proofed to BC Government Level 3 identity standards. By end of 2015, 85% of British Columbians will have been issued new, chip-enabled BC Services Cards.

BC Health Service Locator Application

One of the five ministry-specific transformation priorities and DMCTT performance measure is to:

- *Develop and make available to the public a Health Service Location I-phone Application*[9].

HealthLink BC (HLBC) is leading the ministry's participation in development of an iDevice application, the *BC Health Service Locator*, along with the ministries of Labour, Citizens' Services and Open Government (LCSOG) and Attorney General (AG). The application is to be available to citizens before 31 March 2012. As such, it will be the first step into providing health services information through mobile devices.

The Health Service Locator application (app) will be available as an iPhone app via the online Apple Store. The app uses downloaded extracts from the HLBC 8-1-1 Health System Information Referral and Navigation (HSIRN) directory database and provides application users with information about available health services.

The application will be available on devices running iOS[10] (for iPhone, iPod Touch, iPad devices) and will provide:

- location-specific information, based on data from the GPS[11] in the device and/or Wi-Fi connection;
- location-independent information based on key word search;
- direct dialling access to 8-1-1; and
- direct links to specific pages as well as the full www.HealthLinkBC.ca website.

Once launched, the application will be another service channel provided by HLBC to the citizens of British Columbia.

Progress Update

Progress on the launch of the BC Health Service Locator app is moving quickly. At the time of writing this update, the forecast implementation target is 31 December 2011, well in advance of the above March 2012 timeline. As of November 2011, the project is on track for December 2011 or earlier, in advance of the March 2012 requirement. HLBC will have continuing relationships with the ministries of LCSOG and AG for submitting updates to Apple on behalf of HLBC, accessing Apple analytics, and providing legal advice.

[9] 2011/12 Transformation and Technology Planning, Ministry-Specific Instructions, requirement #1.
[10] Apple's mobile operating system
[11] Global Positioning System

eHealth Implementation

This transformation initiative remains a high-priority and key result area (#11), with particular emphasis on Electronic Medical Record (EMR) systems in physician offices, provincial Electronic Health Record (EHR) solutions and Telehealth expansion. Together, eHealth technologies support a citizen/patient-centric health environment with integrated services to efficiently deliver high-quality and coordinated health care. EHR systems enable patient health information to be securely stored and electronically shared across patients' care settings.

Progress Update

The development effort is largely complete, and the focus has shifted to system integration and clinical deployment. EHR systems provide the foundation that will be leveraged to provide greater benefits as the range of patient information is expanded to address priority clinical needs. This will be accomplished both through the integration of the EHR systems with other patient information systems, such as EMR systems and hospital clinical information systems, and the addition of further patient information repositories within the EHR solution.

Major project components included in project scope for completion by March 31, 2012, include:

- Implementation of a provincial data repository to store results received from public and private laboratory service providers within the province;
- The loading or 'on-boarding' of health authority lab results into the provincial repository;
- Completion of an upgrade to PharmaNet to support ePrescribing;
- Deployment of an eHealth Viewer to Health Authorities to access lab results and diagnostic images from across the province; and,
- Change Implementation and Adoption for stakeholders.

The scope of conformance work includes following standards, including:

- All inbound result messages to the Provincial Laboratory Information System Repository being based on pan-Canadian laboratory nomenclature standards; and,
- All messages being in compliance with BC-identified messaging and technical standards.

Home Health Monitoring

Home health monitoring, also known as Telehomecare, continues to be a priority for 2012/13 as the ministry pursues opportunities to support in-home monitoring of patients' health conditions through electronic transmission of such key health indicators as blood pressure, pulse, and oxygen saturation.

The goal of in-home monitoring is two-fold: citizen-centred services and cost avoidance. Through the use of technology, patients will have easier access to services and will remain independent yet supported in the comfort of a familiar environment. The cost curve will be managed by:

- reducing the number of visits to primary care;
- enabling early recognition and treatment of changing conditions; and,
- avoiding emergency hospital admissions.

Progress Update

Work is underway both within the ministry and in collaboration with the health authorities to develop a shared understanding of the objectives and approaches for home health monitoring. This is a critical step in ensuring the proposed solution is both citizen-focused and based on sound evidence for improved health outcomes. Prior to the selection of a technology solution, business needs must be clearly identified to ensure clinical requirements are met.

Part 2: Alignment and Action for Priority Corporate Initiatives

The 2011/12 T&T plan identified how the Ministry of Health is moving into alignment with the three strategic shifts of the BC e-government strategy, *Citizens @ the Centre: B.C. Government 2.0.* The three shifts are: 1. Citizen Participation, 2. Self-Service, and 3. Business Innovation.

Part 1 of this document updated progress on the ministry's 2011/12 transformation priorities related to the BC Services Card (KRA #10), the Health Services Locator iPhone Application, eHealth Implementation (KRA#11), Home Health Monitoring, and other technology-leveraging initiatives that support the ministry's Innovation and Change Agenda and continue into 2012/13.

This Part 2 extends the ministry's transformation goals to include response to government's expectations for Open Data, Open Information, the BC Internet Strategy and Leading Workplace Strategies. Each topic is addressed in this section, followed by a summary of findings from the ministry's Application HealthCheck template submission. Other template submissions, previously listed on page 1, relate to and are referenced within the four main topics of this section.

Open Data

A defining principle of *Citizens @ the Centre: BC Gov 2.0,* released in 2010, is the commitment:

We will empower citizens to create value from open government data.

In July 2011, the provincial government signalled its clear intent to make government-held data available to the public for its use, adaptation and distribution, whenever possible, by issuing the *Open Information and Open Data Policy*[12]. According to this policy, the objectives of the open data initiative are to increase transparency and accountability across the public sector and to encourage citizen participation and engagement with government.

The purpose of this section of the 2012/13 T&T Plan Update is to set out how the Ministry of Health will support government's commitment to open data. There are four requirements[13] for this submission:

1. *Ministries are required to fill in the Open Data template posted to the T&T site. The template requires ministries/sectors to provide an inventory of their data. If this is not possible within this year's planning window, ministries will need to define a plan to inventory their data, including milestone dates and key responsibilities.*
2. *Sectors must provide a plan to rationalize and prioritize data holdings. Please provide detail on the sectors' data management plans, such as, does the sector need to continue managing all of its current holdings? Identify how the sector will define a new data management strategy to manage revised holdings.*

[12] http://www.cio.gov.bc.ca/local/cio/kis/pdfs/open_data.pdf

[13] *Transformation and Technology Planning Instructions, FY 2012-2013*, July 8, 2011. pg. 9. https://egov.gov.bc.ca/tandt/TTDocuments/TT%20General%20Instructions.pdf

3. *Sectors must provide a plan to open up and make available their data and timelines for publishing to the DataBC catalogue.*
4. *Contribute new data holdings to DataBC* (Ministry-specific instructions, pg. 1)

All requirements are addressed in two document submissions, and are addenda to this T&T update:

Ministry of Health Open Data Implementation Plan, setting out an overall plan for the public release of ministry data in accordance with the new *Open Information and Open Data Policy*.

Ministry of Health Open Data Project Plan, setting out the specifics of implementation, including identification of the project sponsor, scope, timelines, major deliverables and milestones, linkages and dependencies, and roles and responsibilities for implementing the Open Data project. Project implementation will be in two phases:

Phase 1: Early identification of the data files that can be relatively quickly added to the DataBC Catalogue. This work is currently underway to March 31, 2012.

Phase 2: Implementation of planned approach and scope toward full data disclosure with regular and on-going updates.

In addition to contributing new data holdings to DataBC, these plans are the ministry's T&T submission for Open Data. Refer to them for a full understanding of the ministry's approach. The following is a summary introduction to the topic.

The Ministry of Health is responsible for the overall direction and funding of the province's health services, which comprise the largest and most costly social program funded by government. In the course of exercising its responsibilities, the ministry collects a vast amount of related data and, as such, is in a good position to make a significant contribution to the provincial Open Data initiative. Most of the ministry's data are created at the point where health services are delivered to individual citizens. These services include those that are funded directly by the ministry (e.g., most physician services and PharmaCare benefits), as well as those services delivered by the health authorities (e.g., acute care, home and community care, mental health and addiction services, and public health services).

There are criteria and specific requirements identified in the *Open Information and Open Data Policy,* governing the type of data that should be released through DataBC[14]. In keeping with the spirit of the policy, the guiding principle in the ministry's Open Data plan is that most data held by the ministry should be considered suitable for public release, provided that release of data does not contravene legislation, and the data are in a form that complies with the ministry's other major responsibility to protect the privacy of citizens' personal health information. Personally identifiable data will not be released as open data, nor will confidential or incomplete (draft or interim) data.

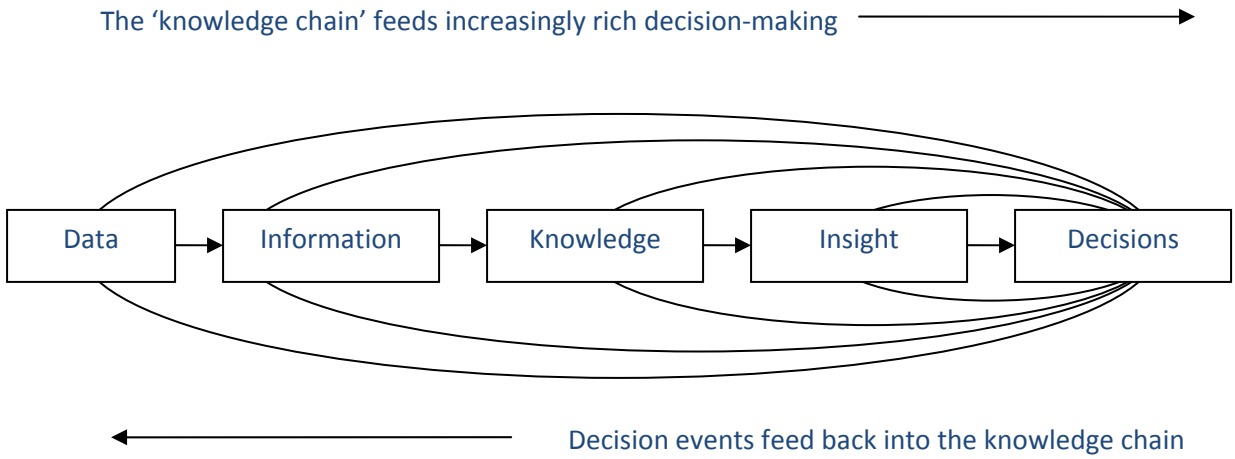
Given the sheer volume and complexity of its data holdings, the ministry is planning to inventory its holdings and release data in a series of phases. Even so, the ministry can begin to make substantial and

[14] http://www.data.gov.bc.ca/

useful contributions to the DataBC Open Data Catalogue in the relatively near term. Over time, the amount and type of data released should grow to the point that it presents a more comprehensive picture of the province's health services. As the overall Open Data initiative proceeds, options will also be explored with DataBC to organize the released data in a manner that makes it easier for users to choose, locate and compile data of interest.

Open Information

Open information is an extension of open data, governed by the same BC policy framework, the *Open Information and Open Data Policy*. Data become information when data are summarized, classified into logical groupings, recognized to be patterns or trends, and considered in their temporal, spatial or relational contexts. This 'knowledge chain' increases value to the health system and to citizens, who also gain insight and make decisions based on open information and growing health system knowledge.



The new BC policy notes that:

"*To the extent practicable and subject to the Freedom of Information and Protection of Privacy Act and other valid restrictions, ministries should use modern technology to disseminate useful information in a routine way rather than waiting for specific requests under the FOIPPA Act. By increasing access to government information and permitting the use, adaptation and distribution of Data, this Policy assists in the creation of a participatory environment in which citizens are engaged with their government, communities and public policy issues. Specifically, the Open Information and Open Data Policy provides direction and assigns responsibility for:*

- *The Proactive Disclosure of responses to access to information requests (FOI Requests) and information designated for Routine Release; and,*
- *The assessment, approval and posting of Open Data for public use, adaptation and distribution.*"[15]

[15] Open Information and Open Data Policy; page 2. http://www.cio.gov.bc.ca/local/cio/kis/pdfs/open_data.pdf

Completion of this section of the 2012/13 T&T Plan Update is primarily the ministry's completion and submission of the provincial T&T Open Information template, listing how the ministry will support government's commitment to opening up its information.

1. *Ministries are required to fill in the Open Information template posted to the T&T site. The template requires ministries to provide information about the routine release of information and information released in response to access requests made under FOIPPA.*
2. *Sectors must provide a plan for what information, specific to the sector that can be routinely released in the future. There is no template for this deliverable - sectors are encouraged to use a format(s) which best suits the information and post the final submission to the final folder on the T&T site.*

The template's Part 1 asked for information about what the ministry currently routinely releases; Part 2, asked to identify the ministry information released through the FOI process; and Part 3, required the ministry to set out its plan for Open Information, going forward, such that citizens would not have to go through the FOI process to obtain information about the Ministry of Health. Part 3 is in essence the ministry's plan for what information it could routinely release in the future.

While the ministry, as evidenced in Part 1 of the template, currently releases a considerable volume of ministry-created information, such as through its web presence, the ministry is shifting its overall approach to one of increased openness. The ministry will encourage all staff, when creating documents, to think in terms of all documents *potentially* being public-facing and to adopt—by habit—an expectation that each could be considered for release. The base assumption will be a shift to release whenever possible; this shift will be guided by the Health Executive team, a consistent ministry-wide approach and the following considerations.

Considerations

- To realize the shift to more routine release, there will be resource impacts and process details to work out. For example, shifting to proactive open information releases, rather than reactive releases through Freedom of Information (FOI) requests and processes, will require the ministry staff, who currently draft or create documents, to proactively identify aspects of them that would be subject to severing before their public release.
- New staff roles will require defining new in-ministry procedures and training for staff to become more familiar with the governing legislation and provisions that direct severing. Currently, FOI severing is work done by the Ministry of Labour, Citizens Services and Open Government's Information Access Operations (IAO) staff; shifting to proactive release, out of the IAO FOI process, would require Ministry of Health staff to do the severing.
- Another consideration with resource impacts and new procedure definition is how and when the parties to a contract or an agreement— or those who would be impacted by its release— would be contacted or consulted before public release.

For the noted considerations of resource impacts and new business processes yet to be defined, this commitment to new routine releases of Health information products is not applied retroactively but applied beginning in 2012/13 and toward the future, as noted in the Open Information template, Part 3.

A ministry's decisions for routinely releasing information are best undertaken in a consistent manner across government. Therefore, the information that the Ministry of Health is now considering to release routinely is subject to some broader conversation across sectors and provincial direction. However, with provisos noted in the submitted Open Information template, the Ministry of Health has identified the following general categories of information products for possible routine release:

- executive calendars
- routine contracts and agreements
- major approved plans
- statements of ministry policy, standards and guidelines
- major reports and performance metrics
- procedure manuals and training materials

The web location(s) for future posting of ministry Open Information releases has not been determined but will be part of consultations within the ministry's Internet Strategy and include discussion with the provincial Open Information team, relative to its Open Information web site: http://www.openinfo.gov.bc.ca/.

Internet Strategy

The ministry-specific instruction for this 2012/13 T&T Plan Update requires completion of the provincial template to "Inventory the Ministry's web presence and management framework", and a 12-month strategy "to rationalize [the ministry's] web properties and render its web presence more citizen-centric and service focused". Refer to the Internet Strategy section of the general instructions for the template and details on the information required.

The General Instructions for an Internet Strategy require the ministry to have:

1. *Appropriate central functions established to ensure effective web management and participation in strategic web governance, including a business owner, content steward and web manager.*
2. *An evidence-based understanding of their end users to effectively direct a citizen-centric response for their online service presence.*
3. *A clear picture of their existing web properties, technologies and business needs.*
4. *A web strategy that details how they will rationalize and improve their current web properties into a citizen-centric, online service presence that will support key needs such as findability, usability and accessibility*.

Specifically, the *Ministry of Health Internet Strategy* is to rationalize web properties and render the Health web presence more citizen-centric and service focused, by:

a. *Identifying the* [Health web] *audience;*
b. *Undertaking citizen-centred research to understand audiences needs;*
c. *Ensuring effective management and governance of web properties;*
d. *Identifying opportunities with other ministries and agencies;*
e. *Moving high-value services online where evidence suggests that this will better meet citizens needs;*
f. *Aligning new web development with gov.bc.ca and the ministry's existing web properties.*
g. *Ensuring out-of-date and unnecessary sites and content are retired;* and,
h. *Improving accessibility and findability*.

The completed inventory template and the separately submitted *Ministry of Health Internet Strategy* address the above submission requirements. The following provides an update on the web-related transformation priorities identified in the 2011/12 T&T Plan, and discussed further in the separate *Health Internet Strategy* document.

Update on 2011/12 Web-related Transformation Priorities

The 2011/12 T&T Plan had two web-related transformation priorities that now come under the above directions for a ministry-specific Internet Strategy.

Health Promotion and Prevention Social Media

This 2011/12 priority project was to begin a phased implementation of social media tools, focusing first on quick win technologies for prevention wikis, such as *Baby's Best Chance,* and a *Sodium and Sweetened Beverage Reduction Public Awareness Campaign* social networking presence, both of which would begin building Heath sector social media experience and lessons to benefit a more expansive use of Web 2.0 technologies across the sector and spanning the provincial shifts of citizen participation, self-service and business innovation.

Progress Update

Because of program-related announcements, which were anticipated last fall, this program-specific priority was split-out of the more encompassing Citizens' Access initiative. This split was done so as not to interfere with planned ministry program announcements and not hold back this work while the broader Citizens' Access was being developed. This priority will now be brought into the overall visioning and planning for the ministry-wide Web 2.0 presence—through the new *Ministry of Health Internet Strategy*. Health Promotion and Prevention Social Media remain a priority but will, henceforth, be included with the following initiative and governed by the *Health Internet Strategy*.

Citizens' Access

As noted above, the 2011/12 priority Citizens' Access initiative was envisioned to encompass all Ministry of Health Web 2.0 and social media—the full footprint or presence of ministry-owned web properties.

Progress Update

This priority continues under the centralized governance and strategic leadership of the *Ministry of Health Internet Strategy*. A new BC government web site (www.gov.bc.ca) and provincial Internet Strategy were introduced after the original envisioning of the Citizens' Access initiative. As such, it is now being redeveloped through the *Health Internet Strategy*, a companion deliverable to this T&T Plan Update. The *Internet Strategy* will guide a coordinated review of all ministry web properties toward achieving a more unified, responsive, citizen-centred web presence and a reduced web footprint. One early development of the strategy is a new *Health Online* initiative, under the leadership of the Health Sector Information Management/Information Technology (HSIMT) division and its HealthLink BC program. Refer to the *Internet Strategy* for more information.

Web Inventory Key Findings

As a foundation to the *Health Internet Strategy*, the ministry completed an inventory of its web properties. The inventory documented that the ministry has 79[16] distinct public-facing websites with unique URL[17] addresses, audiences or business purposes. The sites are reviewed on a regular basis, ranging from daily to annually, with the majority being reviewed and updated on a bi-monthly basis. Ministry web sites contain a vast amount of information available through approximately 50,000 HTML[18] pages, 41,000 documents, 13,000 images, 400 Adobe flash files and a small number of MP3[19] and video files. Of these, 30,376 pages and 29,900 documents—organized for ease of searching[20]—are on one site related to BC's Tobacco Control Program and dedicated to tobacco industry documentation[21].

Of the 79 ministry sites, 17 contain an online transactional component; examples include registering for drug coverage, using an online survey tool, and submitting simple online forms.

The results of the web inventory will be used to guide more in-depth review of Health online services and identify sites that may be candidates for collaboration with other ministries and

[16] Using the definition provided in the inventory, the ministry's previous count of 66 sites is now 79.
[17] Uniform Resource Locator
[18] Hypertext Mark-up Language
[19] A digital audio-encoding format.
[20] The almost one-to-one ratio of web pages to documents is the result of search queries, where each document result has an information summary page. See note, below and: http://www.health.gov.bc.ca/cgi-bin/guildford_search.cgi: .
[21] http://www.health.gov.bc.ca/guildford/ Tobacco industry documents related to US jurisdictions' tobacco litigations are available to citizens. BC's legal team conducted research at the Guildford depository, requesting copies of about 10,000 documents representing about 40,000 pages. Documents retrieved by the provincial government's research team are posted on this web site.

those that can be retired, combined or otherwise improved. The expected result of this work will be to reduce the overall Health web footprint to its most efficient utility and presentation. This effort will be a transformation and collaboration over time and, in particular, achieved through the actions identified in the Internet strategy's component #4, *Rationalize, Research, Redesign and Reduce 'Footprint' of Health Web Properties.*

Also learned through the process of completing the web inventory was a significant difference in technical ability among the ministry's content administrators. This has resulted in a varying quality of analytic information recorded in the web inventory templates. This inconsistency highlights the need for education on the correct use and inherent value of analytic profiles and data-capture tools. This education will be addressed, going forward, and will take regular advantage of the established Web Community of Practice.

The type of web statistics reported by content administrators also varied widely. Page view statistics (visits to web pages within a website) were the most widely reported and spanned, at the low end, 1.7 page views per day for the Primary Health Care BC site and at the high end, 21,970 page views per day for the MSP site. Daily session[22] view statistics were the second-most reported statistic and showed a similar range—a low of 8.6 sessions per day for the Health Innovation Forum site to a high of 4,370 sessions per day for the MSP site.

Given the inconsistent quality of the statistical information recorded in the inventory template, the ministry will set up a standard analytic profile for all of its Internet sites and centralize the web analytic function to the Web Services business area. This centralization will provide more consistent reporting as well as a central repository for web statistics.

Strategy Components

The *Health Internet Strategy* has six action-focused component strategies. Some are being done in advance of other components, and others will be done simultaneously. They are:

1. Confirm the Health Web Vision
2. Establish Strategic Governance and Central Web Functions
3. Identify the Health Web Audience
4. Rationalize, Research, Redesign and Reduce the 'Footprint' of Health Web Properties
5. Build on the HealthLink BC Web Experience
6. Identify Opportunities to Collaborate Across Ministries and Agencies

Each has defined tasks, leads and resource assignments, required involvements, key deliverables and milestones, and completion targets. Refer to the separate *Internet Strategy* document for more information.

[22] A session is initiated by a web browser each time it visits a website. Within one website session, multiple pages may be viewed and with each page viewed, the page view count increases.

Leading Workplace Strategies

As part of annual T&T planning, government asked all ministries to identify a three-year optimization plan for Leading Workplace Strategies (LWS), which would:

- result in more effective use of office space through supporting non-territorial workspace and telework opportunities; and,
- enable the workforce to be mobile and flexible in support of LWS (see Appendix B , *Definitions of Work Styles*).

This section of the T&T update addresses the above and describes:

- how LWS will assist the ministry in achieving its transformation vision and business strategies; and,
- how the current composition of ministry employees will change over time as new work style strategies are implemented.

The following LWS optimization plan augments the ministry's *Workforce Plan: Change Through Innovation 3.0* and related workforce and engagement strategies by providing a more comprehensive analysis and strategies, specific to workforce shifts—shifts resulting from transformation, current and projected changes to workforce work styles, technology enablers and office/space optimization.

Both the *Workforce Plan* and this LWS component of the T&T plan are aligned to the strategic shifts of *Citizens @ the Centre*[23], previously referenced in this T&T plan update. For more information and a larger context for LWS, also refer to the ministry's *Workforce Plan*[24].

Transformation

The BC health system is one of citizens' most valued social programs— every person in the province will access some level of health care or health service during his or her life.

To ensure a sustainable health system, the ministry primarily performs a governance oversight role to the health sector through strategic planning, policy direction, project planning and analysis, project management and performance monitoring.

Transformation Vision

The health sector maximizes the opportunity presented by rapidly advancing technology to drive quality, efficiency and sustainability

—from page 3.

[23] https://gww.gov.bc.ca/gov20

[24] https://gww.health.gov.bc.ca/workforce-plan-flipbook/index.html

The health authorities and contracted service providers are responsible for the majority of health service delivery in the health sector. As a result, workforce or workplace shifts resulting from service delivery transformation initiatives are realized by them, with cost savings applied to other health service priority projects. While transformation LWS approaches reach across the health sector, the scope of the following optimization planning is specific to the Ministry of Health.

To achieve the transformation vision and ministry priorities, discussed earlier in this document, the ministry must be a 'workplace of choice.' The ministry must be attractive to new talent and incent current employees to stay. Implementing strategies that offer increased choice in support of balance—between work, family and community—is critical to success.

The ministry also recognizes the diverse nature of both its business and workforce. Technology enablers and non-traditional work styles give employees greater flexibility and mobility to perform their jobs. The ministry needs to leverage these tools to enhance service and productivity.

Where the ministry manages provincial programs and services (see inset), the ministry will look for innovative opportunities to enable technology to transform those services and to leverage modern work-styles and/or optimize space.

Recap of Ministry Services

While the BC health authorities are primarily responsible for health service delivery, the Ministry of Health manages a number of services to citizens.

Medical Services Plan: Insures medically required services provided by physicians and supplementary health care practitioners, laboratory services and diagnostic procedures.

PharmaCare: Provides prescription drug insurance for British Columbians.

Vital Statistics Agency: Registers and reports on vital events such as birth, death and marriage.

HealthLink BC: Provides a province-wide 24x7 non-emergency health line (8-1-1) staffed by registered health professionals who offer confidential health information, advice and health navigation services to the public and other health professionals. HealthLink BC also publishes the BC HealthGuide.

Office of the Provincial Health Office: Provides independent advice and recommendations to the Minister and public officials on public health issues including health promotion and health protection. The Provincial Health Officer reports annually to the Minister on the health of the population of British Columbia and the extent to which population health targets, established by the government, have been achieved.

Employee Work-Style Profile

To measure future progress, the ministry has established a profile of existing employee work styles.

Current employee work-style composition:

In September 2011, the ministry conducted an assessment[25] across its program-area divisions to document the current composition of employee work-styles. The results were:

Current employee work-style at September 2011				
Resident	Internally Mobile	Externally Mobile	Teleworker	Other
▪ *Assigned* (requires a dedicated workspace; more than 60% at a desk)	▪ *Flexible* (when in the office they used shared workspace; away from desk more than 60%)	▪ *Mobile* (do not have a dedicated workspace in any location; less than 25% of time spent in office space)	▪ *Home Based* (spend 3 or more days working from home; use shared workspace when in the office; more than 80% time at desk/computer at home)	▪ Work styles that do not fit definitions to the left; such as, teleworking one day/week.
97%	1%	0%	1%	1%

In addition to the above results, several ministry divisions reported that many employees participate in informal, ad hoc flexible work opportunities, for example, occasionally working at home when on a special project.

Multi-year work-style change projection:

While the overall BC Public Service is predicted to shrink over the next decade, citizens' needs for health system services will not, with health spending increasing at approximately five percent per year. To meet this challenge, the ministry must not only maintain its current staffing levels, it must adopt an efficient and sustainable model—one that is flexible, seeks innovative ways of delivering business and recognizes the unique attributes of its workforce.

- In February 2011, the ministry had 8% (110) employees working a reduced work week.
- In August 2011, a telework toolkit was developed and implemented to augment BC Public Service Agency policies and assist managers and employees enter into telework arrangements.

[25] Includes approximately 162 nurses who are not public service employees that the ministry is accountable to recruit for the positions, provide employees with day-to-day direction, training and performance management under an agreement.

As part of the September assessment, ministry division managers were also asked to think about opportunities for more:

- modern work styles that could be accommodated now or in the future that would result in optimization of space; or,
- flexibility for employees to have the choice to work differently for improved work/life balance.

Their responses are summarized in the following projection of change:

Year	2011/12	2012/13	2013/14	2014/15
Estimated percentage change in work styles	0	+1%	+1%	+1%

This preliminary projection is based on the current ministry environment and culture. Some divisions indicated a desire to consider modern work styles with more research and planning during this and the next fiscal—this could alter the above estimates.

Culture and Readiness

The ministry has done significant work to support and engage employees (see *Work Environment Survey*[26] results) but acknowledges that there is more work to do to shift the culture to one that empowers and provides employees with the flexibility they need to meet their individual work needs and styles.

For many managers and supervisors, moving to non-traditional ways of working will be a difficult change and a culture shift that will need to be addressed by providing them with support, information, tools, training and awareness.

Technology enablers are critical to support employees to be flexible and mobile. Many ministry divisions cited technology as a major challenge or obstacle to supporting employees to enter into modern work styles.

The ministry currently has a mix of traditional and modern work styles, both formal and informal. Building on those successes, engaging and providing staff with supports and tools, and

- In 2011, six teleworker arrangements were implemented in a work unit.
- 36 Health Service Representatives share 12 dedicated workspaces.
- 162 nurses share 55 tele-nurse work stations.
- 14 branch staff work from seven assigned workplaces, with additional shared options in two cities (located in the health authorities).

[26] https://gww.health.gov.bc.ca/pdf/wes/Ministry%20of%20Health%20WES%202011.pdf

increasing technology enablers will position the ministry to be better ready to adopt modern work styles and continue to shift the culture in a positive direction.

Office Space Optimization

Over recent years, the ministry has been working to reduce its leased space costs by optimizing and relocating employees to other existing ministry space.

As the ministry does not anticipate decreasing the size of its workforce over the next few years, it will continue to explore options to optimize and/or reduce existing space and cost. Some examples of space re-planning and optimization are:

- One branch having implemented a mix of workspace settings to optimize its existing space and accommodate a 40% growth in staff. The branch now includes a combination of open work space, an informal collaboration area, traditional dedicated workspace, a confidential meeting room and a part-time telework arrangement.
- Another branch is 100% open workspace with a dedicated area for team collaboration and confidential meeting space.
- Approximately 40 employees will soon be moving into 1515 Blanshard, Victoria, from a Saanich location.

Leading Workplace Strategies

The following LWS are based on input from all ministry divisions, strategies in the ministry's *Workforce Plan,* and consideration of key success factors, including human resources, technology and facilities/space.

Focus	2011/12 – 2012/13	2013/14	2014/15
Success Enablers	▪ Implement a LWS working group to drive the LWS and ensure an integrated approach to planning, monitoring and reporting. Working group to include (at a minimum) human resource, technology, facilities and an executive sponsor.	▪ Ongoing.	▪ Ongoing.
Flexible and/or Mobile Work Styles	▪ Where enablers exist to support modern work-styles, assess and explore options and employee interests to adopt. ▪ Pilot and/or implement modern work-style arrangements.	▪ Continue to assess and implement modern work-styles. ▪ Review lessons learned from pilots; decision to continue and/or expand to other units. ▪ Share and leverage lessons learned.	▪ Continue to assess and implement modern work-styles. ▪ Continue to leverage and share lessons learned.
	▪ Conduct feasibility study, client consultation and planning phase to pilot modern work-styles for functions or work units identified as potential candidates: o Auditor function identified for potential external mobile work-style o Research/writing identified as potential function to adopt various modern work-styles o Two work units identified as potential for internally mobile and teleworker work-styles for approximately 40 employees	▪ If approved, implementation to occur over two years 2013/14 - 2014/15. ▪ Monitor, share and leverage lessons learned. ▪ Identify other functions or work units that may be able to enable greater flexibility and mobility options.	▪ Ongoing.
	▪ Participate and/or provide input into development of corporate human resources policies, supports, etc., where opportunities exist. ▪ Work with other ministries where it makes good business sense (e.g., options for similar-type work functions) and to leverage and share best practices.	▪ Ongoing.	▪ Ongoing.

Focus	2011/12 – 2012/13	2013/14	2014/15
Space Optimization	▪ Moves in process or scheduled to occur to consider reconfiguration to support modern work-styles and to optimize space.	▪ Ongoing.	▪ Ongoing.
	▪ Explore options to share workspace with other organizations (e.g., health authorities; other ministries).	▪ Ongoing.	▪ Ongoing.
	▪ Facilities to work with divisions to identify and address needs for confidential meeting space resulting from modern work-styles implemented or contemplated.	▪ Ongoing.	▪ Ongoing.
	▪ Monitor upcoming lease expirations for potential optimization and to reduce real estate footprint and costs.	▪ Ongoing.	▪ Ongoing.
Cultural Readiness	▪ Provide managers/supervisors with supports, information, resources, tools and training. Training to include how to manage remote staff including performance management, and how to build teams and working relationships that don't involve face-to-face contact. ▪ Provide employees with training/awareness session on their role and responsibilities on how to be successful in a modern work-style arrangement.	▪ Continue to review, update and provide awareness/training sessions as required.	▪ Ongoing.
	▪ Provide managers/supervisors with change management support, training and tools.	▪ Ongoing.	▪ Ongoing.
	▪ Communicate; engage employees at all levels; tell employees' stories.	▪ Ongoing.	▪ Ongoing.
	▪ Ensure LWS are aligned with ministry workforce engagement strategies.	▪ Ongoing.	▪ Ongoing.
Technology Enablers	▪ Determine budget and options to provide mobile technology devices (e.g., lap-tops, tablets, iPads, etc.)	▪ Ongoing.	▪ Ongoing.
	▪ Determine options to support increased mobility (e.g., wireless access).	▪ Ongoing.	▪ Ongoing.

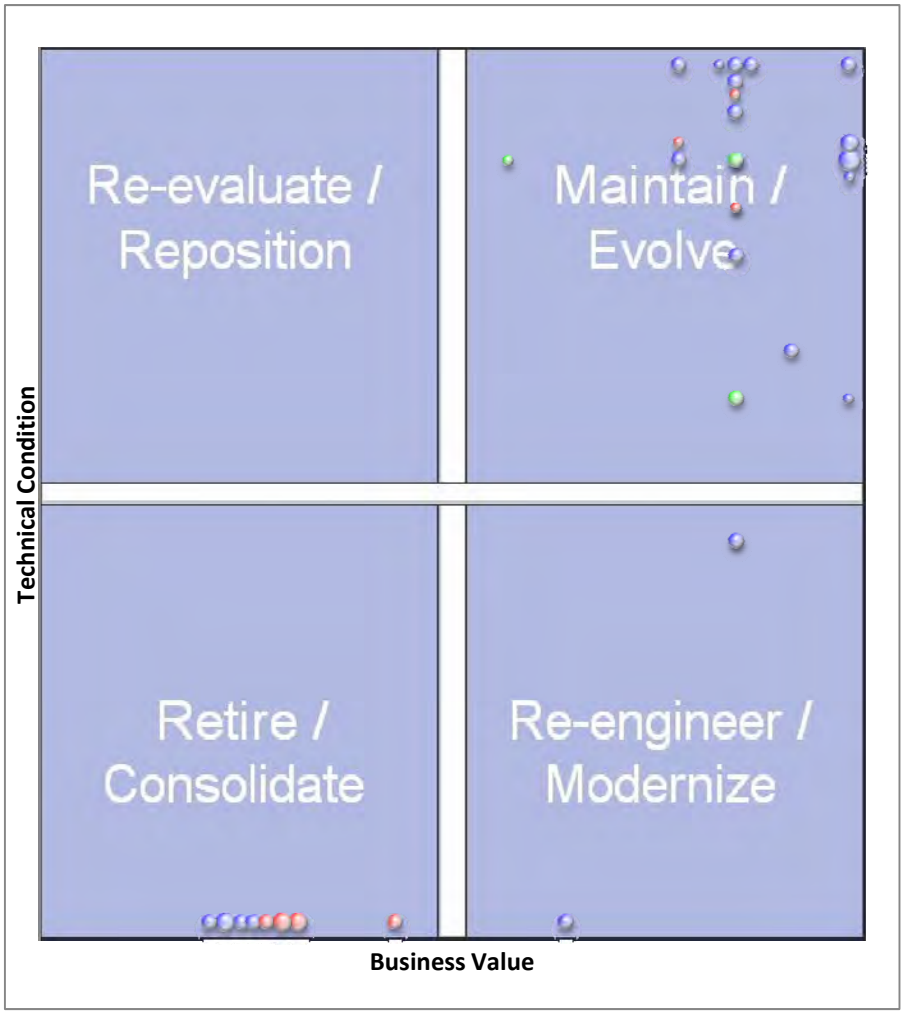
Focus	2011/12 – 2012/13	2013/14	2014/15
	▪ Work units piloting or considering modern work-styles to determine cost/budget and ability to provide employees with access required (e.g., DTS)	▪ Ongoing.	▪ Ongoing.
	▪ Provide technology training as required (e.g., live meeting, video conferencing, how to use mobile devices, etc.)	▪ Ongoing.	▪ Ongoing.
	▪ Determine current helpdesk support and access requirements to support different work-style access.	▪ Ongoing.	▪ Ongoing.

Application Health Check Summary Findings

The ministry completed the provincial IM/IT Application Health Check Inventory template as part of this 2012/13 T&T Plan Update. "*The purpose of this deliverable is to enable sectors and corporate government (Treasury Board Staff, DMCTT, OCIO, and SSBC) to understand and strategically plan the future requirements of our IM/IT systems. The value of the IM/IT Application Health Check is to provide:*

- *A common corporate and ministry view of the status of our IM/IT applications.*
- *Sectors and ministries with a tool to have real time view of the results as data is entered. This, in turn, provides sectors and ministries with the information to support future planning*" (General Instructions, page 17).

The matrix (to the right) charts the ministry's Application Health Check results. The 'bubbles' and their placement in quadrants are generated by the answers provided to the template.



The upper right quadrant (Maintain/Evolve) contains the largest number of applications. Each has good business value and good technical condition. These applications require no major investment at this time.

The upper left quadrant (Re-evaluate/Reposition) contains applications with good technical condition but fail to meet business needs. These applications may require major enhancements to add business value and, as such, will be subject to a more in-depth analysis.

The lower right quadrant (Re-engineer/Modernize) notes applications that provide good business value but have a below average technical score. These applications will be re-engineered to better meet

technical standards; in fact, most applications in the lower half of this matrix (including the following quadrant) have projects currently underway to replace them.

The lower left quadrant (Retire/ Consolidate) contains a large number of applications that do not meet technical standards or business needs. Most with the lowest technical scores are either legacy mainframe applications that were developed for a different business environment or they are applications that were developed by non-professionals and do not meet current industry or government standards. These applications will be replaced, consolidated into other systems, or retired. Being in the lower half of the matrix, as previously noted, they have projects underway to replace them, have replacements built but not fully adopted, or have a proposed solution still subject to further considerations, including funding.

2011/12 IM/IT Capital Projects

There are thirteen IM/IT capital projects identified in the ministry's 2011/12 T&T Plan. Each project is now going through the ministry Project Review Committee's gated process, which is to ensure IM/IT projects are managed responsibly from concept through to execution. Aside from the BC Services Card and eHealth Implementation projects, discussed in Part 1 of this T&T Plan Update, the projects are:

1. Enterprise Master Patient Index (EMPI) Enhancement
2. Emergency Medical Assistant (EMA) Continued Competency Website
3. Alternative Payments Program (APP) Claims Management System Replacement
4. Data Analysis Tools, also known as the Business Intelligence (BI) Tools project
5. Service Utilization and Planning Tool, also known as the 'Blue Matrix' project
6. Third-Party Liability (TPL) Enhancement
7. Health Authority Capital Projects Submission Application Enhancement
8. Diagnostic Imaging Wait Time Tracking Tool, also known as the Medical Imaging Wait Times Data Warehouse and Reporting project
9. 8-1-1 Health System Information Referral and Navigation (HSIRN) System Service Upgrade
10. HealthLink BC Workforce Management Solution
11. Home Care and Residential Assessment Reporting
12. Delivery Site Registry for Service Contracted Providers and Agencies
13. Open Data Infrastructure Upgrade

Refer to last year's T&T Plan for summary descriptions of the projects; business case descriptions were also part of the 2011/12 submission.

The ministry has established monthly status reporting on T&T capital projects to fulfil a Health leadership commitment to keep stakeholders apprised of projects' progress. The structure of the report is outlined below. Report format may evolve over time to incorporate stakeholders' feedback and to ensure relevant information is provided throughout the project lifecycle.

Section	Description and Status
Project Status	For each project, provides a status bar, status by project phase, highlights key activity from the reporting period and outlines current challenges of note.
Implementation Status	Indicates planned phase progression for the current and next fiscal year.
Approved Change Requests	Summary of approved change requests that impact scope, time or budget.
Budget Status	Outlines the projects' projected budget for the duration of the project.

Of relevance to this section, the following templates and updates were submitted, 15 September 2011, and are considered part of this 2012/13 T&T Plan Update.

- Ministry of Health - Vote 32 (IMIT Related Operational Budgets Template)
- MOH TT Capital Projects FY Re-Profiling Sep 1 2011
- MOH Capital Project Update (6-Question Response)
- Corporate Infrastructure Forecast Reports (14 completed templates) for the above 2011/12 capital projects and for the eHealth initiative.

Conclusion

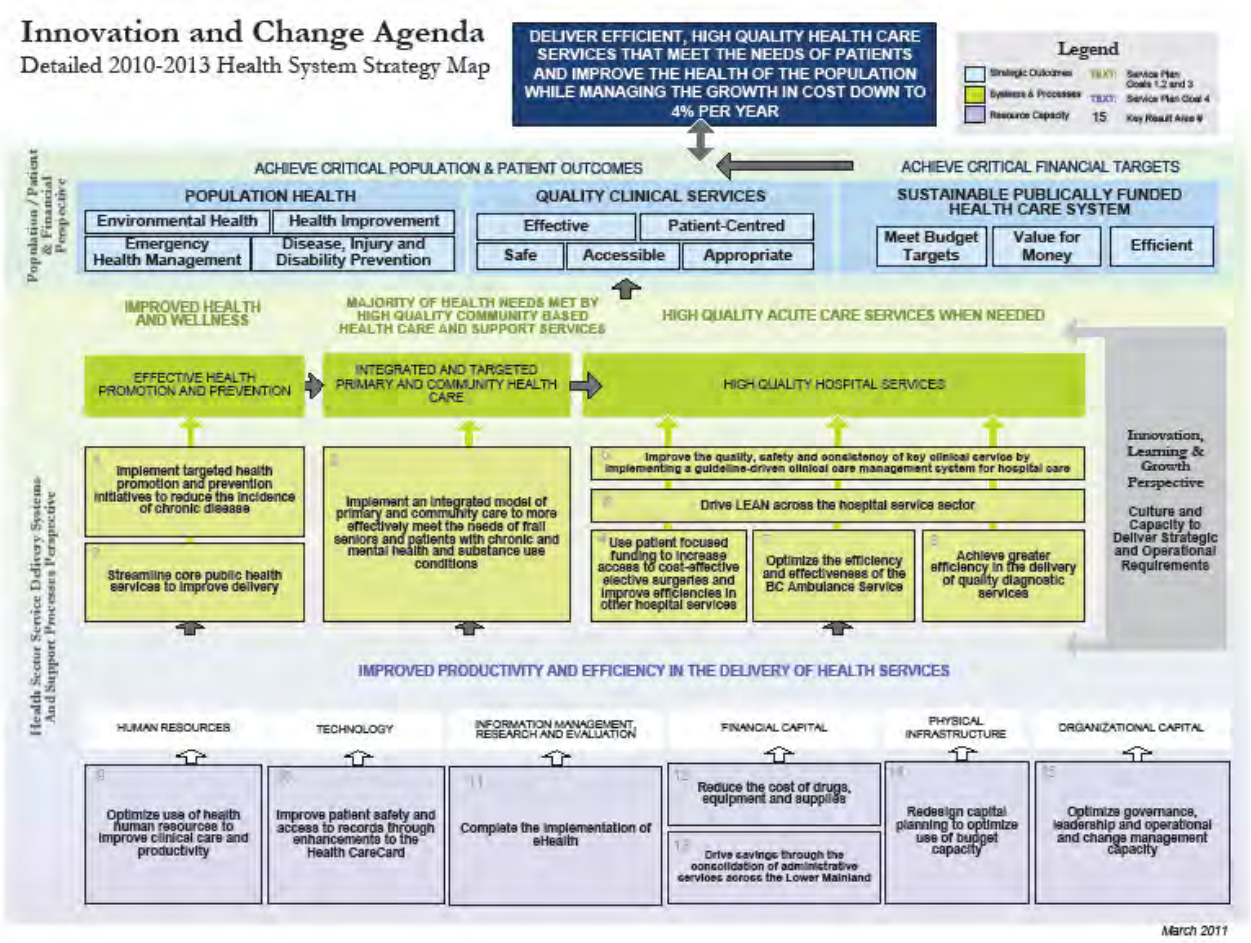
The 2012/13 Ministry of Health vision for health sector transformation and technology is a provincial health sector that maximizes the opportunity presented by rapidly advancing technology to drive quality, efficiency and sustainability. This T&T Plan Update sets a course for how the ministry is and will continue to leverage technology to achieve transformation, realize the strategic Innovation and Change Agenda and respond to government's priorities for Open Data, Open Information, the Internet Strategy and Leading Workplace Strategies.

Appendices

Appendix A: *Change and Innovation Agenda Themes and Key Result Areas*

Appendix B: *Leading Workplace Strategy, Work Style Definitions*

Appendix A: *Change and Innovation Agenda Themes and Key Result Areas*



Ministry Vision: ***A sustainable health system that supports people to stay healthy, and when they are sick, provides high quality publicly funded health care services that meet their needs.***

Strategic Actions

The ministry's strategic direction, known as the Innovation and Change Agenda, was developed to achieve the above vision. This strategy is focused on making positive impacts to the quality of life for those who are facing increasing frailty, are managing chronic diseases, or dealing with mental illness, as well as continuing to contribute to a sustainable health system. The agenda consists of four broad themes, with project-focused teams collaborating on fifteen key result areas.

1. Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

   Key Result Area #1: Implement targeted health promotion and prevention initiatives to reduce the incidence of chronic disease

   Key Result Area #2: Streamline core public health services to improve delivery.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   Key Result Area #3: Implement an integrated model of primary and community care to more effectively meet the needs of frail seniors and patients with chronic and mental health and substance use conditions

3. High-quality hospital services are available when needed.

   Key Result Area #4: Use patient-focused funding to increase access to cost-effective elective surgeries and improve efficiencies in other hospital services

   Key Result Area #5: Improve the quality, safety and consistency of key clinical service by implementing a guideline-driven clinical care management system for hospital care

   Key Result Area #6: Drive LEAN across the hospital service sector

   Key Result Area #7: Optimize the efficiency and effectiveness of the BC Ambulance Service.

   Key Result Area #8: Achieve greater efficiency in the delivery of quality diagnostic services.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   Key Result Area #9: Optimize use of health human resources to improve clinical care and productivity.

   Key Result Area #10: Improve patient safety and access to records through enhancements to the Health CareCard.

   Key Result Area #11: Complete the implementation of eHealth.

   Key Result Area #12: Reduce the cost of drugs, equipment and supplies.

   Key Result Area #13: Drive savings through the consolidation of administrative services across the Lower Mainland.

   Key Result Area #14: Redesign capital planning to optimize use of budget capacity

   Key Result Area #15: Optimize governance, leadership and operational and change management capacity

Appendix B: *Leading Workplace Strategy, Work Style Definitions*

Resident
Assigned
(requires a dedicated workspace)

The employee has a dedicated workspace in a particular location within the organization that is provided for their exclusive use while at the office. Because of the employee's work requirements, the daily use of a workspace within a specific location is necessary. The employee rarely works from an alternate location. Employees generally most suited to be Assigned are non-mobile, have a frequent need for immediate face-to-face interaction with co-workers, and have special IT or physical resource needs that make their work place-dependant.

Internally Mobile
Flexible
(may spend the majority of a day away from an individual workspace engaged in internal collaboration)

To support high levels of internal 'campus' mobility within an organization the employee has the ability to work from a variety of spaces and locations. The employee may also work from home up to 2 days a week, based on suitability and desire. They do not have a dedicated workspace in any organizational locations. When in the office they use shared workspace within departmental areas or reservable space in other organizational locations. Employees generally most suited to be flexible are internally mobile, desire choice and variety in the options available to work and interact with individuals across the organization, and most often have the ability and need to work on the go.

Externally Mobile
Mobile
(spends the majority of a day outside of base workplace)

To support high levels of external mobility the employee has the ability to work from a variety of places outside of the organizations' locations. The employee may also base their work primarily from home or up to 2 days a week, based on suitability and desire. they do not have a dedicated workspace in any company locations. Employees generally most suited to be Mobile are externally mobile, have a frequent need for face-to-face interaction with partners, vendors, or customers, and most often have the ability and need to work on the go.

Teleworker
Home Based
(spends the majority of a week working from home)

The employee's home is their primary place of work. In a typical week they will spend 3 or more days working from their home office. They do not have an assigned office in any company location. When they have a need to be in a company location they use shared workspace on an availability or reservation basis. Employees generally most suited to be home based are non-mobile, have an autonomous workstyle with low special resource needs.

Jason
Resident

"I help people when they get stuck. It's pretty cool to be able to sort things out...while I work around others I don't work with them"

- Navigates government process on a daily basis.
- Typically spends **more than 60% of his time at his desk** working on his computer.
- Works independently, but assists others in their work
- Workload is steady except at the end of the fiscal year.
- Requires a uniquely assigned workspace with specialized IT infrastructure and tools to achieve work objectives

Sonia
Internally Mobile

"I need to keep up with changing client needs, informing and advising others within our Head Office. I'm often away from my workspace meeting with others and juggling priorities."

- **She's typically away from her desk more than 60%** of the time, often in meetings around Head Office and off site
- Requires space for physical presence with her direct reports
- Reliant on mobility technology to achieve work goals

Kevin
Externally Mobile

"To get the information I need, I have to collect it off-site. I spend most of my time outside of the office. When I do go into the office I feel more connected to everyone else."

- Nature of work doesn't require a dedicated workspace
- **Typically less than 25%** of time is spent in an office space and much of this time is spent in meeting rooms or touch-down workspace
- The office space isn't the main tool he uses to get his job done

Deb
Teleworker

"I can access and provide people with the information needed from home. It's great to be able to have the option to work from home... while still feeling connected to the workplace when I do come in"

- Navigates government process on a daily basis. Typically spends **more than 80% of his time at her desk** working on her computer.
- Works independently, but assists others in their work through email and phone conversations.
- Does not require a uniquely assigned workspace or physical references but rather relies on technology to achieve work objectives

4 November 2011

GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE FRASER HEALTH AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Fraser Health Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The mandate of the Health Authority, defined by the *Health Authorities Act*, is to plan, deliver, monitor, and report on health services, which include population and public health programs, high quality community based health care and support services and acute care, as well as improved productivity and performance.

The mandate for the Health Authority applies to the geographic region stretching from Burnaby to Boston Bar and includes the communities of Delta, Surrey, White Rock, New Westminster, Maple Ridge, Pitt Meadows, Tri Cities, Mission, Abbotsford, Langley, Chilliwack, Agassiz, Harrison Hot Springs and Hope.

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. <u>Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.</u>

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality and management of clinical services to achieve effective, appropriate, efficient and safer care. In addition, the Health Authority will undertake all necessary actions to address the patient congestion and quality issues raised in the Fraser Health Congestion Review Report and the Gardam Report on Infection Control.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

   The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

   Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by Government (some of this information is included in annual reports and does not need to be otherwise displayed);
- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and

- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;
- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;
- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;
- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	David Mitchell Chair of the Board Fraser Health Authority
Date	Date

pc: Honourable Christy Clark
Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Dr. Nigel Murray
President and Chief Executive Officer
Fraser Health Authority

Pages 330 through 340 redacted for the following reasons:
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s. 13

Fraser
Health Authority

2012/13 – 2014/15
SERVICE PLAN

June 2012

For more information on the
FRASER HEALTH AUTHORITY
see Contact Information on the last page of this document or contact:

Fraser Health Authority
Suite 400, Central City Tower
13450 – 102nd Avenue
Surrey BC V3T 0H1

or visit our website at
www.FraserHealth.ca

Message from the Board Chair and Accountability Statement

On behalf of the Board of Directors and employees of the Fraser Health, I am pleased to submit our Service Plan for fiscal years 2012/13 to 2014/15.

The *2012/13 – 2014/15 Fraser Health Authority Service Plan* was prepared under my direction in accordance with the *Health Authorities Act* and the BC Reporting Principles. The Plan is consistent with Government's strategic priorities and Strategic Plan, and the Ministry of Health goals, objectives and strategies. The Board is accountable for the contents of the Service Plan and for ensuring the Fraser Health Authority achieves the specific goals and strategies identified in it. The Plan takes into account all significant assumptions and policy decisions and specifically incorporates the Goals and Objectives of the Ministry of Health. Many of the specific strategies in this Plan were determined based on an assessment of Fraser Health Authority's operating context and its Strategic Imperatives.

This Service Plan outlines the actions needed to deliver the highest quality care and services possible while managing within our budget. There are many important needs to attend to, and we have carefully prioritized our total funding to focus on achieving the greatest good for the greatest number of people. We will be increasing our efforts at clinical standardization, optimizing capacity, service integration and consolidation. In addition, we will continue to build on our progress with shared services, both provincially and in the Lower Mainland to ensure we remove any unnecessary duplication and to ensure the optimization of facilities and human resources.

In 2012/13 Fraser Health has budgeted for total revenues of $2.93 billion, primarily contributions from the Ministry of Health. The 2012/13 contribution from the Ministry of Health at $2.41 billion represents an increase of $112.6 million over the 2011/12 base funding. All new revenues will be committed to fixed and inflationary cost increases and the highest priority services changes outlined in this Service Plan. Fraser Health will continue to work with the Ministry of Health on investments required for the 2013/14 and 2014/15 years of this plan.

The Board, staff, physicians and volunteers of Fraser Health are dedicated to doing the very best we can to provide better health and the best in healthcare to patients, clients and residents.

On behalf of our Board and of Fraser Health as a whole, we look forward to working very closely with Government, as together we seek ways to meet the needs of those who live in the largest and fastest growing health authority in British Columbia, in a responsible, responsive and sustainable manner.

Sincerely,

David Mitchell
Chair, Board of Directors
Fraser Health Authority

Table of Contents

Organizational Overview

As one of five regional health authorities in British Columbia, Fraser Health organizes and operates a 'system for health' and delivers prevention, hospital, residential, community-based and primary health care services. Fraser Health's legal authority is specified by the Health Authorities Act.

Fraser Health serves approximately 1.66 million people in the Lower Mainland, just over one third of the total provincial population. It is a geographically large area, running west to east from Burnaby to Hope and south to north from the Canada/US border to Boston Bar. It is the fastest growing health authority in British Columbia and has almost doubled in population since 1986. Between 2012 and 2017, the population is expected to increase by approximately 167,700 people to 1.83 million or by approximately 10 percent over all, with some of our communities growing at even faster rates[1].

The communities in Fraser Health are very diverse, with several sub-populations at risk for poor health outcomes due to the prevalence of certain chronic diseases and other health issues. In Fraser Health, there were approximately 38,100 Aboriginal peoples in 2006. There are 32 First Nations Bands in the region.[2] Fraser Health has large Asian, Indo-Canadian, Korean, and Filipino populations with specific health care needs.

The Ministry of Health appoints nine Directors to the Board to govern the Fraser Health Authority. Its governance approach is guided and assessed by "Best Practice Guidelines, Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations".

Vision
Better Health, Best in Health Care

Purpose
Our purpose is to improve the health of the population and the quality of life of the people we serve.

Our Values
Respect, caring and trust characterize our relationships.

The Board provides oversight to ensure Fraser Health fulfills its vision and purpose and operates in accordance with its stated values.

Central to Fraser Health's vision of the future (Better Health) and its core mission is the optimization of the health status of its residents which is influenced heavily by the broader determinants of health including economic, social, and environmental forces. Enjoying good health and a high quality of life throughout the course of one's lifetime is a consequence of many factors, including access to quality education, meaningful employment, stable family and community environments, and making healthy lifestyle choices.

In consideration of this vision and purpose, Fraser Health has set out the Strategic Imperatives that guide our overall approach.

[1] BC STATS, Service BC, BC Ministry of Labour and Citizens' Services, P.E.O.P.L.E. 36 projections
[2] First Nations Health Council. Regional Summary of Governance Discussions 2011: Summary of Feedback from the Fraser Regional Caucus and Health Partnership Workbook. Retrieved from http://www.fnhc.ca/pdf/Fraser_Regional_Report.pdf

This model reflects the important base upon which these imperatives are placed; namely a sustainable system that is fundamentally delivered through the dedication of people committed to the values of respect, caring and trust. These six strategic imperatives are reflected in the Goals, Objectives and Strategies section of this Service Plan.

Strategic Context

The health system in BC is a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand.

Although the BC health system effectively meets the majority of the population health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to frail seniors, a rising burden of illness from chronic diseases, mental illness and cancer, and advances in technology and pharmaceuticals driving new costly procedures and treatments. The pressure is compounded by the need for new care delivery models by health professionals and health care workers, and the need to maintain and improve the health system's physical infrastructure (i.e. buildings and equipment). In the current economic climate it is even more important for the health system to find new and creative ways to ensure the resources available for health care services are used effectively and in ways that most benefit the people of BC.

BC also faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved significantly in several respects over the past few decades, the Aboriginal population in BC continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other BC residents. Fraser Health, in partnership with Government, is working with First Nations, Metis and other partners to improve Aboriginal people's health and to close this gap in health status.

The Aging Population

BC's senior population currently makes up 15.7 percent of the total population and is expected to grow by 90 percent within the next 20 years, making it one of the fastest growing seniors populations in Canada.[3] The aging population is a significant driver of demand because the need for health services rises dramatically with age. In 2009/10 people over age 65 made up 15 percent of the BC population, but used 34 percent of physician services, 49 percent of acute care services, 47 percent of PharmaCare expenditures, 76 percent of home and community care services and 93 percent of residential care services.[4] There is also an increasing need to provide appropriate care for those with frailty or dementia and to help seniors stay healthy, independent and in the community for as long as possible. In addition to the impact of aging, Fraser Health faces the fastest growing population in British Columbia, and is expected to grow by 16 percent by 2020. In 2012, roughly 14 percent of

[3] PEOPLE 36 Population Data, BC STATS

[4] Health System Planning Division, Ministry of Health; using MSP Expenditures 2009/10; Acute Care: Inpatient and Day Surgery workload weighted cases, DAD 2006/07; HCC community services by age group 2005/06, summed based on average unit costs; Residential care days 2006/07.

the population in Fraser Health is estimated to be over 65 years of age. By 2020, the over 65 age group is expected to increase by approximately 35 percent or 84,400 people.[5]

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, asthma and some cancers. People with chronic conditions represent approximately 38 percent of the BC population and consume approximately 80 percent of the combined physician payment, PharmaCare and acute (hospital) care budgets.[6] Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions could increase 58 percent over the next 25 years[7] and be a significant driver of demand for health services. Chronic diseases can be prevented or delayed by addressing key risk factors, including physical inactivity, unhealthy eating, obesity, alcohol consumption and tobacco use.

Advances in Technology and Pharmaceuticals

New treatment and technology development over the past 10 years has included less invasive surgery, increased use of diagnostic imaging and the introduction of biological and tailored drug therapies that have made health care more efficient and effective, but has also led to a significant increase in demand for products and services. For example, the expansion of technology has seen the number of CT exams increase by approximately 100 percent and the number of MRI exams increase by almost 170 percent in the province since 2001.[8] In addition, new surgical techniques and equipment have contributed to expanded use of joint replacement procedures. In BC the number of hip replacements has increased by 102 percent and the number of knee replacements by 180 percent over the past decade.[9]

Human Resources

Although attrition rates have recently decreased, looming retirements in the health workforce, combined with the rising demand for services, are still key challenges that will impact the Province's ability to maintain an adequate supply and mix of health professionals and workers. The retention and development of our people remain key goals within Fraser Health's Great Workplaces strategic imperative. Replacement of employees who will resign or retire and the recruitment of additional people to meet the needs of expanded programs/services will continue to be a focus and a challenge. The recruitment and development of specialty registered nurses (RNs) will be a particular challenge. Using the same model as all other health authorities to project staffing needs, we estimate the need to recruit at least 350 RNs each year over the next five years.[10]

While ensuring that we have the required number of qualified healthcare providers entering the workforce is important, it is equally important that we retain the people we already have. Through building and maintaining healthy, supportive workplaces that enhance working and learning conditions, we have the opportunity to both attract and retain the workforce we need to provide high quality services. We also need to continue focusing on redesigning care delivery models so that we are fully utilizing the skill sets of our professionals, including creating and supporting interprofessional care teams.

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[5] BC STATS, Service BC, BC Ministry of Labour and Citizens' Services, P.E.O.P.L.E. 36 projections
[6] Discharge Abstract Database (DAD), Medical Service Plan (MSP) and PharmaCare Data 2006/07
[7] BC Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis*, march 2007, (2007-064); as cited in Primary Health Care Charter: a collaborative approach (2007), Ministry of Health
[8] HAMIS/OASIS, Management Information Branch, HSPD, Ministry of Health as of October 12, 2010
[9] Discharge Abstract Database, October 2010, Management Information Branch, HSPD, Ministry of Health
[10] Looking Forward: Health Human Resources, Our Demographics and Future Needs, March 2012, People and Organization Development, Fraser Health

Efficiency in Clinical and Support Operations

It is critical that every health care dollar is spent as efficiently as possible and savings from efficiencies are directed back into needed health care and service. With approximately 20% of our total expenditure on medical supplies, services and medications it is critical that we continuously find ways to reduce prices and any inappropriate use. BC is a leader in creating critical mass through the group purchasing of goods, services and medications resulting in price reductions in many areas. Fraser Heath Authority will continue to be a very active partner in this group purchasing program. The remaining 80% of total expenditure is on staffing (sometimes through contracted services). It remains critical that we have the right mix of individuals, allocated to the right service or function and that the processes in which they work are made to be efficient as possible. In addition, in considering how the parts of the health system work in harmony, it is essential that there is a continuous effort to find the right balance of services. Optimizing the overall system efficiency ensures that we find and eliminate such things as inappropriate waiting to be discharged from hospital to an alternative level of care (ALC), avoiding stays in hospitals for which there is no clinical need and eliminating unnecessary differences in care or care processes which do not contribute to a positive outcome. This plan identifies strategies being implemented to reduce these inefficiencies and ensure we make the best use of every dollar spent.

Health System Infrastructure

Another challenge in delivering health services is the need to maintain and improve the health system's physical infrastructure. The health system is faced with the continuous need to update or expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to British Columbians.

Since 2006, Fraser Health Authority has worked to expand physical capacity through the opening of the Abbotsford Regional Hospital, the Jim Pattison Outpatient Care and Surgical Centre and most recently, through ongoing construction of the new Surrey Memorial Hospital Critical Care Tower. Supporting these changes and ensuring a plan into the future, Fraser Health undertook an intensive study examining the acute service needs in Fraser Health today and out to 2020. The study concluded that a comprehensive approach to optimizing our existing capacity, combined with bold efforts to expand physical capacity throughout Fraser Health was essential to meet future acute care demand. Fraser Health is committed to achieving ambitious capacity optimization targets and continues to work on plans to increase physical capacity. Specifically, Fraser Health faces a bed gap of approximately 1,100 additional acute beds by 2020.[11]

In addition to the very significant need for capacity in the acute care sector, there is a critical need to grow resources in the community. Without community growth, the acute care sector will not be functional and appropriate services to individuals in the acute care sector and community will simply not be available.

[11] Fraser Health acknowledges that the bed numbers in this document are for planning purposes and final numbers are subject to change based on approvals by Government.

Goals, Objectives, Strategies and Performance Measures

This plan reflects alignment to the goals and objectives of the Ministry of Health's revised 2011/12 – 2013/14 Service Plan.[12] The following presents the main strategies which Fraser Health will pursue to achieve these goals and objectives.

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

We want to support the excellent health status of the majority of our citizens while also helping those who do not enjoy good health or are at risk of diminished health from factors such as poor diet, obesity, inactivity, injuries, tobacco use or problematic substance use. We will help people make healthy lifestyle choices by providing information, tools, choices, and support for people to invest in their health to prevent or delay the onset of chronic diseases, cancer and frailty.

Objective 1.1: Individuals are supported in their efforts to maintain and improve their health through health promotion and disease prevention.

Strategies

- Work with Fraser Health family doctors, primary care providers, community partners and others to advance the health of women and children through comprehensive and effective programs and services.
- Support communities, including schools, workplaces and municipalities, to strengthen healthy living opportunities with a focus on healthy eating, physical activity, reduced salt and sugary drink consumption, tobacco reduction and responsible alcohol use in order to reduce childhood obesity and the prevalence of chronic disease.
- Support families and individuals to invest in their own health through programs and incentives that lead to healthy lifestyle choices.

[12] MoH Service Plan link http://www.bcbudget.gov.bc.ca/2012/sp/pdf/ministry/hlth.pdf

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average sodium content in adult hospital care diets	4061 mg	3700 mg	3200 mg	2800 mg

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure focuses on the average sodium content of the general/regular diets for adults within health authority hospitals. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and asthma. According to the World Health Organization, interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective. [1]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease. [1] Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. BC has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the Guidelines for Food and Beverage Sales in BC Schools.

Health authorities are required to reduce the average sodium content of the general/regular diet for adults to the population goal of an average intake of 2300 mg of sodium per day by 2016.

Performance Measure 2: Health of Aboriginal Children

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of Aboriginal Kindergarten children receiving vision screening	91%	92%	93%	93%

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure supports Aboriginal children's access to vision screening. Vision deficits such as amblyopia (lazy eye), strabismus (crossed eyes), and refractive errors (nearsightedness and farsightedness) are

[1] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/related-info-connexe/strateg/index-eng.php

common problems in the preschool and school age population. Early detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child's opportunity for academic success and learning potential.

Goal 2: British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

Fraser Health is committed to providing the best possible quality of care and service which means the care people receive responds to their needs and will lead to the best health outcomes. We must proactively address the increasing needs of the population due to aging, rising burden of illness from chronic disease and an increased prevalence of frailty by providing integrated care in the community. Managing care in the community effectively, will reduce demands on emergency departments, acute care hospitals and residential care.

Objective 2.1: Providing a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services.

Strategies

- Promote the use of integrated health care teams, coordination between health care providers, improved access to family doctors and more responsive care in community settings for frail seniors, patients with chronic diseases, and people with mental health and substance use conditions to improve health outcomes and reduce the need to access care through emergency departments and hospitals, and delay the need for residential care.
- Implement priority strategies for community based health service redesign, including care management practice and actions for people with dementia and those requiring end-of-life care.
- Promote the patient attachment initiative to provide every citizen of British Columbia the opportunity to have a family doctor as a first point of contact for care that is comprehensive, accessible, coordinated and continuous.
- Engage with patients, families, caregivers and community organizations to ensure voice, choice and representation in individual care planning and health service redesign.
- Invest in community based resources to respond to known and forecasted needs in home care, assisted living and residential care.

Performance Measure 3: Managing Chronic Disease in the Community

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people with a chronic disease admitted to hospital (per 100,000 people aged less than 75 years)	234	229	216	203

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health
Note: The 2009/10 baseline has been restated from 225 to 234, according to the new methodology of the Canadian Institute for Health Information, which determines the calculation of this rate nationally. The new methodology includes more people with diabetes. The 2012/13 target of 229 is a reduction from the new baseline of 234.

Discussion

This performance measure tracks the number of people with selected chronic diseases, such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic diseases need the expertise and support of family doctors and other health care providers to manage their disease in the community in order to maintain their functioning and reduce complications that will require more medical care. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which help to control the costs of health care. As part of a larger initiative of strengthening community based health care and support services, family doctors, home health care providers and other health care professionals are working to provide better care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home Health Care and Support for Seniors

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of people aged 75+ receiving home health care and support	13.2%	14.5%	15.5%	16.5%

Data Source: P.E.O.P.L.E. 35, population estimates, BC Stats 2. Continuing Care Data Warehouse, Management Information Branch, Health System Planning Division, Ministry of Health. A small amount of baseline data is currently unavailable due to the transition to new reporting mechanisms. 3. Home and community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management information Branch, Planning and Innovation Division, Ministry of Health.
Note: The data for this measure may be restated at a later time when the new data reporting system is fully implemented. Targets may be revised accordingly.

Discussion

This performance measure tracks the percent of seniors (aged 75+ yrs) who receive home health care such as home nursing and rehabilitative care, clinical social work, light housekeeping, assisted living and adult day programs. While the majority of seniors experience healthy aging at home, there is growing need for community care options to support those who can no longer live independently. This support helps people manage chronic

disease and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community-based health care and support services, the health authorities are expanding home health care services and ensuring that high risk seniors are made a priority in the provision of care. This focus, combined with the use of technology, can significantly improve health outcomes for seniors.

Goal 3: British Columbians have access to high quality hospital services when needed.

While the majority of health needs can be met through community based care, British Columbians also require timely access to high quality hospital care for advanced conditions.

Objective 3.1: Acute care services are accessible, effective and efficient.

Strategies

- Continue patient-focused funding to provide appropriate incentives to encourage increased access, efficiency as well as clinical and service excellence across the health system, including incentives to support care in communities.
- Expand the clinical care management system to improve the quality, safety and consistency of key clinical care services.
- Improve access to diagnostic imaging services such as MRI and CT exams by working with health authorities to improve efficiency and appropriateness.
- Strengthen optimization of our current clinical resources, including timely discharge through care and discharge planning.
- Strengthen infection control practices throughout the system.

Performance Measure 5: Access to Surgery

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of non-emergency surgeries completed within the benchmark wait time	67%	72%	79%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Health System Planning Division, Ministry of Health. Notes:
1. The total wait time is the difference between the date the booking form is received at the hospital and the report date (end of the month). The day the booking form is received at the hospital is NOT counted.
2. This measure uses adjusted wait times that are calculated by excluding periods when the patient is unavailable from the total wait time.

Discussion

In the last several years, British Columbia's health system has successfully reduced wait times for cataract, hip and knee replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding, combined with continuous effort to foster innovation and efficiency in British Columbia's hospitals, will improve the timeliness of patients' access to an expanding range of surgical procedures. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times. These benchmark wait times are new and give a priority rating for each surgical patient, based on individual need. Because of the need to 'catch up' on surgeries for patients without a priority rating who have already been waiting, surgery for some patients with the new priority rating may be delayed. The target for 2012/13 will allow for this 'catch up' period, after which wait times for patients with priority ratings should gradually decrease.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

A high performing health system is one that uses its resources in the best way possible to achieve the best possible outcomes for patients and the population as a whole. To be sustainable the system must ensure it has enough, and the right mix of, health professionals to provide the services required. We must also ensure that those professionals are appropriately supported by information management systems, technologies and the physical infrastructure to deliver high quality services as efficiently as possible.

Objective 4.1: Optimize supply and mix of health human resources, information management, technology and infrastructure in service delivery.

Strategies

- Support health service redesign and an affordable, sustainable health system by ensuring that British Columbia has the required supply of health care providers and that their skills are being used effectively.
- Strengthen and align performance assessment processes and systems for medical professionals, including licensure, credentialing, privileging, and monitoring, in order to improve public confidence in the quality of care provided in British Columbia.
- Expand the implementation and adoption of eHealth systems to enable patient health information to be securely stored and shared electronically by authorized users. This will enable the availability of timely clinical information such as laboratory test results and patient medication histories to support health care providers in decision making and improving patient care.

Performance Measure 6: Nursing Overtime

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Nursing overtime hours as a percent of productive nursing hours	3.8% (2010 calendar year)	No more than 3.5%	No more than 3.4%	No more than 3.3%

Data Source: Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

Discussion

This performance measure compares the amount of overtime worked by nurses to the overall amount of time nurses work. Overtime is a key indicator of the overall health of a workplace. High rates of overtime may reflect inadequate staffing or high levels of absenteeism, resulting in workload issues and increased costs. Reducing overtime rates by addressing the underlying causes not only assists in reducing direct (e.g. labour) and indirect (e.g. unengaged staff) costs to the health system, it also helps promote both patient and caregiver safety.

Resource Summary

Resource Summary Table

This Resource Summary Table expresses the high-level financial budgets for Fraser Health's revenues and expenses, and the major capital expenditures to support the planned level of services to be delivered. Health authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Budget	2014/15 Budget
Operating Summary				
Provincial government sources	2,658.4	2,791.9	2,910.2	3,037.0
Non-provincial government sources	147.8	142.0	141.3	142.6
Total Revenue:	2,806.2	2,933.9	3,051.5	3,179.6
Acute Care	1,613.4	1,683.5	1,732.2	1,839.8
HCC – Residential	492.8	505.9	541.3	561.0
HCC – Community	244.3	262.4	273.7	274.7
Mental Health & Substance Use	154.2	171.4	176.5	178.5
Population Health & Wellness	72.5	73.2	74.3	75.0
Corporate	228.2	237.5	253.5	250.6
Total Expenditures:	2,805.4	2,933.9	3,051.5	3,179.6
Surplus (Deficit)	0.8	-	-	-
Capital Summary				
Capital Funded by Provincial Government	134.9	237.1	110.6	29.5
Capital Funded by Foundations, Regional Hospital Districts, and other non-government sources	30.9	60.4	34.5	8.49
Total Capital Spending	165.8	297.5	145.1	37.99

Capital Project Summary

Following is a list of Fraser Health Authority approved capital projects over $2 million in total capital cost:

Community Name	Facility Location (as applicable)	Project Name	Total Capital Cost (in millions)
Facility Projects			
Surrey	Surrey Memorial Hospital Site	SMH Site Redevelopment Phase 1A	486.4
Surrey	Surrey	Riverview - Timber Creek - Renovations	16.8
White Rock	Peace Arch Hospital	Electrical Upgrade	3.6
Langley	Langley Memorial Hospital Site	Maternity Unit Expansion	6.5
Mission	Mission Memorial Hospital Site	MMH Campus of Care	31.2
New Westminster	Royal Columbian Hospital Site	RCH Multipurpose Interventional Suite	5.0
Information Management			
Various FHA	Various FHA	Community Care Clinical	5.0
Various FHA	Various FHA	My Health System Integration (Meditech - PARIS)	2.1
Various FHA	Various FHA	PARIS Phase II	3.3
Various FHA	Various FHA	Clinical Roles Based Desktop (Meditech Upgrade)	5.3
Various FHA	Various FHA	Physician Care Manager Phase 1	4.7

Excluded from the above table are those equipment and information technology plans that are grouped together in a single project in WebCAPS, but comprised of numerous under $2.0 million items.

Approved Capital Projects Over $2 million currently underway include:

Jim Pattison Outpatient Care and Surgery Centre

The Jim Pattison Outpatient Care and Surgery Center provides additional space and programming for the expected future volume of outpatient, diagnostic and treatment services, and includes a primary care clinic. The $236.9 million project officially opened on May 31, 2011.

Surrey Memorial Hospital Critical Care Tower and Expansion Project

The new Surrey Memorial Hospital Critical Care Tower will include a new emergency department that is substantially larger than the existing emergency department. The new emergency department area will include specialized units for mental health, geriatric care, a separate children's emergency area, an enhanced minor treatment unit and an improved area for acute patients.

The facility will include a tertiary perinatal centre incorporating 48 neonatal intensive care unit beds to treat premature infants and newborns in critical distress. The maternity department will also be expanded and 13 new obstetric beds will be added.

The project will also include 151 additional inpatient beds thereby increasing the bed capacity at Surrey Memorial Hospital by 30 per cent. An expanded adult intensive care unit (10 new additional beds to a total of 25) will also help meet the acute care needs of Surrey, and will play a crucial role in decreasing emergency room congestion. Additional academic space will be created to support the growing partnership between Fraser Health and the University of British Columbia medical school. A new helipad will be located on the top of the new tower. The

capital cost of the project is $486.4 million. Construction on the new tower began in 2010. The new emergency department is planned to open to patients in the summer 2013, with final construction of the tower complete in spring 2014.

Mission Memorial Hospital – Campus of Care

The Mission Memorial Hospital Campus of Care project will replace two aging residential care facilities in the Mission community (i.e. the Dr Stuart Pavilion and Pleasant View), which do not meet current standards for complex residential care and are considered to be a high priority for replacement by Fraser Health. In addition, this project will build capacity for 49 new beds.

Contact Information

The 2012/13 – 2014/15 Service Plan was prepared by:

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GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE INTERIOR HEALTH AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Interior Health Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The mandate of the Health Authority, defined by the *Health Authorities Act*, is to plan, deliver, monitor, and report on health services, which include population and public health programs, high quality community based health care and support services and acute care, as well as improved productivity and performance.

The mandate for the Health Authority applies to the geographic region stretching from Williams Lake to the US border, and from Kleena Kleene in the Chilcotin to the Alberta border.

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. <u>Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.</u>

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality and management of clinical services to achieve effective, appropriate, efficient and safer care.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by

Government (some of this information is included in annual reports and does not need to be otherwise displayed);

- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and
- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;

- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;
- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;
- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in

the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	Norman Embree Chair of the Board Interior Health Authority
Date	Date

pc: Honourable Christy Clark
Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Dr. Robert Halpenny
President and Chief Executive Officer
Interior Health Authority

Pages 369 through 379 redacted for the following reasons:
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s. 13

Interior
Health Authority

2012/13 – 2014/15
SERVICE PLAN

July 2012

Interior Health

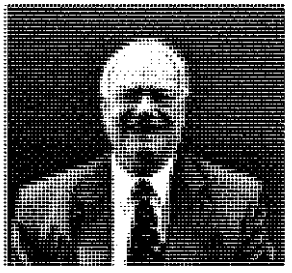
BRITISH COLUMBIA | Ministry of Health

For more information on the
Interior Health Authority
see Contact Information on Page 17 or contact:

Interior Health Authority
220 – 1815 Kirschner Road
Kelowna, BC
V1Y 4N7

or visit our website at
www.interiorhealth.ca

Message from the Board Chair and Accountability Statement



On behalf of the Board of Directors, I am pleased to present Interior Health's three-year Service Plan. The Service Plan provides an overview of our organization and describes the challenging environment we are currently operating in, our priorities for the coming years, and the strategic initiatives by which we intend to achieve our goals. A key aspect of our service planning is aligning with Government priorities. To this end, our goals reflect our responsibilities to promote health and wellness, deliver high quality care, operate in a sustainable manner and foster engagement and health among our employees and physicians.

This Service Plan highlights several initiatives that will assist Interior Health in achieving our goals and meet the needs of the population we serve. Firstly, our commitment to quality is clear by our ongoing efforts to maintain Accreditation Canada's standards of excellence in health services. Secondly, ensuring patients are cared for in the most appropriate settings will continue to be a priority for Interior Health. Appropriate settings vary depending on the needs of patients and communities, but strongly linked to this priority is providing more care in community settings, again, as appropriate. Initiatives to improve access to surgical services and the implementation of clinical care management guidelines to provide standardized, safe, quality care based on best practices remain key areas of focus for Interior Health.

Engaging with our staff and physicians is one of Interior Health's four goals identified in our Service Plan and is also a key priority within our overall strategic direction. In June 2011, Interior Health conducted its first Gallup Employee Engagement Survey, an initiative to help the health authority create a healthier, more productive work environment where staff are valued and engaged in the work they do. The response rate for the survey was exceptional and was the highest amongst all health authorities in British Columbia. The results will help us to determine where to focus improvement efforts as an organization and as a way to evaluate our success in the future.

Of course achieving our goals comes with inherent challenges. As a health authority, Interior Health has a widely dispersed population spread over a large geographic area that includes urban centres as well as many rural communities. Geography and distance present access challenges, both from a transportation perspective and from our ability to recruit a sufficient critical mass of health human resources to deliver quality care. Finally, increased fiscal pressures on public funds will require more effective deployment of our financial resources.

Interior Health continues to invest in capital infrastructure to meet increasing demands for health services and enhance patient care. Key examples include the new Polson Tower in Vernon which opened in September 2011 and the Centennial Tower in Kelowna which opened in the spring of 2012. Furthermore, Interior Health will expand capacity in residential care through the addition of almost 500 residential care beds across the region. Planning continues for possible future hospital expansions in Penticton, Kamloops and Williams Lake.

The *2012/13 - 2014/15 Interior Health Service Plan* was prepared under the Board's direction in accordance with the *Health Authorities Act* and the BC Reporting Principles. The Service Plan is consistent with Government's strategic priorities and Strategic Plan, and the Ministry of Health's goals, objectives and strategies. Interior Health's Board of Directors is accountable for the contents of the Service Plan.

Norman Embree
Board Chair

Table of Contents

Organizational Overview

Interior Health (IH) is mandated by the *Health Authorities Act* to plan, deliver, monitor, and report on publicly funded health services for the people that live within its boundaries. Interior Health's Vision, Mission, Values, and Guiding Principles inform how it delivers on its legislated mandate.

Interior Health provides health services to over 740,000 people across a large geographic area covering almost 215-thousand square kilometres, the geography of which includes larger cities and a multitude of rural and remote communities. Population health needs across the continuum of care drive the mix of services and enabling supports Interior Health provides. This continuum includes staying healthy, getting better, living with illness, and coping with end of life.

Structurally, Interior Health has both service delivery and support portfolios. Service delivery portfolios include:

- Community Integration
- Residential Care
- Acute Services

A variety of support portfolios enable the delivery of care. These include (but are not limited to): Quality and Safety, Health Human Resources, Professional Practice, Medical Administration, Information Management/Information Technology, Laboratory, Diagnostic Imaging, Pharmacy, Planning, Finance, Food Services, Housekeeping, Laundry, and Communications & Public Affairs.

Service delivery is coordinated through a regional "network of care" that includes hospitals, community health centers, residential and assisted living facilities, supports for housing for people with mental health and substance use problems, primary health clinics, homes, schools, and other community settings. Health services are provided by Interior Health staff or through contracted providers.

Vision
To set new standards of excellence in the delivery of health services in the Province of British Columbia

Mission
Promote healthy lifestyles and provide needed health services in a timely, caring and efficient manner, to the highest professional and quality standards

Values

- Quality
- Integrity
- Respect
- Trust

Guiding Principles

- Innovative
- Clear and respectful communication
- Continual growth and learning
- Teamwork
- Equitable access
- Evidence-based practice

Interior Health is governed by a nine-member Board of Directors appointed by and responsible to the Provincial Government. The primary responsibility of the Board is to foster Interior Health's short- and long-term success while remaining aligned with its responsibility to Government and stakeholders.

The day-to-day operations of IH are led by the Chief Executive Officer and a team of senior executives. This Senior Executive Team is responsible for leading strategic and operational services for the health authority and for meeting the health needs of the population of the region in an effective and sustainable manner. Further information about Interior Health's service sectors, Senior Executive Team, and key board policies that may be of interest to stakeholders (as identified in the Disclosure Report on Governance Policies and Practices submitted to the Province's Board Resourcing and Development Office) can be accessed at www.interiorhealth.ca.

Strategic Context

The health system in British Columbia is a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand.

Although the British Columbia health system effectively meets the majority of the population health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to frail seniors, a rising burden of illness from chronic diseases, mental illness and cancer, and advances in technology and pharmaceuticals that drive new costly procedures and treatments. Demand pressures are compounded by the need for new care delivery models by health professionals and health care workers, and the need to maintain and improve the health system's physical infrastructure (i.e. buildings and equipment). In the current economic climate it is even more important for the health system to find new and creative ways to ensure the resources available for health care services are used effectively and in ways that most benefit the people of British Columbia and Interior Health.

British Columbia also faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved significantly in several respects over the past few decades, the Aboriginal population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other residents in British Columbia. Government is working with First Nations, Métis and other partners to improve Aboriginal people's health and to close this gap in health status.

Within the British Columbia context, this Service Plan is based on an understanding of Interior Health's current operations, and of trends and challenges that may impact delivery of health care services into the future. When determining Interior Health's direction, key trends and challenges are considered and include population characteristics, the increasing incidence of chronic diseases, the mix of rural and urban communities, advances in technology and pharmaceuticals, shortfalls in human resources, and infrastructure demands. While these trends are largely outside of Interior Health's control, specific actions are outlined in this Service Plan to influence their impact or outcome.

Population Characteristics

Population characteristics are considered in the planning and delivery of health services provincially and specifically in Interior Health.

In 2011, British Columbia's senior population, aged 65 and over, made up 15 per cent of the province's total population and is expected to double within the next 20 years, making it one of the fastest growing seniors populations in Canada[1]. The aging population is a significant driver of demand as the need for health services rises dramatically with age. In 2006/07 people over age 65 made up 14 per cent of the British Columbia population, but used 33 per cent of physician services, 48 per cent of acute care services, 49 per cent of PharmaCare expenditures, 74 per cent of home and community care services and 93 per cent of residential care services.[2] There is also an increasing need to provide appropriate care for those with frailty or dementia and to help seniors stay healthy, independent and in the community for as long as possible.

Interior Health also continues to face both a growing, and an aging population. The total IH population is expected to be just over 749,000 in 2012, representing 16.1 per cent of the British Columbia population.[3] Between 2012 and 2017, the total population is projected to increase by 5.3 per cent or approximately 39,700

[1] PEOPLE 36 Population Data, BC Stats
[2] Health System Planning Division, Ministry of Health Services; using MSP Expenditures 2006/07; Acute Care: Inpatient and Day Surgery workload weighted cases, DAD 2006/07; HCC community services by age group 2005/06, summed based on average unit costs; Residential care days 2006/07.
[3] PEOPLE 36 Population Data, BC Stats

people. The population in IH over the age of 65 is forecast to be 19.6 per cent in 2012 and increase to 22.1 per cent in 2017. The five year growth rate for the IH over 75 populations is expected to be slightly more rapid than the British Columbia growth rate for this age group.

The population over age 85 is also growing and presents the health system with an increased need to provide appropriate care for those with frailty or dementia, who are unable to live independently at home. This group is forecast to grow by 18.3 per cent in the coming five years.

In 2006, there were 44,900 Aboriginal people living in the Interior Health region, constituting 6.7 per cent of the overall IH population (British Columbia's overall rate is 4.8 per cent).[4] While improvements in overall mortality and increasing life expectancy in the Aboriginal population have been made, significant gaps in health status between Aboriginal and non-Aboriginal populations still exist. For instance, the Aboriginal population in B.C. experiences a disproportionate rate of chronic diseases and injuries compared to other British Columbia residents.[5]

Within Interior Health, there are notable variations in health status and other social determinants of health. Premature mortality has been generally accepted as a good measure of health status and health needs in the population. Vital Statistics data for potential years of life lost index indicate significant variation in premature mortality across IH Local Health Areas (LHAs), with Windermere & Summerland having very low ranking on the index and South Cariboo, Merritt, Lillooet, Cariboo-Chilcotin, and North Thompson having high premature mortality. Provincial socio-economic risk indices highlight the relatively low socio-economic status for Cariboo Chilcotin and Merritt LHAs. Rural areas are often at increased risk of poorer health outcomes and socio-economic risk measures.

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, asthma and some cancers. People with chronic conditions represent approximately 38 per cent of the British Columbia population and consume approximately 80 per cent of the combined physician payment, PharmaCare and acute (hospital) care budgets.[6] Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions within British Columbia could increase 58 per cent over the next 25 years[7] and be a significant driver of demand for health services. Chronic diseases can be prevented or delayed by addressing key risk factors, including physical inactivity, unhealthy eating, obesity, alcohol consumption and tobacco use.

Within Interior Health, circulatory system diseases, cancer, and respiratory diseases are the leading causes of death, and the prevalence of these and other chronic conditions is increasing. Not surprisingly, chronic disease accounts for a significant proportion of health care services used by Interior Health's population. As the population ages, the burden of chronic conditions will increase.

The Rural / Urban Mix

Interior Health covers a large geographic area and serves larger, urban centres alongside a large number of small, rural and remote communities. Only 12 of the 59 incorporated communities in the health authority have a population of 10,000 or more.[8] Within IH there are 53 First Nations Bands, the majority of which are rurally located. Many incorporated rural communities and First Nations Bands may be geographically isolated, and cannot support the same number or types of services available in larger centres. On the other end of the spectrum, there are several larger, growing cities in the health authority that accommodate higher population density and diversity. Urban centers are more complex environments that often have large concentrations of

[4] BC Stats. Statistical Profile of Aboriginal Peoples 2006, Interior Health Authority – 1.
[5] British Columbia Provincial Health Officer (2009). Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Ministry of Healthy Living and Sport.
[6] Discharge Abstract Database (DAD), Medical Services Plan and PharmaCare data 2006/07.
[7] BC Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis*, march 2007, (2007-064); as cited in Primary Health Care Charter: a collaborative approach (2007), Ministry of Health
[8] Statistics Canada. 2011 Census of Canada (Census Subdivisions, Population and Dwelling Counts) (database). Accessed February 8, 2012.

populations with specific health concerns (like isolated seniors or unemployed youth). The challenge for Interior Health is to identify and provide the right mix of services within each community, and to consider how these services will link across the health authority to provide integrated and coordinated care.

From a change perspective, the vast geographic area of IH and the mix of rural and urban populations, presents challenges in planning and implementing new initiatives in communities. Engaging with our staff, physicians and communities will be essential to implementing key initiatives across Interior Health.

Advances in Technology and Pharmaceuticals

New treatment and technology development over the past 10 years has included less invasive surgery, increased use of diagnostic imaging and the introduction of biological and tailored drug therapies that have made health care more efficient and effective, but has also led to a significant increase in demand for products and services. For example, the expansion of technology has seen the number of CT exams increase by approximately 100 per cent and the number of MRI exams increased by almost 170 per cent in the province since 2001.[9] In addition, new surgical techniques and equipment have contributed to expanded use of joint replacement procedures. In British Columbia the number of hip replacements has increased by 102 per cent and the number of knee replacements by 180 per cent over the past decade.[10]

Similarly, Interior Health has also experienced increases in both the number of MRI and CT exams. Between 2003/04 and 2011/12, the number of MRI exams increased 198 per cent while CT exams increased 87 per cent.[11] Additionally, the number of joint replacement procedures performed within Interior Health has also increased. In Interior Health, the number of hip replacements has increased by 83 per cent and the number of knee replacements by 127 per cent between 2001/02 and 2010/11.[12]

Human Resources and Health System Infrastructure

Although attrition rates have recently decreased, projected retirements in the health sector workforce, combined with the rising demand for services are still key challenges that will impact the Province's ability to maintain an adequate supply and mix of health professionals and health care workers. Planning for, and ensuring that we have the required number of qualified health care providers entering the workforce is still important. However, we also need to continue focusing on redesigning health service delivery models so that we are fully leveraging the skill sets of professionals, including creating and supporting integrated health care teams. Through building and maintaining healthy, supportive workplaces that enhance working and learning conditions, we have the opportunity to attract and retain the workforce we need to provide high quality services while ensuring we are flexible enough to adapt to the changing needs of the population as we move forward.

Anticipated retirements by physicians and clinical staff in the coming five to ten years are expected to contribute additional challenges for health service delivery in Interior Health. Physician shortages are exacerbated by the fact that younger cohorts of physicians generally work fewer hours compared with older cohorts.[13] This is often compounded in rural areas, where difficulty recruiting and retaining physicians and clinical staff can limit sustainability of services. Clearly, the health care workforce must change in response to the trends and challenges outlined in this section.

Another challenge in delivering health services is the need to maintain and improve the health system's physical infrastructure, which is faced with the continuous need to update or expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to British Columbians. Interior Health continues to invest available capital funds in new equipment, new facilities and expansions or upgrades to existing facilities and equipment but with the limited investments to date, the organization's capital/ assets are approaching the end of their useful life.

[9] HAMIS/OASIS, Management Information Branch, Planning and Innovation Division, Ministry of Health. As of October 12, 2011
[10] Surgical Patient Registry, MoH, http://www.health.gov.bc.ca/swt/faces/PriorityAreas.jsp. Accessed Jan 13, 2012.
[11] Radiology Information System, IH Meditech System
[12] Discharge Abstract Database, April 2012, Information Support Interior Health
[13] Watson DE, Katz A, Reid RJ, Bogdanovic B, Roos N, Heppner P. Canadian Medical Association Journal. 2004 August 17; 171(4):339-342

Goals, Objectives, Strategies and Performance Measures

IH Goal 1: Improve Health and Wellness

Interior Health will enable people to live healthier lives by working at the environmental, policy, community and individual levels to protect the health of the population, reduce health inequities.

Strategies

- Support communities, including schools, businesses and municipalities to strengthen healthy living opportunities with a focus on healthy eating, physical activity, reduced salt consumption, tobacco reduction and responsible alcohol use in order to reduce childhood obesity and the prevalence of chronic disease.
- Meet the needs of First Nations and Aboriginal communities by collaborating with them to plan and deliver culturally sensitive health care services and to monitor health outcomes. This includes aligning services with the development of the First Nations Health Authority.
- Assess, recommend and implement actions to improve the health of Interior Health's population through smoking cessation initiatives and by ensuring and maintaining water quality.
- Partner with patients, clients, residents and their families to participate, as they choose, in the delivery of their health care and in the planning, design, and evaluation of health services.

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average daily sodium content of adult hospital diets	2700 mg	2700 mg	2400 mg	2300 mg

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure focuses on the average sodium content of the general/regular diets for adults within health authority owned and/or operated hospitals. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and asthma. According to the World Health Organization, interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective.[14]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease.[15] Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. British Columbia has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the Guidelines for Food and Beverage Sales in British Columbia Schools.

Health authorities are required to reduce the average sodium content of the general/regular hospital diet for adults to the population goal of an average intake of 2300 mg of sodium per day by 2016.

[14] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21
[15] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21.

Performance Measure 2: Health of Aboriginal Children

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of Aboriginal Kindergarten children receiving vision screening	87%	89%	91%	93%

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure supports Aboriginal children's access to vision screening. Vision deficits such as amblyopia (lazy eye), strabismus (crossed eyes), and refractive errors (nearsightedness and farsightedness) are common problems in the preschool and school age population. Early detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child's opportunity for academic success and learning potential.

IH Goal 2: Deliver High Quality Care.

Interior Health will provide care that is accessible, safe, effective, evidence informed, and delivered in the most appropriate setting. This care will be respectful of and responsive to the preferences and values of patients, clients, residents and their families.

Strategies

- Work with physicians and other stakeholders to shift care to the community by developing collaborative planning and decision making structures and integrating community based services and supports to meet population health needs. Interior Health will partner with Divisions of Family Practice working groups to develop and implement initiatives that focus on target populations.
- Improve services in the community for Mental Health and Substance Use (MHSU) clients, with a focus on children and youth, the elderly, Aboriginal populations, and marginalized populations to improve health outcomes. This includes developing and implementing 30 day follow up plans for clients at MHSU acute settings and reducing return rates to emergency departments.
- Develop and implement chronic disease prevention and management strategies focusing on diabetes, heart failure and chronic obstructive pulmonary disease.
- Implement initiatives to ensure patients have access to the care they need and smooth transitions between sectors. This includes the strategies to reduce Alternate Level of Care rates in acute care through the development of standardized coding processes.
- Implement and evaluate Patient Focused Funding initiatives to shift both surgical and non-surgical procedures from inpatient acute care settings to day clinics or outpatient settings.
- Improve quality of and access to surgical services by developing, implementing and evaluating clinical practice guidelines and pathways.
- Improve patient transport services. This includes expanding High Acuity Response Teams in the region to provide high acuity inter-facility ground transfers, integrating paramedics into health authority operations, improving low-acuity transportation services and implementing care guidelines and transportation protocols.
- Develop and implement a strategy for laboratory and diagnostic imaging services to ensure appropriate access and equitable outcomes for rural and remote sites.

- Continue to implement phased plan for evidence informed clinical care guidelines and safety initiatives in community, acute care, and residential settings including ones for falls prevention and medication management.
- Develop an IH End-of Life plan which incorporates provincial components to meet the rural and urban needs of our palliative population.
- Improve physician credentialing, privileging, and peer-review processes to improve the quality of care and public confidence in the services.
- Meet or exceed Accreditation standards of excellence.
- Meet the health care needs of seniors by implementing the BC Seniors Action Plan and other clinical initiatives. This includes the development of an IH Dementia Strategy as well as the implementation of Advance Care Planning and Advance Directives protocols.

Performance Measure 3: Managing Chronic Disease in the Community

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people under 75 years with a chronic disease admitted to hospital (per 100,000 people)	329	269	244	214

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health
Note: The 2009/10 baseline has been restated from 317 to 329, according to the new methodology of the Canadian Institute for Health Information, which determines the calculation of this rate nationally. The new methodology includes more people with diabetes.

Discussion

This performance measure tracks the number of people with selected chronic diseases, such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic diseases need the expertise and support of family doctors and other health care providers to manage their disease in the community in order to maintain their functioning and reduce complications that will require more medical care. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which help to control the costs of health care. As part of a larger initiative of strengthening community based health care and support services, family doctors, home health care providers and other health care professionals are working to provide better care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home Health Care and Support for Seniors

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of people aged 75+ receiving home health care and support	19.9%	20.2%	20.3%	20.4%

Data Source: P.E.O.P.L.E. 35, population estimates, BC Stats 2. Continuing Care Data Warehouse, Management Information Branch, Health System Planning Division, Ministry of Health. A small amount of baseline data is currently unavailable due to the transition to new reporting mechanisms. 3. Home and community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management information Branch, Planning and Innovation Division, Ministry of Health.

Note: The data for this measure may be restated at a later time when the new data reporting system is fully implemented. Targets may be revised accordingly.

Discussion

This performance measure tracks the per cent of seniors (aged 75+ yrs) who receive home health care such as home nursing and rehabilitative care, clinical social work, light housekeeping, assisted living and adult day programs. While the majority of seniors experience healthy aging at home, there is a growing need for community care options to support those who can no longer live independently. This support helps people manage chronic disease and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community-based health care and support services, the health authorities are expanding home health care services and ensuring that high risk seniors are made a priority in the provision of care. This focus, combined with the use of technology, can significantly improve health outcomes for seniors.

Performance Measure 5: Access to Surgery

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of non-emergency surgeries completed within the benchmark wait time	71%	72%	79%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Health System Planning Division, Ministry of Health. Notes:

1. The total wait time is the difference between the date the booking form is received at the hospital and the report date (end of the month). The day the booking form is received at the hospital is NOT counted.
2. This measure uses adjusted wait times that are calculated by excluding periods when the patient is unavailable from the total wait time.

Discussion

In the last several years, British Columbia's health system has successfully reduced wait times for cataract, hip and knee replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding, combined with continuous effort to foster innovation and efficiency in British Columbia's hospitals, will improve the timeliness of patients' access to an expanding range of surgical procedures. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times. These benchmark wait times are new and give a priority rating for each surgical patient, based on individual need. Because of the need to 'catch up' on surgeries for patients without a priority rating who have already been waiting, surgery for some patients with the new priority rating may be delayed. The target for 2012/13 will allow for this 'catch up' period, after which wait times for patients with priority ratings should gradually decrease.

IH Goal 3: Ensure Sustainable Health Care by Improving Innovation, Productivity, and Efficiency

Interior Health will promote new ways of working to provide better service and reduce costs.

Strategies

- Implement innovative approaches and service delivery models. This includes:
  - Achieving financial targets and administrative cost savings through Shared Services Organization and consolidation.
  - Collaborating with Northern Health Authority and other system partners on administrative opportunities to enhance efficiencies.
  - Developing acute care service benchmarks to monitor cost efficiency and productivity of similar programs across multiple sites in order to ensure resources are used more effectively and efficiently.
  - Focusing on process improvement by applying quality improvement approaches including Lean.
  - Developing strategies to identify priority clinical applications for telehealth.
- Develop priority plans and transparent decision-making and accountability processes to achieve objectives and mitigate risks. This includes:
  - Developing and implementing an Enterprise Risk Management Framework.
  - Ensuring all levels of IH are capable of responding to and managing significant incidents, disasters, and emergencies.
  - Advancing capital planning efforts to ensure the ongoing provision of IH infrastructure, equipment and technology.
- Ensure sustainability of services by developing health human resource business continuity and succession plans.
- Enhance information technology solutions to meet population health service needs. This includes electronic care delivery solutions, Provincial eHealth initiatives, and enhancing telehealth infrastructure.
- Engage in community consultations and partner with community stakeholders to actively meet population health needs.
- Enhance academic capacity by working with UBC and other academic partners to provide clinical education experiences for physician undergraduates/residents.

Performance Measure 6: Nursing Overtime

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Nursing overtime hours as a per cent of productive nursing hours	3.0% (2010 calendar year)	No more than 3.5%	No more than 3.4%	No more than 3.3%

Data Source: Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

Discussion

This performance measure compares the amount of overtime worked by nurses to the overall amount of time nurses work. Overtime is a key indicator of the overall health of a workplace. High rates of overtime may reflect inadequate staffing or high levels of absenteeism, resulting in workload issues and increased costs. Reducing overtime rates by addressing the underlying causes not only assists in reducing direct (e.g. labour) and indirect (e.g. unengaged staff) costs to the health system, it also helps promote both patient and caregiver safety.

IH Goal 4: Cultivate an Engaged Workforce and a Healthy Workplace

Interior Health will enhance relationships and encourage all who work or volunteer with Interior Health to reach their full potential. Advance practices in the workplace that address health and safety issues, and influence individual life style choices.

Strategies

- Create a healthy and safe work environment by implementing respectful workplace environment initiatives and health and safety initiatives.
- Improve employee, physician, and volunteer engagement by building on the metrics and tools from the Gallup Employee Engagement Survey.
- Work collaboratively with partners to enhance leadership capacity.

Resource Summary

($ millions)	2011/12 Actual	2012/13 Budget (note 1)	2013/14 Plan (note 1)	2014/15 Plan (note 1)
OPERATING SUMMARY				
Provincial government sources	1,621.7	1,680.2	1,741.7	1,769.2
Non-provincial government sources	139.3	135.6	135.5	135.6
Total Revenue:	1,761.0	1,815.8	1,877.3	1,904.8
Acute Care	950.7	985.4	1,026.1	1,042.3
Residential Care	340.2	353.5	372.0	375.3
Community Care	177.3	188.5	191.1	192.9
Mental Health & Substance Use	108.9	117.2	119.3	120.5
Population Health & Wellness	52.1	56.2	57.5	58.0
Corporate	126.2	115.0	111.3	115.8
Total Expenditures:	1,755.4	1,815.8	1,877.3	1,904.8
Surplus (Deficit)	5.6	nil	nil	nil
CAPITAL SUMMARY				
Funded by Provincial Government	55.6	83.1	58.2	55.2
Funded by Foundations, Regional Hospital Districts, and other non-government sources	78.9	59.7	30.6	24.2
Total Capital Spending	134.5	142.8	88.8	79.4

Note 1: The 2012/13 Operating Budget and 2013/14 and 2014/15 Operating Plans exclude any potential revenue or related expenditures related to BC HSPO Patient Focused Funding. These amounts are included in the 2011/12 actuals.

Note 2: Health authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

Capital Project Summary

The following table lists capital projects currently underway that have a project budget greater than $2 million. Some of these projects commenced prior to the 2011/12 fiscal year, some are substantially complete (e.g. Arrow Lakes Health Centre Residential Care Addition), while others will be constructed over the next few years such (Kelowna Interior Heart and Surgical Centre).

Community Name	Facility location	Project Name	Total Project Cost ($ million)
Facility Projects			
Kelowna/Vernon	Kelowna General Hospital / Vernon Jubilee Hospital	Kelowna General Hospital – Patient Care Tower UBCO Clinical Academic Campus Vernon Jubilee Hospital – Patient Care Tower	436.1[16]
Kelowna	Kelowna General Hospital	Interior Heart and Surgical Centre	381.5 [16/17]
Kelowna	Kelowna General Hospital	Coronary Revascularization – Transition Plan	21.1[17]
Nelson	Kootenay Lake Hospital	Emergency Department Redevelopment & CT Scanner	14.9
Kamloops	Royal Inland Hospital	Intensive Care Unit Renovation	11.0
Kamloops	Royal Inland Hospital	Medical Device Reprocessing Redesign and Expansion	10.8
100 Mile House	Fischer Place/Mill Site Lodge	Residential Care Addition	7.2
Invermere	Invermere Hospital	Redevelopment & Emergency Department Expansion	4.3
Keremeos	South Similkameen Health Centre	Residential Care Addition – 10 beds	4.2
Nakusp	Arrow Lakes Health Centre	Residential Care Addition – 10 beds	3.8
Vernon	Vernon Jubilee Hospital	P3 Maintenance Obligations	3.6

[16] Including planning costs
[17] Excluding reserves held by the Province

Contact Information

For more information about Interior Health and the services it provides, visit www.interiorhealth.ca or contact:

Interior Health Administrative Offices
220-1815 Kirschner Road
Kelowna, BC V1Y 4N7
Phone: 250-862-4200
Fax: 250-862-4201
Email: webmaster@interiorhealth.ca

Hyperlinks to Additional Information

Ministry of Health - www.gov.bc.ca/health/

Interior Health Authority - www.interiorhealth.ca/

Fraser Health Authority - www.fraserhealth.ca

Northern Health Authority – www.northernhealth.ca/

Provincial Health Services Authority - www.phsa.ca/default.htm

Vancouver Coastal Health Authority - www.vch.ca/

Vancouver Island Health Authority - www.viha.ca/

HealthLink BC - www.healthlinkbc.ca

GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE NORTHERN HEALTH AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Northern Health Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The mandate of the Health Authority, defined by the *Health Authorities Act*, is to plan, deliver, monitor, and report on health services, which include population and public health programs, high quality community based health care and support services and acute care, as well as improved productivity and performance.

The mandate for the Health Authority applies to the geographic region stretching from (and including) Quesnel, and is bordered by the Northwest and Yukon Territories, Alberta, Alaska and the Pacific Ocean.

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. <u>Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.</u>

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality and management of clinical services to achieve effective, appropriate, efficient and safer care.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by

Government (some of this information is included in annual reports and does not need to be otherwise displayed);

- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and
- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;

- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;
- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;
- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in

the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	Dr. Charles Jago Chair of the Board Northern Health Authority
Date	Date

pc: Honourable Christy Clark
Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Cathy Ulrich
President and Chief Executive Officer
Northern Health Authority

Pages 407 through 417 redacted for the following reasons:
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Northern Health

2012/13 – 2014/15
SERVICE PLAN

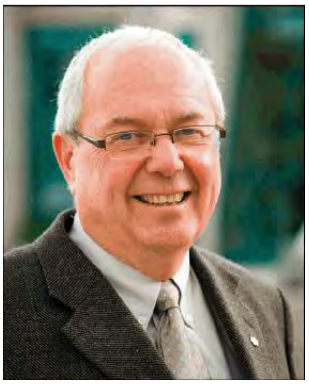
2012

For more information on
Northern Health, see Contact Information (page 23)

Northern Health
#600 299 Victoria Street
Prince George, British Columbia
V2L 5B8

www.northernhealth.ca

Message from the Board Chair *and* Accountability Statement



Dr. Charles Jago, C.M., Board Chair

On behalf of the Board of Northern Health, I am pleased to present to you Northern Health's Service Plan for 2012/13 – 2014/15.

The past year has been successful for Northern Health. Surveyors from Accreditation Canada visited many of our sites in June 2011. Northern Health received accredited status and feedback from the surveyors was very positive and encouraging. There was specific interest in the focus of our Strategic Plan and the ways in which the organization is moving toward its fulfillment. Mention was made of a number of successes in governance, partnership, quality improvement, infection control, risk management, public health initiatives such as Road Health, community integration/primary health care and information management. Accreditation Canada continues to seek focused improvement efforts specific to practices considered to be Required Organizational Practices (ROP's) so the Board will look to pay further attention to these in the upcoming years.

Northern Health has seen a marked improvement in employee engagement. 2011/12 saw the third iteration of the Employee Engagement Survey. While the level of engagement falls short of the ideal, the Board members are pleased with the improvement that has been demonstrated since the first survey in 2007.

Northern Health has worked with the six Regional Hospital Districts, Foundations and Auxiliaries to implement significant capital development projects across the region. In Fort St John, where a new hospital and residential care facility nears completion, $112 million has been spent this year. In Prince George, as major components of the Northern Cancer Strategy, Northern Health completed diagnostic service upgrades and infrastructure improvements at the University Hospital of Northern British Columbia totaling $6.4 million. The Northern Cancer Control Strategy continues to unfold and there has been tremendous success in recruitment of critical medical positions. Further capital projects to keep our facilities running efficiently have been undertaken. These Building Integrity projects across Northern Health total $6.8 million.

Consistent with the Board's expectation, the 2011/12 fiscal year ended with a small surplus. The Board continues to applaud the organization's operational leadership and staff for the strong and ongoing work to achieve efficiencies while maintaining or growing service delivery.

In 2012/13, Northern Health will continue to enact and direct resources toward its strategic plan and priorities. Northern Health will accelerate work in partnership with physicians to establish integrated, multidisciplinary "primary health care homes" as they are seen as foundational to improvements in health.

At the same time, a variety of steps will be taken to engage with staff and physicians with the purpose of continuously improving the quality of services provided to the residents of northern British Columbia.

As always, Northern Health will continue to develop and deliver balanced budgets for 2012/13 through to 2014/15. While, overall, the economic picture is improving, the improvements and prospects are not necessarily consistent across the region. In upcoming years, Northern Health will face some challenges as the organization seeks to ensure levels of service that align well with needs as community size, demographics and socio-economic conditions change. As a Board, we are confident in the future of Northern Health, in our staff, physicians and volunteers, and in their ability to rise to these challenges. Northern Health will respond to the people it serves, provide quality health services, and continue to seek innovation in order to make Northern Health the model for outstanding rural health care delivery.

The 2012/13 – 2014/15 Northern Health Service Plan was prepared under the Board's direction in accordance with the Health Authorities Act and the British Columbia Reporting Principles. The Service Plan is consistent with Government's strategic priorities and Strategic Plan, and the Ministry of Health goals, objectives and strategies. The Board is accountable for the contents of the Service Plan, including the selection of performance measures and targets.

On behalf of the Board,

Dr. Charles Jago

Board Chair, Northern Health

April 2012

Table of Contents

Overview of Northern Health

Northern Health provides a full range of health care services to the 289,974[1] residents of Northern British Columbia. Serving an area of 592,116 square kilometers[2], it is the largest health region in the province, covering over two-thirds of British Columbia and comprising largely rural and remote communities.

The Health Authorities Act[3] gives Northern Health the legislative authority to develop policies, set priorities, prepare budgets and allocate resources for the delivery of health services under a regional health plan that includes: (i) health services provided in the region, or in a part of the region, (ii) type, size and location of facilities in the region, (iii) programs for delivering health services in the region, and (iv) human resources requirements under the regional health plan. Northern Health provides the following health services:

- Acute care services at 18 hospitals[4] and nine diagnostic and treatment centres;
- Residential long term care at 13 complex care facilities, and in 10 acute care facilities;[5]
- Home support services and home care nursing visits to clients in their homes;
- Mental health and substance use services, including an extensive network of inpatient, clinic and community services; and
- Population and public health services focusing on health promotion and injury prevention toward the improvement of health for people across the North.

Northern Health works collaboratively with a medical staff -comprising 241 family physicians and 125 medical and surgical specialists. Northern Health is organized into three Health Service Delivery Areas (HSDAs): the Northeast, the Northwest, and the Northern Interior. Each HSDA is led by a Chief Operating Officer, who has overall responsibility for the operations of his or her HSDA. Reporting to each Chief Operating Officer are Health Service Administrators, senior managers who handle the day-to-day provision of services in their community cluster. There are currently ten Health Service Administrators in Northern Health.

Northern Health is moving to an organizational structure that is highly integrated at the community and HSDA levels. Services including mental health and substance use and home and community care will be managed within the HSDA, with regional coordination and quality improvement through program councils that are supported clinically and administratively. Population and public health is coordinated on a regional basis. Aboriginal Health is centrally led by an executive director providing expert advice, guidance and oversight. Much of the improvement activity in this area is coordinated by local Aboriginal Health Improvement Councils -- collaborative groups designed to enhance relationship-building with Aboriginal communities and guide Northern Health in the culturally competent delivery of appropriate services.

Corporate services, including finance, human resources, materials management, and others, are based in Prince George. Northern Health is an active partner in the province's Health Shared Services BC.

Northern Health is committed to primary care renewal: working through physicians and community programs to keep people healthy, prevent hospital admissions, and actively manage chronic health conditions such as diabetes or high blood pressure. The vast majority of northern physicians practice within Northern Health facilities. They recognize the need for focusing on quality in primary health care and are actively participating with Northern Health to improve service delivery.

Residential complex care facilities in the North are operated by Northern Health, with the exception of two[6] operated under contract. Most northern assisted living facilities are operated by non-profit societies, with Northern Health providing personal care support services and nursing care in most of these settings.

Northern Health is governed by a Board of Directors following the best practices outlined in Part 3 of the Board Resourcing and Development Office's *Best Practice Guidelines Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations*.

Strategic Context

The context for providing health services in British Columbia, and across northern British Columbia, is complex and ever-changing. When planning for the next three years, a number of environmental factors must be considered. These are presented below.

Rural and Remote Nature of Northern British Columbia

With small clustered populations (less than 0.4 persons per sq. km)[7] scattered across vast geographies, economies of scale are difficult to achieve, accessing services is difficult, and referrals and relationships between practitioners are complicated.[8] Additionally, many communities are on the other side of the digital divide and lack other supporting infrastructures such as low-cost public transit.[9]

As it is a highly distributed health region, relatively small facilities/services are common in Northern Health. These are difficult to maintain, as they are often dramatically impacted by the presence or absence of a single individual. The departure of one practitioner, for instance, can have a significant impact. They also operate within a cost structure that is nearly all fixed. Therefore, efficiencies are not available "on the margin" –facilities and services are either open or they are not.

The distributed nature of the northern population challenges Northern Health when considering service distribution and mix. Many types of service benefit both in efficiency and effectiveness from consolidation into units that can achieve critical staffing levels and patient volumes. It is often true that service quality is directly related to volume of work and repetition of clinical skills. In spite of this, healthcare services are seen as essential to sustainability of each of our communities and patients have an overall preference for service closer to home.

To address this paradox, Northern Health has entered into dialogue with some of our communities to collectively and creatively find the right balance of sustainable local service and strong, reliable secondary/specialty services as close to home as possible.

Dynamic and Changing Resource Economy

The northern economy is significantly a resource based economy that has been described as the "engine" of British Columbia's economy. Estimates suggest that approximately 1/3 of British Columbia's total Gross Domestic Product (GDP) stems from export of natural resources which arise, predominantly, from the North.[10] Resource based research and development continues to flourish in the North as do efforts to enhance and expand infrastructure (transportation, energy and communications) to enable further commercialization.

While northern development is a very positive thing, it is important to recognize the inherent changes and challenges arising. Developments in energy and mining industries offset declines/challenges in forestry – necessitating a fundamental realignment of labour and support and conferring different impacts in communities across the region. Northern British Columbia is now host to over 1,800 camps of varying size and composition. Northern Health is making a considerable effort to understand the existing and potential impact of this non-census population as we work with industry to ensure good alignment between health needs and services as economic development/transformation continues in northern British Columbia.

Human Resources and Health System Infrastructure

Although education and training programs for health professionals and health workers in British Columbia have significantly expanded since 2001, ensuring the availability of human resources remains a challenge for the health care system. As the population ages, so does the health care workforce. Looming retirements in the health workforce combined with the rising demand for services and increased national and international competition for health professionals impact the province's ability to maintain an adequate supply and mix of health professionals and workers. As new staff members are recruited, Northern Health must respond to a new set of challenges, including variations in values, broader family needs/expectations, and different management styles and levels of comfort with technology. As a larger proportion of staff members are in

their childbearing years, Northern Health will also face greater needs for employment flexibility and temporary coverage solutions.

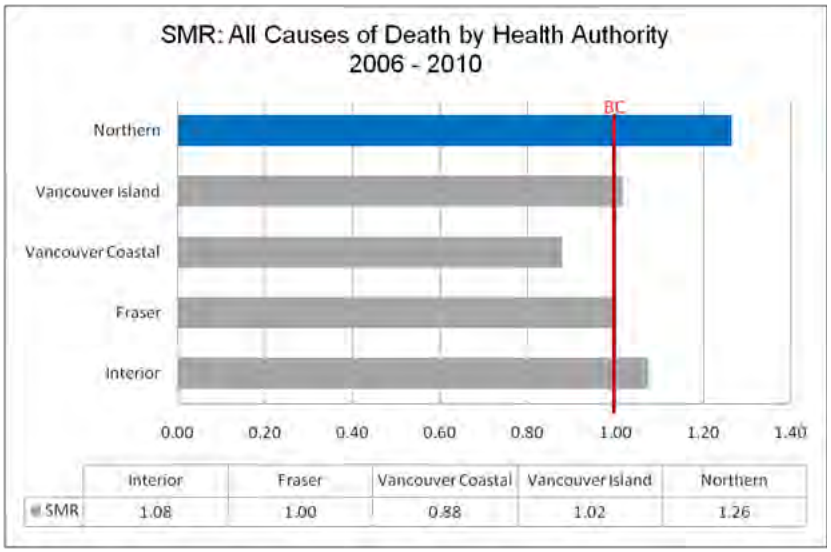
Given Northern Health's unique rural context and service mix, there will continue to be a need for ongoing development of Northern education in partnership with community colleges and the University of Northern British Columbia (UNBC).

Another challenge in delivering health services is the continuous need to update/expand health facilities, medical equipment and information technology to ensure they provide high-quality, safe health care. While a number of capital projects are under way within Northern Health, including renovations to the University Hospital of Northern British Columbia (UHNBC) and the replacement of the Fort St. John Hospital and North Peace Care Centre, there are other facilities and information technology systems that need improvements.

Health Status

Residents of Northern British Columbia have significantly poorer health than residents of the province as a whole. This burden is broadly distributed throughout the population and is not, as is commonly supposed, only associated with poorer health among Aboriginal people.

This poorer health status is reflected in all health indicators, including the Standardized Mortality Ratio (SMR), which compares the actual number of deaths in a population to the number of deaths that are expected. As demonstrated in Figure 1, the SMR for Northern Health residents is 1.26. [11]



Based on data from British Columbia Vital Statistics Agency Annual Reports.
http://www.vs.gov.bc.ca/

Figure 1: Standardized Mortality Ratio (SMR) for all causes of death, by British Columbia health authority

This means that, after adjusting for age, there are 26 per cent more deaths in northern BC than would occur if its residents enjoyed the average health of British Columbians.

The SMR for other British Columbia health authorities is in the range of 0.88 to 1.08. The SMR has been correlated with poorer health status (particularly with the incidence of chronic conditions), a higher burden of illness, and with more use of health services. [12] [13]

Aboriginal Peoples and Communities

While the health status of Aboriginal people has improved in several respects over the past few decades, the Aboriginal population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other British Columbia residents.

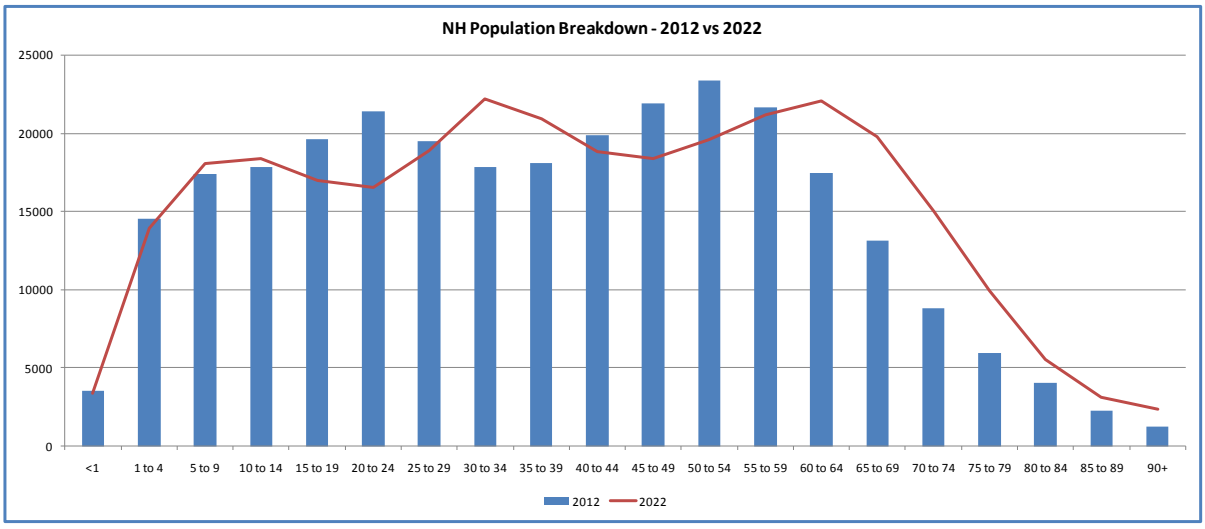
Overall, approximately 17.5 per cent of the population of the Northern Health region is Aboriginal (primarily First Nations but with a significant number of Métis and Inuit people as well). This is the highest proportion of Aboriginal people of all British Columbia with the other health regions ranging from 2.4 to 6.7 per cent. Within Northern Health, the highest proportion of Aboriginal people is in the Northwest HSDA. [14]

Population Change

While the British Columbia population is experiencing significant growth overall, the total population of Northern British Columbia is not expected to increase dramatically over the next 15 years. Between 2012 and 2026 the total population is expected to increase by just 6.9 per cent (from 292,030 to 312,262), averaging to 0.5per cent per year. This aggregate analysis, however, masks two somewhat paradoxical challenges facing Northern Health arising from changes in the composition of the population and its resultant impact on family stability and dynamics:

- A rapidly aging population, bringing with it a variety of health challenges including frailty, chronic disease and dementia
- Proportionately more children and youth, many of whom are considered "at risk."

The bimodal (a distribution with two peaks) and aging nature of the northern British Columbia population can be seen in the following chart for 2012 with projections to 2022.



The Aging Population

British Columbia's elderly population is the fastest growing in Canada. Within the next 10 years there will be fewer school age children than people over 65, and more people retiring than entering the workforce. The aging population is a significant driver of demand since the need for health services rises dramatically with age.

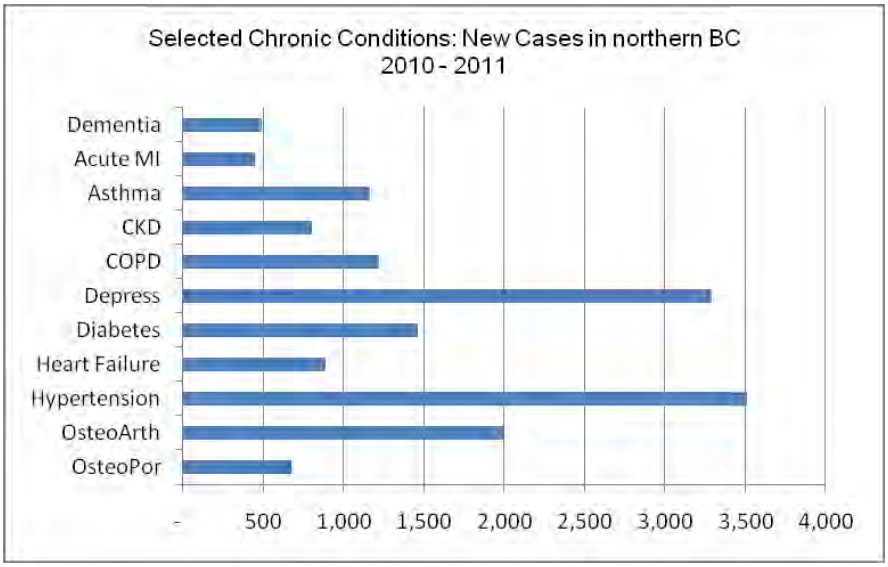
Northern Health will be significantly challenged by the upcoming growth of the northern British Columbia seniors' population. Although the percentage of seniors in the region's general population is currently the smallest of all the health regions (approximately 11.5 per cent), the seniors population is expected to grow quickly over the next 15 years from 2012 to 2026. During this period, both the 65+ and the 75+ populations are expected to grow by over 82 per cent and 91 per cent respectively. These are the highest growth rates of all the health authorities and effectively represent a near doubling of these populations by 2026. [15] While many elderly British Columbians enjoy good health, aging continues to be associated with a variety of complex health challenges necessitating a wide range of health services and family supports from acute through to palliative care. Frailty, increasing symptoms of chronic disease and dementia are three related challenges facing the health system as the population ages.

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis and asthma. People with chronic conditions represent approximately 34 per cent of the B.C. population and consume approximately 80 per cent of the combined physician payment, PharmaCare and acute (hospital) care budgets. [16]

The evidence shows there are opportunities to prevent these diseases and that many deaths, hospitalizations and costs can be attributed to a handful of risk factors: smoking; obesity; physical-inactivity; and, poor nutrition. It is known that addressing these risk factors can prevent or delay the onset of many chronic conditions. [17] The evidence also shows that there are opportunities to better manage these conditions and to improve outcomes through integrated approaches that include patient self-management strategies.[18] [19] [20]

During 2010 /11 there were an estimated 15,955 newly diagnosed cases related to chronic illness among northern residents.[21] The graph below shows the relative proportions for each of these conditions.



Source: British Columbia Ministry of Health, Medical Service Economic Analysis Branch, Chronic Conditions by Cost, Incidence and Prevalence: 2001/02 - 2010/11: February 2012.

With the recent advances in health, we might consider the impact of expanding the existing definition of chronic diseases to include certain cancers, mental illnesses, HIV, and Hepatitis C, as people with these conditions can often live long, productive and rewarding lives if their care is well managed. [22] [23] [24]

Since many chronic conditions appear in older populations and our population is aging, we can expect that the prevalence of chronic conditions will increase. This will drive a significant demand for health services.

Frailty and Dementia

Frailty is a general term reflecting weakness, susceptibility to sickness/injury and prolonged recovery faced by a proportion of the population, particularly in aging. Such individuals often interact frequently with the health service system such that frail elderly individuals are usually the highest users of healthcare services in northern communities. When in care, they face significant risk of further difficulties as they are susceptible to nosocomial (in facility) infection, falls, depression and other forms of decompensation.

Dementia is a condition where cognitive ability declines in a manner beyond that associated with normal aging. While dementia can arise in non-elderly individuals, its prevalence is highest among those aged 75 and above. Individuals with dementia often need a variety of supports either at home or in conjunction with some form of residential care. While relatively rare, dementia can be associated with wandering and violent behaviours so can be particularly challenging in home and residential care settings when the individual is otherwise relatively physically able.

The table below provides the 2012 population for northern British Columbia aged 75+ along with a projection to 2022. Beside the overall 75+ population are estimates of the number of individuals in the North who may be considered frail and those with mild, moderate and severe dementias. Estimates of frailty are made

based on assessments and use of services such as non-acute home nursing and support, residential care, and assisted living supports. Dementia is estimated using the Cognitive Performance Scale (CPS) which is part of the assessment for home care and residential care services. Projecting existing estimates of frailty (approximately 16.5 per cent of the 75+ population) and moderate and severe dementia (approximately 4.6 per cent of the 75+ population) forward to 2022, it can be anticipated that Northern Health will see an increase in the order of 50 per cent in the number of individuals who are frail and/or experience dementia (moderate and severe) over the next ten years. This increase threatens to place a significant burden on primary, acute and long-term care health services unless new ways of managing dementia and/or serving individuals with dementia can be found.

Year	Population 75+	Frailty		CPS 2: Mild		CPS 3-4: Moderate		CPS 5-6: Severe	
	(PEOPLE36)	#	% of Pop	#	% of Pop	#	% of Pop	#	% of Pop
2012	13,536	2,237	16.5%	466	3.4%	419	3.1%	207	1.5%
2022	21,036	3,476	16.5%	724	3.4%	651	3.1%	322	1.5%

*Straight line prevalence projections based on population change

Proportionately More Children and Youth: Many at Risk

Northern British Columbia has proportionately more children in the population than the rest of British Columbia. As shown in the table below, overall birth counts have risen in recent years with the greatest increase seen in the Northeast.

Deliveries by Northern British Columbia Mothers, 2005/06 through to 2009/10

Mother's HSDA	**2005/2006**	**2009/10**	**5-Year % Change**
Northeast	878	1,051	20.2%
Northern Interior	1,607	1,680	4.5%
Northwest	879	890	1.2%
NORTHERN HEALTH Total	**3,364**	**3,621**	**7.6%**

Source: Northern Health Mothers that Delivered a Baby in British Columbia: British Columbia Perinatal Database Registry: Special analysis for Northern Health. Request No. 2011011. June 2011. http://chip.northernhealth.ca

Given the distributed nature of northern British Columbia communities, Northern Health faces a particular challenge in ensuring accessible, high quality perinatal services. Some individual facilities in the Lower Mainland see volumes equivalent to or greater than those of the northern British Columbia total but in the North they are spread over a geographic area of some 592,000 square kilometres.

Currently, children and youth between the ages of 0 – 17 years comprise about 24 per cent of the Northern British Columbia population whereas for British Columbia overall, the proportion is about 19 per cent. [25] At least 22 per cent of the population aged 0 - 17 in Northern British Columbia is Aboriginal. This proportion is three times that of British Columbia overall, double that of Interior Health or Vancouver Island Health Authorities and five times greater than the Fraser or Vancouver Coastal Health Authorities. [26] This young population has unique health needs and can be difficult to reach for a number of reasons. The consistently high teen pregnancy and birth rates in northern British Columbia may be reflective of this challenge as it is assumed that most pregnancies among teens are unintended. [27] [28]

In addition to having a larger proportion of children and youth, it is well known that a significant number of children and youth in northern British Columbia are considered to be "at risk". For example, the Northwest and Northern Interior HSDAs have the highest percentage of children living in families receiving Income Assistance. In other words, many children are living in poverty and deprivation. The Northwest and Northern Interior HSDAs also have the highest percentages of youth receiving Employment Insurance and are further distinguished as the areas with the highest child neglect and abuse rates in the province. Throughout the North, academic achievement and high school graduation rates fall far behind other areas in British Columbia. [29] [30]

We know that these circumstances are predictive of individual future success and of health needs. This is why they are called the "Determinants of Health." [31] We also know that most, if not all, of these circumstances are outside of the direct control of the health system. This is why Northern Health is committed to "a Population Health Approach" and, through community based initiatives in Primary Health Care, to building partnerships with communities, other agencies and organizations. [32]

Mental Health and Substance Use Disorders

In addition to the pressures arising from the upcoming demographic changes, mental health and substance use issues continue as endemic factors in northern rural communities. While some aboriginal communities face particularly severe challenges with evidence of higher rates of addiction and suicide, non-aboriginal communities face significant pressures as well. Mental health and substance use issues pose a significant challenge to the health care system. They are, in and of themselves, difficult to address and recidivism rates are high, especially where affected individuals cannot easily leave a high risk environment. Homelessness or unreliable low standard housing and minimal positive family/social networks continually expose individuals to risk and offer little in the way of reliable support. Mental health and substance use issues also present as difficult underlying complications in other clinical/physical problems, preventing or significantly impeding successful treatment and management.

Goals, Objectives and Performance Measures

Northern Health is responsible for providing health services within the context of government priorities and directions. The Ministry of Health has established four overarching goals that set the context for Northern Health:

- Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians;
- British Columbians have the majority of their health needs met by high-quality primary and community-based health care and support services;
- British Columbians have access to high-quality hospital services when needed; and
- Improved innovation, productivity and efficiency in the delivery of health services.

On February 23, 2009, the Northern Health Board publicly announced a new Strategic Plan for 2009 to 2015. The Strategic Plan was developed following extensive consultation with key stakeholders across the region. The Strategic Plan's Mission, Vision, and Values provide the framework for oversight and management over the next four to five years.

Goals and Objectives

In addition to the Mission, Vision and Values, the Northern Health Board has established four focused strategic priorities. The following table presents Northern Health's strategic priorities within the context of the government's goals.

Ministry of Health Goals	Northern Health Strategic Direction
Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians	***A Population Health Approach*** *Northern Health will lead initiatives that improve the health of the people we serve.*
British Columbians have the majority of their health needs met by high-quality primary and community based health care and support services.	***Integrated Accessible Health Services*** *Northern people will have access to integrated health services, built on a foundation of primary health care.*
British Columbians have access to high-quality hospital services when needed.	***High-Quality Services*** *Northern Health will ensure quality in all aspects of the organization.*
Improved innovation, productivity and efficiency in the delivery of health services.	***A Focus on Our People*** *Northern Health will create a dynamic work environment that engages, retains and attracts staff and physicians.*

To ensure focused activity toward achievement of the Strategic Plan, the Northern Health Board and Executive have established four clear objectives for 2012/13 to 2014/15:

1. Realign Northern Health community services to create and support multidisciplinary primary health care homes in communities across the North
2. Enhance engagement of staff, physicians and communities
3. Use a comprehensive approach (Ottawa Charter) to affect upstream risk factors that will have a positive impact on the health of the population
4. Strengthen Northern Health's safety and quality culture.

These objectives lead to 13 concrete initiatives to be undertaken by Northern Health over the next three years. The following section describes each of these initiatives under its overarching Ministry of Health goal.

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians

Objective: Use a comprehensive approach to affect upstream risk factors that will have a positive impact on the health of the population

Northern Health will base public and population health improvement efforts on the five population health approaches described in the Ottawa Charter (a seminal consensus document on effective approaches for improving the health of populations). To ensure focus, Northern Health will establish position papers to initiate discussion and improvement work on a few priority areas: physical inactivity, unhealthy eating and tobacco use. Following are specific initiatives related to this important objective.

1. Enhance awareness of population health concepts (based on the conclusions of the Ottawa Charter);
2. Partner with communities and support community leadership in aspects affecting the health of populations;
3. Partner with the developing First Nations Health Council and draw on the wisdom of the local Aboriginal Health Improvement Committees (AHICs) to improve the health of Aboriginal people.

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average daily sodium content of adult hospital diets	3232 mg	2900 mg	: 2600 mg	2300 mg

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure focuses on the average sodium content of the general/regular diets for adults within health authority owned and/or operated hospitals. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and

asthma. According to the World Health Organization, interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective. [1]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease. [1] Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. British Columbia has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the Guidelines for Food and Beverage Sales in British Columbia Schools.

Health authorities are required to reduce the average sodium content of the general/regular diet for adults to the population goal of an average intake of 2300 mg of sodium per day by 2016.

Performance Measure 2: Health of Aboriginal Children

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of Aboriginal Kindergarten children receiving vision screening	71%	83%	88%	93%

Data Source: Population and Public Health Division, Ministry of Health

Discussion
This performance measure supports Aboriginal children's access to vision screening. Vision deficits such as amblyopia (lazy eye), strabismus (crossed eyes), and refractive errors (nearsightedness and farsightedness) are common problems in the preschool and school age population. Early detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child's opportunity for academic success and learning potential.

Goal 2: British Columbians have the majority of their health needs met by high quality primary and community-based health care and support services

Objective: Realign Northern Health community services to create and support multidisciplinary primary health care homes in communities across the North

Northern Health is interested in working with physicians to continually improve and better align primary health care and community services so all residents of northern British Columbia are served better. It is believed that frail elderly, people with mental health and substance use issues, and people with chronic conditions will benefit most from such improvements so these populations will be the focus of much of the work. Following are four streams of work that comprise this critical strategic objective for Northern Health.

[1] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21

1. Understand and improve functions/processes supporting community and primary health care
2. Realign and integrate primary health care and community service system functions based on understanding of community needs, understanding of our system and patient experience
3. Promote and support ongoing collaborative quality improvement in/with primary care practices
4. Partner with communities and support community leadership in aspects affecting the health of populations (this initiative is common to a number of objectives).

Performance Measure 3: Managing Chronic Disease in the Community

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people with a chronic disease admitted to hospital (per 100,000 people aged less than 75 years)	460	431	414	396

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health

Discussion
This performance measure tracks the number of people with selected chronic diseases, such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic diseases need the expertise and support of family doctors and other health care providers to manage their disease in the community in order to maintain their functioning and reduce complications that will require more medical care. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which help to control the costs of health care. As part of a larger initiative of strengthening community based health care and support services, family doctors, home health care providers and other health care professionals are working to provide better care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home Health Care and Support for Seniors

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of people aged 75+ receiving home health care and support	16.2%	16.8%	17.0%	17.3%

Data Source: P.E.O.P.L.E. 35, population estimates, British Columbia Stats 2. Continuing Care Data Warehouse, Management Information Branch, Health System Planning Division, Ministry of Health. A small amount of baseline data is currently unavailable due to the transition to new reporting mechanisms. 3. Home and Community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management information Branch, Health System Planning Division, Ministry of Health.

Discussion
This performance measure tracks the percent of seniors (aged 75+ yrs) who receive home health care such as home nursing and rehabilitative care, clinical social work, light housekeeping, assisted living and adult day

programs. While the majority of seniors experience healthy aging at home, there is growing need for community care options to support those who can no longer live independently. This support helps people manage chronic disease and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community-based health care and support services, the health authorities are expanding home health care services and ensuring that high risk seniors are made a priority in the provision of care. This focus, combined with the use of technology, can significantly improve health outcomes for seniors.

Goal 3: British Columbians have access to high-quality hospital services when needed

Objective: Strengthen Northern Health's safety and quality culture

By establishing clinical programs, Northern Health has put in place the expertise and capacity to identify and follow up on opportunities to improve clinical care across the organization. Northern Health will continue to strengthen clinical programs and support them in their work through enhanced quality training and tools and strong alignment with research and education. Following are the specific elements of this important objective.

1. Develop and implement quality education/training initiatives for staff and physicians
2. Work with the University of Northern British Columbia where applicable to further align education, research and health service in northern British Columbia
3. Support quality improvement activities with evidence, data and tools/methodologies
4. Support clinical programs in the identification and achievement of targeted improvements
5. Undertake focused initiatives to improve safety by promoting leading practice in:
    a. Hand hygiene
    b. Medication reconciliation.

Specific priority improvement areas have been identified for 2012/13 – 2014/15. They are:

- Implement a consistent surgical checklist across Northern Health surgical sites
- Implement a strategy to improve community follow-up upon discharge from acute care for people with mental health problems
- Examine and address factors leading to arbitrary variation in the use of c-section in Northern Health facilities
- Implement a falls prevention strategy to reduce falls in Northern Health facilities.

Surgical Services has been identified as an area where focused improvement work will take place. Particularly effort will continue to be made to improve surgical wait times for residents of northern British Columbia. In addition to the above improvement priority, process improvement work will be undertaken as follows:

- Use Lean methodology to examine, prioritize and improve key surgical processes
- Examine requirements for automation of OR booking and plan/implement system enhancement to support these requirements.

Performance Measure 5: Access to Surgery

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Per cent of non-emergency surgeries completed within the benchmark wait time	76%	78%	80%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Health System Planning Division, Ministry of Health. Notes:

1. The total wait time is the difference between the date the booking form is received at the hospital and the report date (end of the month). The day the booking form is received at the hospital is NOT counted.
2. This measure uses adjusted wait times that are calculated by excluding periods when the patient is unavailable from the total wait time.

Discussion

In the last several years, British Columbia's health system has successfully reduced wait times for cataract, hip and knee replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding, combined with continuous effort to foster innovation and efficiency in British Columbia's hospitals, will improve the timeliness of patients' access to an expanding range of surgical procedures. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times. These benchmark wait times are new and give a priority rating for each surgical patient, based on individual need. Because of the need to 'catch up' on surgeries for patients without a priority rating who have already been waiting, surgery for some patients with the new priority rating may be delayed. The target for 2012/13 will allow for this 'catch up' period, after which wait times for patients with priority ratings should gradually decrease.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services

Objective: Enhance engagement of staff, physicians and communities

Northern Health aspires to create a dynamic work environment that engages, retains and attracts staff and physicians. The level of engagement of staff (and, ultimately of physicians working in/with Northern Health) is measurable and can be tied to recruitment, retention and other organizational outcomes (including sick and overtime rates). Specifically, Northern Health will undertake the following initiatives toward this objective:

1. Enhance staff engagement through focused measurement, planning and improvement
2. Initiate a physician engagement measurement and improvement framework
3. Partner with communities and support community leadership in aspects affecting the health of populations (this initiative is common to a number of objectives).

Northern Health continues to build and support partnerships with communities and organizations. Such partnerships are highly beneficial as they greatly enhance the leverage with which change can be affected while enhancing relationships and engagement. Northern Health's valued partnership with the University of Northern British Columbia is a specific example. Through this partnership both organizations can gain strength and capacity while achieving the mutually beneficial goal of alignment among health research, education and clinical care.

Performance Measure 6: Nursing Overtime

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Nursing overtime hours as a per cent of productive nursing hours	4.9% (2010 calendar year)	4.3%	4.2%	4.0%

Data Source: Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

Discussion

This performance measure compares the amount of overtime worked by nurses to the overall amount of time nurses work. Overtime is a key indicator of the overall health of a workplace. High rates of overtime may reflect inadequate staffing or high levels of absenteeism, resulting in workload issues and increased costs. Reducing overtime rates by addressing the underlying causes not only assists in reducing direct (e.g. labour) and indirect (e.g. unengaged staff) costs to the health system, it also helps promote both patient and caregiver safety.

Financial Summary

Following is a summary of Northern Health's 2011/12 closing financial status and budgets/plans for 2012/13 through to 2014/15.

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Plan	2014/15 Plan
Operating Summary				
Provincial government sources	630.419	670.981	674.608	686.969
Non-provincial government sources	60.623	61.336	62.267	63.614
Total Revenue:	**691.042**	**732.317**	**736.875**	**750.583**
Acute Care	409.727	437.959	439.787	452.202
Residential Care	85.763	86.757	88.878	89.710
Community Care	48.733	55.296	54.542	55.609
Mental Health & Substance Use	48.452	52.409	53.490	53.997
Population Health & Wellness	34.007	36.644	38.103	38.513
Corporate[(a)]	63.642	63.252	62.075	60.552
Total Expenditures:	**690.324**	**732.317**	**736.875**	**750.583**
Surplus (Deficit)	**0.718**	**-**	**-**	**-**

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Plan	2014/15 Plan
Capital Summary[(b)]				
Funded by Provincial Government	91.8	31.4	6.1	4.8
Funded by Foundations, Regional Hospital Districts, and other non-government sources	38.6	31.3	13.3	4.2
Total Capital Spending	**130.4**	**62.7**	**19.4**	**9.0**

a) Includes information technology infrastructure, corporate expenditures, human resources, financial services, capital planning, workplace health and safety, internal/external communications and administration
b) Due to the timing of the financial reporting the capital summary does not include the Queen Charlotte/Haida Gwaii Hospital Replacement or the Lakes District Hospital Replacement

Health authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

Capital Projects

Northern Health's Capital Asset Management Plan consists of three major avenues of spending to maintain and improve the asset base consisting of human resources, technology, facilities and equipment. These resources are applied strategically in order to provide the breadth of services Northern Health is responsible for across its geography. Funding is received from the Ministry of Health, Regional Hospital Districts, and through donations from Foundations and Auxiliaries. Maintenance and enhancement of capital and information infrastructure improves Northern Health's capacity to fulfill its strategic plan and to continue to operate in an efficient, effective manner.

Following is a list of approved capital projects (those with a total project cost of greater than $2 million) currently under way.

Facility Location	**Project Name**	**Total Project Cost ($millions)**
Projects underway:		
Fort St. John	Fort St. John Hospital & Residential Care: Replacement	301.8
Prince George, University Hospital of Northern British Columbia	Northern Cancer Control Strategy: Renovations	8.6
Various Sites	Northern Cancer Control Strategy: Infrastructure Upgrades	1.8
Burns Lake	Lakes District Hospital & Health Centre Replacement	55.1
Village of Queen Charlotte	Queen Charlotte/Haida Gwaii Hospital Replacement	50.0
Regional	SurgiNet (OR Booking and Care Documentation)	4.1
Regional	HLN – Application Upgrade – Care Documentation	2.3

Contact Information

For more information on Northern Health, please visit www.northernhealth.ca, send an email to hello@northernhealth.ca or call 250- 565-2649.

For information specific to this service plan or other Northern Health plans, please contact:

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[3] Health Authorities Act. Chapter 180 (December 2009) http://www.qp.gov.bc.ca/statreg/stat/H/96180_01.htm

[4] As at April 1, 2012 there are 525 acute care beds open and in operation

[5] As at April 1, 2012 there are: 1,062 complex care beds and 35 respite care beds provided in the 23 noted facilities. Also allocated across northern British Columbia are 307 assisted living units

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GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE PROVINCIAL HEALTH SERVICES AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Provincial Health Services Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The Health Authority is governed by *The Society Act* and provides both a service delivery and a leadership role for specialized services and selected province-wide programs.

As part of the service delivery role the Health Authority collaborates with the five regional health authorities to provide access to specialized provincial services, either through a decentralized model of care with provincial linkages or through a single service delivery resource.

In addition, the Health Authority fulfills a leadership role to actively address issues that span all areas of the province, including:

- Identification of innovative solutions to make system-wide improvements through specific provincial initiatives. This may include developing provincial standards/guidelines and data collection processes to improve resource planning and decision-making at both the regional and provincial level; and
- Co-ordination, planning, monitoring, evaluation and, in some cases, providing direct funding, of specialized health services and select province-wide programs and services.

The Health Authority manages the following provincial agencies and services:

- BC Cancer Agency (BCCA);
- BC Centre for Disease Control (BCCDC);
- BC Children's Hospital and Sunny Hill Health Centre for Children (BCCH);
- BC Women's Hospital & Health Centre (BCWH)
- Perinatal Services BC (PSBC);
- BC Mental Health and Addiction Services (BCMHAS);
- BC Provincial Renal Agency (BCPRA);
- BC Transplant (BCT);
- Cardiac Services BC (CSBC);
- Emergency and Health Services Commission (EHS); and
- Health Shared Services BC (HSSBC).

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality

and management of clinical services to achieve effective, appropriate, efficient and safer care.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

   The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

   Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by Government (some of this information is included in annual reports and does not need to be otherwise displayed);
- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and
- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;
- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;

- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative

Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;

- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	G.W. (Wynne) Powell Chair of the Board Provincial Health Services Authority
Date	Date

pc: Honourable Christy Clark

Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Lynda Cranston
President and Chief Executive Officer
Provincial Health Services Authority

Pages 452 through 462 redacted for the following reasons:
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s. 13

Provincial Health Services Authority

2012/13 – 2014/15 SERVICE PLAN

July 2012

Provincial Health Services Authority
Province-wide solutions. Better health.

BRITISH COLUMBIA

For more information on the
Provincial Health Services Authority
see Contact Information on Page 23 or contact:

Provincial Health Services Authority
#700 – 1380 BURRARD STREET
VANCOUVER, BC
V6Z 2H3

or visit our website at
www.phsa.ca

Message from the Board Chair and Accountability Statement

On behalf of the Board of Directors and the staff of the Provincial Health Services Authority (PHSA) and its agencies, services and divisions, I am pleased to introduce the 2012/13 – 2014/15 PHSA Service Plan.

This year's Service Plan highlights priority initiatives that are underway and focuses on strategies that leverage our assets and expertise, while honouring the principles of the public health care system. It also reflects the three key strategic directions that underpin PHSA's own strategic plan:

- Improving Quality Outcomes and Better Value for Patients
- Promoting Healthier Populations
- Contributing to a Sustainable Health Care System

The nature of the care we provide means that many of our patients have complex, chronic conditions requiring highly specialized assessment and care. Given our province-wide mandate, it also means that many of them live outside the Lower Mainland. We continue to evolve our network and knowledge exchange strategies, working in partnership with the regional health authorities to improve access to evidence-based practice closer to where people live and to effectively promote health, prevent illness, manage chronic conditions and generally lessen the burden of disease.

At the same time, health care decision makers, providers and planners are faced with the task of doing more with finite resources. PHSA will continue to seek opportunities to meet new demands for health care services in the most efficient way possible. We are committed to looking for ways to keep health care sustainable through innovation and working together with the regional health authorities and our partners to achieve greater efficiency without compromising patient care.

British Columbians are fortunate to have a comprehensive network of highly specialized agencies providing the best possible tertiary and specialized care. We are also fortunate to benefit from PHSA's dedicated people – its physicians, nurses, allied health professionals, administrative and support staff, students, volunteers and board of directors – who work hard to deliver the very best. Through the commitment of these people we strive to reach our vision: Province-wide solutions. Better health.

The 2012/13 – 2014/15 Provincial Health Services Authority Service Plan was prepared under the Board's direction in accordance with the Health Authorities Act and BC Reporting Principles. . The Service Plan is consistent with Government's strategic priorities and Strategic Plan, and the Ministry of Health's goals, objectives and strategies. The Board is accountable for the contents of the Plan.

G.W. (Wynne) Powell, FCGA, D. Tech (Hon.)
Board Chair, Provincial Health Services Authority
July 13, 2012

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Organizational Overview

Provincial Health Services Authority (PHSA), established in December 2001, is responsible for select specialized and province-wide health care services in BC. The first organization of its kind in the country, PHSA works with the five regional health authorities and the Ministry of Health to meet local and provincial health needs. PHSA does this by:

- Governing and managing nine agencies that plan and/or provide specialized health services on a province-wide basis: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital & Sunny Hill Health Centre for Children, BC Mental Health & Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital & Health Centre, Perinatal Services BC and Cardiac Services. PHSA also supports major health system collaboratives through its two divisions, the Emergency Health Services Commission and Health Shared Services BC;

- Working with the five regional health authorities and the Ministry of Health to plan, coordinate and, in some cases, fund the delivery of highly specialized provincial services; and

- Leading and coordinating a number of priority system improvement initiatives, including the Riverview Hospital Redevelopment project.

PHSA plays a significant role in planning and ensuring accessibility, quality, efficiency and effectiveness of province-wide programs and services such as the BC Autism Network, the Childhood Screening and Hearing Program, the Thoracic Surgery Program, the Surgical Patient Registry, the Provincial Blood Coordinating Office, PHSA Laboratories, the Provincial Language Service, Stroke Services BC, Trauma Services and Telehealth. Additionally, PHSA has responsibility for its Lower Mainland Consolidation (LMC) components.

PHSA is also a research-intensive, academic health sciences organization with a mandate for:

- Basic and clinical research to inform health care and health service decision making;

- Multidisciplinary, integrated research programs supporting translational science; and

- Education and training of more than 4,000 students per year in the specialized health and human services provided by our agencies.

Research and development creates many benefits for patients, the health care system and society. It provides British Columbians with access to new discoveries and technologies, offers opportunities to deliver better and more effective heath care services, attracts the best and the brightest scientists and health care professionals to BC and produces economic benefits for British Columbia. Research is also key to the sustainability of the system, providing the best possible evidence to inform decision-making and directing our scarce resources to those that represent the best value.

Please visit our website for more information on PHSA services:
http://www.phsa.ca/AboutPHSA/PHSA-Agencies-Services-Programs/default.htm

PHSA operates under the Society Act and is accountable to the Ministry of Health through a twelve member Board of Directors appointed by the Minister of Health. The composition of the board is intended to be geographically representative of the population of British Columbia, with board members living in all regions of the province. As a public sector organization, the PHSA is mandated to meet the needs of the people we serve. The Governance policies and practices of the PHSA are compliant with the *Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations (Best Practice Guidelines)* issued by the Board Resourcing and Development Office (BRDO), Office of the Premier of British Columbia. These guidelines define how the Board carries out its duties of stewardship and accountability and are available on our website: http://www.phsa.ca/AboutPHSA/PHSAboard/CorporateGovernance.htm

Strategic Context

The health system in BC is a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand.

Although the BC health system effectively meets the majority of the population health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to frail seniors, a rising burden of illness from chronic diseases, mental illness and cancer, and advances in technology and pharmaceuticals driving new costly procedures and treatments. The pressure is compounded by the need for new care delivery models by health professionals and health care workers, and the need to maintain and improve the health system's physical infrastructure (i.e. buildings and equipment). In the current economic climate it is even more important for the health system to find new and creative ways to ensure the resources available for health care services are used effectively and in ways that most benefit the people of BC.

The Aging Population

BC's senior population currently makes up 15 percent of the total population and is expected to double within the next 20 years, making it one of the fastest growing seniors populations in Canada.[1] The aging population is a significant driver of demand because the need for health services rises dramatically with age. In 2006/07 people over age 65 made up 14 percent of the BC population, but used 33 percent of physician services, 48 percent of acute care services, 49 percent of PharmaCare expenditures, 74 percent of home and community care services and 93 percent of residential care services.[2] There is also an increasing need to provide appropriate care for those with frailty or dementia and to help seniors stay healthy, independent and in the community for as long as possible.

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis and asthma. People with chronic conditions represent approximately 38 percent of the BC population and consume approximately 80 percent of the combined physician payment, PharmaCare and acute (hospital) care budgets.[3] Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions could increase 58 percent over the next 25 years[4] and be a significant driver of demand for health services. Chronic diseases can be prevented or delayed by addressing key risk factors, including physical inactivity, unhealthy eating, obesity, alcohol consumption and tobacco use.

With increasing survivorship of individuals with chronic conditions, patients are living longer and are likely to develop additional conditions as they age, which has a potential impact on health care costs. Despite efforts to reduce the incidence of disease (new cases) through prevention and health

[1] PEOPLE 36 Population Data, BC Stats

[2] Planning and Innovation Division, Ministry of Health; using MSP Expenditures 2006/07; Acute Care: Inpatient and Day Surgery workload weighted cases, DAD 2006/07; HCC community services by age group 2005/06, summed based on average unit costs; Residential care days 2006/07.

[3] Discharge Abstract Database (DAD), Medical Service Plan (MSP) and PharmaCare Data 2006/07

[4] BC Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis*, march 2007, (2007-064); as cited in Primary Health Care Charter: a collaborative approach (2007), Ministry of Health

promotion activities, overall cost reductions to the system may not be evident as costs of maintenance therapy remain constant or increase.

Advances in Technology and Pharmaceuticals

New treatment and technology development over the past 10 years has included less invasive surgery, increased use of diagnostic imaging and the introduction of biological and tailored drug therapies that have made health care more efficient and effective, but has also led to a significant increase in demand for products and services. For example, the expansion of technology has seen the number of CT exams increase by approximately 120 percent and the number of MRI exams increased by almost 249 percent in the province between 2001/02 and 2011/12.[5]

In July 2010, the Government announced that BC residents will now benefit from lower generic drug prices. These savings and other improvements to our drug system will benefit all British Columbians by keeping drug costs sustainable and redirecting the money to cover new drugs and provide better services, including those highly specialized services provided by PHSA.

Genomic medicine holds potential for great advancements in medical technology[6]. We know that humans differ in their responses to medication, in part due to the genetic make-up of the individual. We can leverage our strength in genomics and the Genome Sciences Centre[7] to gain a better understanding of the role of genetic variation in disease and drug response which could lead to improved safety, cost-effectiveness of treatment and contribute to the sustainability of our health care system.

Human Resources and Health System Infrastructure

Although education and training programs for health professionals and health workers in British Columbia have been significantly expanded since 2001, ensuring the availability of human resources remains a challenge for the health system. As the population ages, so too does the health care workforce. Although attrition rates have recently decreased, looming retirements in the health workforce, combined with the rising demand for services, are still key challenges that will impact the Province's ability to maintain an adequate supply and mix of health professionals and workers. Planning for, and ensuring we have the required number of qualified healthcare providers entering the workforce is still important. However, we also need to continue focusing on optimizing care delivery models to ensure we leverage the skill sets of our professionals, including creating and supporting interprofessional care teams.

PHSA agencies and programs face added challenges to recruit and retain the highly skilled health professionals needed to deliver the very specialized care that is the core of our provincial services. Flexibility and collaboration will be essential to devise sustainable attraction and retention solutions that support continued learning, healthy workplaces, and promote work/life balance in these professions.

Another challenge in delivering health services is the need to maintain and improve the health system's physical infrastructure. The health system is faced with the continuous need to update or

[5] HAMIS/OASIS, Management Information Branch, Planning & Innovation Branch, MoH as of May 29, 2012
[6] Khoury, M. (2008). The Evidence Dilemma in Genomic Medicine. Health Affairs, 27(6), 1600 – 1611.
[7] Canada's Michael Smith Genome Sciences Centre is located in Vancouver, BC and operates under the auspices of the BC Cancer Agency, an agency of PHSA. For more information please see: www.bcgsc.ca

expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to British Columbians.[8]

Goals, Objectives, Strategies and Performance Measures

The *Ministry of Health's Revised 2012/13 – 2014/15 Service Plan* aligns with the priorities of the Government of BC, and outlines the strategic focus and direction for the health authorities. Specific deliverables and performance measures for the health system are identified in the Ministry of Health's Revised Service Plan. PHSA operates in alignment with the Ministry's goals, objectives, strategic initiatives, and key result areas, and developed its strategic plan and framework to be consistent with the four broad goals for BC's health care system:

1. Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.
2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.
3. British Columbians have access to high quality hospital services when needed.
4. Improved innovation, productivity and efficiency in the delivery of health services.

Alignment with these health system goals, as established by the Ministry of Health, is part of every strategic effort made at PHSA as evidenced by the three key directions laid out in our strategic plan:

1. Improving Quality Outcomes and Better Value for Patients;
2. Promoting Healthier Populations; and
3. Contributing to a Sustainable Health Care System.

As a provincial health authority and an Academic Health Sciences Organization, we aim to provide safe, high-quality clinical services, conduct world-class research, and deliver excellence in education and training. Integral in the achievement of this aim is the belief that there are three cross-cutting themes that are relevant to all that we do. These cross-cutting themes are implicitly embedded within the strategic plan and are critical to the successful implementation of our plan and realization of our vision and goals.

1. Quality and Safety
2. Research
3. Learning

The *2012/13 – 2014/15 Service Plan* that follows describes PHSA's objectives and strategic initiatives for the planning period in the context of the Ministry of Health's goals for the health system.

[8] Ministry of Health Revised 2012/13 – 2014/15 Service Plan. February 2012, p 8

MoH Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

Objective 1.1: Individuals are supported in their efforts to maintain and improve their health through health promotion and disease prevention

British Columbians are in general among the healthiest people in the world. One of Government's top priorities is to support the excellent health status of the majority of our citizens while also helping those who do not enjoy good health, or who are at risk of diminishing health from factors such as poor diet, obesity, inactivity, injuries, tobacco use and problematic substance use.

PHSA Alignment:

PHSA embraces a broad definition of health, and in addition to providing specialized treatments for illness when it occurs, PHSA develops strategies to promote wellbeing and the highest quality of life, in alignment with Ministry goals. Working together with the Ministry of Health and the regional health authorities, PHSA has a role in developing health promotion and illness prevention strategies[9]. PHSA is committed to improving the health of British Columbians by supporting the development of healthy communities, informing healthy public policy and providing information and tools that help individuals make healthier choices to prevent the onset of many chronic diseases and to assist those living with chronic disease to stay as healthy as possible.

PHSA Strategies:

- Lead the implementation of key elements of the Provincial Breast Health Strategy including the review and updating of provincial guidelines for breast screening.
- Lead the implementation of a provincial colorectal cancer screening program developed in partnership with the Ministry of Health.
- Support healthy eating initiatives that encourage healthy eating choices and reduce sodium consumption by British Columbians through industry engagement, public education and the Provincial Restaurant Recognition Program.
- Support initiatives that encourage individuals to lead healthier lives where they live, work, learn and play and work with the regional health authorities to coordinate physical activity and healthy eating programs in BC schools and healthy workplaces.
- Implement strategies to improve Aboriginal health care services in cancer, heart failure, perinatal services, maternity and mental health & substance use services.
- With the Ministry of Health, co-lead the development of a plan for a renewed Provincial Women's Health Strategy.
- Test the model of a gender-sensitive heart health promotion program for women at BC Women's Hospital by engaging with different population groups and settings.

[9] PHSA Strategic Direction #2: Promoting Healthier Populations

- Through Child Health BC, collaborate with partners in the ministries, HAs, the community and our academic partners to inform a child and youth service delivery plan based on an overarching child health service delivery framework.
- Lead the further development of BC Mental Health & Addiction Services' Cross Cultural Mental Health Literacy Initiatives to enhance the mental health literacy among culturally diverse families in BC, including video creation, website enhancement, and community education and awareness activities.
- Lead the further development and implementation across PHSA of Health Compass: Transformative Practices Embracing Mental Wellbeing, an innovative, collaborative multi-phased cross agency project led by BC Mental Health & Addiction Services to enhance the capacity of PHSA's health care providers to further promote the positive mental wellbeing of patients, clients, and families that access PHSA's health care services.
- Continue to lead the operations of Panorama, a Pan-Canadian public health e-Health system, to improve population health by supporting service delivery and enabling secure access to integrated public health data to support policy changes and measure the impact of public health interventions.
- Through a co-leadership partnership between PHSA Aboriginal Health Program and BC Mental Health & Addiction Services leadership, identify key stakeholders and partners in order to develop a Provincial Aboriginal-focused youth website, utilizing current web based frameworks and introducing content related to the needs of Aboriginal youth and communities.

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average sodium content in adult hospital diets	3447 mg.	3100 mg.	2800 mg.	2400 mg.

Data Source: Population and Public Health Division, Ministry of Health

(Note: performance measure applicable in PHSA to BC Women's Hospital only)

Discussion

This performance measure focuses on the average sodium content of the general/regular diets for adults within health authority owned and/or operated hospital facilities. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and asthma. According to the World Health Organization,

interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective.[1]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease. Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. BC has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the Guidelines for Food and Beverage Sales in BC Schools.

Health authorities are required to reduce the average sodium content of the general/regular hospital diet for adults to the population goal of an average intake of 2300 mg of sodium per day by 2016.

Performance Measure 2: Cancer Screening

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of women aged 50-69 years participating in screening mammography once every 2 years	53.8%	56.0%	60.0%	62.0%

Data Source: Mammography: Screening Mammography Program of BC, Provincial Health Services Authority.

Discussion

This performance measure tracks how many women between 50 and 69 years of age, the age when women are most at risk for breast cancer, are screened at least every two years as recommended. The targets for 2012/13 through to 2014/15 reflect PHSA's commitment to reaching the long-term target of 70%, which is the national benchmark developed in accordance with the provincial and federal First Ministers' *10-year Plan to Strengthen Health Care* in September 2001.

[1] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21

MoH Goal 2: British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

Objective 2.1: Providing a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services.

BC's health system is committed to providing the best possible quality of care and service which means the care people receive responds to their needs and will lead to the best health outcomes. We must proactively address the increasing needs of the population due to aging, a rising burden of illness from chronic disease and an increased prevalence of frailty by providing integrated care in the community that best meets the needs of patients[10]

PHSA Alignment:

From the patient's perspective, a quality outcome means early and timely treatment that responds to their needs and is safe, evidence-based and results in a fast and complete recovery or minimal complications related to their condition. Health care in general is moving away from the delivery of episodic care to embrace a more holistic view of the individual and the full continuum of care. Optimizing flow of information, services, and care to improve the patient experience across our systems and programs are key PHSA priorities[11].

PHSA Strategies:

- Continue to promote innovative dialysis options and supportive strategies for chronic kidney disease patients to enhance quality of life and promote improved outcomes while maximizing scarce resources.
- Provide provincial leadership and coordination in the translation and adoption of best practice guidelines for stroke, atrial fibrillation and heart failure into all parts of the care continuum including primary care, community, and residential care.
- Develop integrated advanced care plans for cancer patients that will ensure terminally ill patients and their family receive appropriate care and improved access to support tools.
- Enhance services, outreach and provincial education and training at BC Women's Hospital to develop an HIV/AIDS Centre of Excellence for women, children and families.
- Create, implement and evaluate a comprehensive plan for implementation of a provincial hip surveillance program in support of a holistic approach to the care of children with Cerebral Palsy (in partnership with Ministry of Health, Child Health BC and Child Development Centres)

[10] Ministry of Health Revised 2012/13 – 2014/15 Service Plan. February 2012, p 11.
[11] PHSA Strategic Direction #1: Improving Quality Outcomes and Better Value to Patients

- Lead the implementation of the Provincial Emergency Medical Services Transportation of Psychiatric Clients requiring Sedation Project and engage in research, province-wide planning, information sharing, standard setting, performance evaluation and system-wide improvements.

Performance Measure 3: Independent Dialysis

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of dialysis patients on independent dialysis modalities (peritoneal dialysis & home haemodialysis)	31%	31%	32%	33%

Data Source: BC Renal Agency, Provincial Health Services Authority.

Discussion

This performance measure tracks independent dialysis uptake in BC. People with kidney failure (also referred to as end stage renal disease) require dialysis or a transplant to stay alive. Independent dialysis (most often home-based) has proven benefits with respect to health outcomes, patient quality of life and fiscal sustainability. Patients who manage their own dialysis treatments at home can set their own schedule and dialyze more often or for longer periods of time, which better replicates the function of the kidneys. This innovative program is less costly than traditional dialysis, and reduces requirements for new facility infrastructure over time.

Performance Measure 4: Child Mental Health

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of children admitted to an inpatient psychiatric unit bed within 42 days	49%	60%	65%	70%

Data Source: Child and Youth Mental Health Database, Provincial Health Services Authority.

Discussion

This performance measure tracks access to inpatient care for children with mental health or substance use concerns. Community-based child and youth mental health and substance use services are provided across the province by the Ministry of Children and Family Development. Some of the children, youth and their families served in the community need the BC Mental Health & Addiction Services (BCMHAS) specialized psychiatric services located at BC Children's Hospital (BCCH) in Vancouver. Although treatment is increasingly provided on an outpatient basis to enable the children and youth served to remain at home with their families, inpatient services are available for those who need them.

MoH Goal 3: British Columbians have access to high quality hospital services when needed.

Objective 3.1: Acute care services are accessible, efficient and effective.

While the majority of health needs can be met through primary and community based health care, British Columbians also require timely access to high quality hospital care for advanced health conditions[12]

PHSA Alignment:

All British Columbians should be able to access appropriate health services when they need them. PHSA and its agencies are committed to ensuring that hospitals, services and health professionals are utilized in the most efficient and effective way possible so people receive the right type of care in the right setting that is most likely to lead to the best health outcome[13].

PHSA Strategies:

- Expand protocol-driven clinical care management and develop and improve pathways and related standard operating procedures for treatment services within PHSA's mandate to improve quality, and access and speed the patient's journey.
- Work in partnership with the regional health authorities to improve access to diagnostic imaging services provincially, with an initial focus on MRI and CT. This is in addition to our partnership work in this area as part of the Lower Mainland Consolidation Initiative.[14]
- Continue to decrease wait times for complex pediatric hip and spine surgery at BC Children's Hospital.
- Implement the provincial heart surgery service delivery plan for the new Interior Heart and Surgical Centre in Kelowna and optimize capacity within the system.
- Provide provincial leadership through Stroke Services BC (SSBC) for coordination, communication and project support for the implementation of the provincial stroke strategy. Regional Health Authorities are represented on the SSBC Steering Committee and are accountable for providing appropriate funding for and implementing local stroke strategies in response to provincial priorities.
- Enhance the Neonatal Intensive Care Unit infrastructure and model of care at BC Women's Hospital to create a neonatal centre of excellence.
- Implement a quality, safety and training and education program at BC Women's Hospital to improve clinical and leadership skill development and reduce the number of adverse events related to team communication and enhance the delivery of quality, safe and effective patient care.

[12] Ministry of Health Revised 2012/13 – 2013/14 Service Plan. February 2012, p 13.
[13] PHSA Strategic Direction #1: Improving Quality Outcomes and Better Value for Patients
[14] Lower Mainland Consolidation denotes the initiative to consolidate selected corporate and clinical support functions among the lower mainland health authorities: PHSA, Vancouver Coastal Health Authority(VCHA), Providence Health Care (PHC) and Fraser Health Authority (FHA) to reduce costs and is described in more detail under objective 4.2.

- Lead the collaborative development of updated Provincial Reproductive Mental Health Guidelines, including updated recommendations for pharmaceutical interventions / medication management for women with mental health issues during their perinatal period.
- In collaboration with Northern Health Authority, the Ministry of Health and other partners, improve access to cancer care for residents of northern BC by opening a new full service cancer centre in Prince George in November 2012 as part of the overarching Northern Cancer Control Strategy.
- Collaborate with the regional health authorities on opportunities to integrate paramedics (particularly those in rural/remote areas) into additional roles in the health sector.
- Lead the continued implementation of the BC Patient Transfer Network Plan in collaboration with regional health authorities.
- Lead the collaborative development of updated Provincial maternal/newborn transfer guidelines including implementation in partnership with the Provincial Transfer Network.

Performance Measure 5: Paediatric Surgery

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of non-emergency complex paediatric hip surgeries completed within established benchmarks	42%	40%	50%	60%

Data Source: BC Children's Hospital Database, Provincial Health Services Authority.

Note: The 2010/11 baseline of 42% was stated as 39% in the PHSA 2011/12-2013/14 Service Plan. The 2012/13 target of 40% is lower than the baseline of 42% and the 2012/13 target of 50% in the previous Service Plan because of the need to complete the surgeries of the patients who have already been waiting longer than the benchmark time frame.

Discussion

This performance measure tracks the percentage of non-emergency paediatric complex hip surgeries completed within established benchmarks. The benchmark is based on urgency of care required in the paediatric care setting and is not comparable to adult hip surgery cases. Through expanded surgical activity and focused funding, combined with continuous efforts to foster innovation and efficiency, BC Children's Hospital (BCCH) has reduced wait times for paediatric surgeries, including complex hip surgeries. Because BCCH has prioritized completion of cases outside established wait-time benchmarks (those that have been waiting the longest), the proportion of completed cases within benchmark timeframes for complex hip procedures does not demonstrate the gains made in overall waitlist reduction. From the beginning to the end of 2011/12, the number of children waiting for complex hip procedures was reduced by approximately 50%.

Over the next three years BCCH plans to maintain achieved levels for surgical specialties that have reduced their waitlist. For complex hip procedures, we will continue to focus on completing cases that

exceed established wait-time benchmarks. As a result, our percent of complex hip surgeries completed within benchmark will remain lower than usual, until the backlog of long wait cases is addressed.

Performance Measure 6: Maternity Care

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of women who plan for a vaginal births after a previous caesarean section	25.7%	27%	28%	29%

Data Source: BC Women's Hospital and Health Centre Database, Provincial Health Services Authority.

Note: The target for 2012/13 stated in the previous Service Plan was 28%. It has been reduced slightly to adjust for delay in implementation of new program initiatives.

Discussion

Many women who have previously given birth through Caesarean section (C-section) can still safely give birth through a normal vaginal delivery. Planning for and attempting Vaginal Birth After Caesarean (VBAC), a safe option for the majority of women, has a high success rate, and many benefits. Benefits include reduced blood loss, reduced injury and risk of infection, elimination of complications associated with surgery, a shorter hospital stay, and more rapid recovery. Attempted or Planned VBAC is a measure of access to VBAC. Resources are required to support women in making the decision to plan a VBAC. Increasing the opportunity for women to deliver vaginally after a prior C-section will have a positive impact on lowering the overall C-section rate.

MoH Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

Objective 4.1: Optimize supply and mix of health human resources, information management, technology and infrastructure in service delivery.

A high performing health system is one that uses its resources in the best way possible to achieve quality clinical and health outcomes for patients and the broader population. To be sustainable the system must ensure it has enough, and the right mix of, health professionals to provide the services that will meet British Columbians' needs now and in the future. We must also ensure those human resources are appropriately supported by information management systems, technologies and the physical infrastructure to deliver high quality services as efficiently as possible[15]

PHSA Alignment:

Skilled and caring health professionals are the cornerstone of our health system. Thousands of British Columbians seek medical attention every day, confident they are in the care of competent professionals who hold themselves to the highest standards. To be effective, we must also ensure that our human resources are appropriately supported by information management systems, technology and the physical infrastructure to deliver high quality services as efficiently as possible[16].

PHSA Strategies:

- Continue to support the education and training of more than 4,000 students and over 800 research trainees each year in the specialized health and human services provided by our agencies in collaboration with the Ministry of Advanced Education and our academic partners.
- Continue PHSA's comprehensive workforce strategy focusing on employee engagement, specialized recruitment and retention initiatives, and supporting the development of leaders across the organization using the provincial leadership development programs and other strategies.
- Continue to lead the implementation of various Provincial eHealth systems to improve patient care by providing health care providers with secure access to clinical information. Better access to information results in faster, more informed clinical decisions, fewer duplicated tests, and a reduction in unnecessary patient transfers.
- Continue the implementation of Clinical Information Solution systems to improve the quality and accessibility of patient information by creating an integrated health record for each patient based on a single identifier and using standardized processes.
- Implement, improve and leverage PHSA's registries and databases in services such as Cancer, Perinatal, Cardiac, Renal and Transplant to provide information to highly specialized practitioners that will inform and improve quality, safety, and efficiency.

[15] Ministry of Health Revised 2012/13 – 2014/15 Service Plan. February 2012, p 14
[16] PHSA Strategic Direction #3: Contributing to a Sustainable Health Care System

- Expand the use of Telehealth, leveraging the Telehealth Scheduler (an automated scheduling system for videoconferencing), to promote and improve access to diagnostic programs and specialized care, by enabling clinical consultation, continuing professional education, health promotion, and healthcare management and administration.
- Continue to explore the application of emerging social media technologies to involve patients in the management of their care.
- Optimize care delivery models to deliver safe, high quality care that is focused on patient needs to improve patient experiences and outcomes, and make the best use of staff time and expertise.

Performance Measure 7: Health Human Resources

Performance Measure	2010 Baseline	2012 Target	2013 Target	2014 Target
Nursing overtime hours as a percent of productive nursing hours	2.24%	Maintain at or below 3.3%	Maintain at or below 3.3%	Maintain at or below 3.3%

Data Source: Ministry of Health. Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

Discussion

This performance measure tracks how much of nursing hours in hospital are overtime hours. The core of health care is the people who provide the service - the nurses and other health professionals such as occupational therapists, physiotherapists, medical technologists, social workers, pharmacists and medical radiation technologists. When a staff member is sick or there are long-time vacancies in one of these positions, other staff must provide the care to meet patient needs. Reducing sick time and filling vacancies quickly should reduce overtime and also help to manage health care costs.

Objective 4.2: Drive efficiency and innovation to ensure sustainability of the publicly funded health system.

The Ministry is committed to managing the health system efficiently to ensure resources are spent where they will have the best outcome. The public health system must continually drive improvement in innovation, productivity and efficiency to ensure the health system is affordable and effective for British Columbians[17]

PHSA Alignment:

As stewards of taxpayers' dollars PHSA must prioritize limited resources to ensure we are providing the best value to the populations we serve. PHSA has implemented imPROVE, a Lean-based process improvement system. PHSA agencies and services look for essential value-added services, while minimizing ineffective or redundant efforts. Our limited resources will be utilized more efficiently,

[17] Ministry of Health Revised 2012/13 – 2014/15 Service Plan. February 2012, p 16

technology will be leveraged to a greater degree, and our processes will become more reflective of an integrated system that is focused on improving the patients' experience while in our care[18].

PHSA also continues to lead, participate and support designated services involved in the Lower Mainland Consolidation (LMC) initiative, to redirect savings to the provision of health care services[19]. Currently, fourteen select services and support areas are consolidating as part of the first phase of this initiative[20].

PHSA Strategies:

- Continue to implement imPROVE, PHSA's Lean management program for achieving excellence in quality, safety and efficient patient care through the redesign of processes.
- Continue to lead the Lower Mainland Consolidation of Information Management Services, Provincial Laboratory Services and Provincial Interpretation Services that will generate savings and improve efficiency through cross-health authority consolidation of services.
- Through Health Shared Services BC, a division of the PHSA, continue to create enhanced value to the health system through effective and efficient delivery of agreed upon support services focused on service efficiency and standardization, service quality and service integration across the health authorities.
- Implement the BC Health Authority Leadership Development Collaborative to develop physician and health care providers' leadership skills and capacity.

[18] PHSA Strategic Direction #3: Contributing to a Sustainable Health Care System
[19] Lower Mainland Consolidation denotes the initiative to consolidate selected corporate and clinical support functions among the lower mainland health authorities: PHSA, Vancouver Coastal Health Authority(VCHA), Providence Health Care (PHC) and Fraser Health Authority (FHA) to reduce costs and is described in more detail under objective 4.2.
[20] Examples of departments included in Lower Mainland Consolidation are:, Pharmacy, Diagnostic Imaging Services, Facilities Management, Parking and Protection Services and Payroll (HSSBC).

Financial Summary

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Plan	2014/15 Plan
Operating Summary:				
Provincial government sources	$ 2,246.6	$ 2,227.2	$ 2,283.4	$ 2,321.6
Non-provincial government sources	$ 171.3	$ 181.2	$ 182.8	$ 182.8
Total Revenue:	$ 2,417.9	$ 2,408.4	$ 2,466.2	$ 2,504.4
Acute Care	$ 1,627.6	$ 1,694.2	$ 1,757.8	$ 1,806.5
Residential Care	$ 3.1	$ 1.6	$ 1.6	$ 1.6
Community Care	$ 122.9	$ 127.5	$ 129.4	$ 130.6
Mental Health & Substance Use	$ 195.9	$ 149.0	$ 127.6	$ 112.6
Population Health & Wellness	$ 206.0	$ 191.2	$ 195.0	$ 196.2
Corporate	$ 261.7	$ 244.9	$ 254.8	$ 256.9
Total Expenditures:	$ 2,417.2	$ 2,408.4	$ 2,466.2	$ 2,504.4
Surplus (Deficit)	$ 0.7	$ -	$ -	$ -
Capital Summary:				
Funded by Provincial Government	$ 90.0	$ 119.5	$ 44.3	$ 14.7
Funded by Foundations, Regional Hospital Districts, and other non-government sources	$ 21.3	$ 19.4	$ 7.0	$ 7.0
Total Capital Spending	$ 111.3	$ 138.9	$ 51.3	$ 21.7

Note:
Health Authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

Capital Project Summary

The following is a list of PHSA projects approved by the Ministry of Health Services with funding greater than $2 million:

Community Name (as applicable)	**Facility location** (as applicable)	**Project Name**	**Total Project Cost** ($ million)
Facility Projects			
Vancouver	Children's & Women's	Children's & Women's Redevelopment – Phase 1 & Phase 2 (Planning)	92.9
Prince George	BC Cancer Agency	BCCA Centre for the North	92.7
Various Communities	BC Cancer Agency	Radiation Therapy and Diagnostic Equipment	47.9
Victoria	BC Cancer Agency	Radiation Therapy and Diagnostic Equipment	12.0
Victoria	BC Cancer Agency	Vancouver Island Centre Expansion	7.1
Vancouver	Children's & Women's	Boiler Replacement	4.8
Vancouver	Children's & Women's	3T MRI Facility	3.5
Information Management/Information Technology Projects			
Various Communities	Various Facilities	Clinical Information System	8.0
Kamloops	Health Shared Services BC	Provincial Data Centre	15.8
Equipment Projects			
Various Communities	BC Ambulance Service	Ambulance Replacements	16.0
Vancouver	Children's & Women's	Digital Mammography Equipment	4.0
Vancouver	Children's & Women's	CT Scanner Replacement	3.0

Contact Information

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Web site: www.phsa.ca

Hyperlinks to Additional Information

BC Ministry of Health www.gov.bc.ca/health

BC Cancer Agency www.bccancer.bc.ca

BC Centre for Disease Control www.bccdc.ca

BC Children's Hospital and Sunny Hill Health Centre for Children www.bcchildrens.ca

BC Mental Health & Addiction Services (Forensic Psychiatric Services, Riverview Hospital, Children and Women's Mental Health & Substance Use Services located at BC Children's Hospital, Provincial Specialized Eating Disorders Program) www.bcmhas.ca

BC Provincial Renal Agency www.bcrenalagency.ca

BC Transplant Society www.transplant.bc.ca

BC Women's Hospital and Health Centre www.bcwomens.ca

Cardiac Services BC www.phsa.ca/AgenciesAndServices/Agencies/Cardiac/default.htm

Perinatal Services BC www.perinatalservicesbc.ca/default.htm

Emergency & Health Services Commission (including BC Ambulance Service and BC Bedline) www.health.gov.bc.ca/ehsc/

Health Shared Services BC (HSSBC) www.hssbc.ca/default.htm

GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE VANCOUVER COASTAL HEALTH AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Vancouver Coastal Health Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The mandate of the Health Authority, defined by the *Health Authorities Act*, is to plan, deliver, monitor, and report on health services, which include population and public health programs, high quality community based health care and support services and acute care, as well as improved productivity and performance.

The mandate for the Health Authority applies to the geographic region stretching from Vancouver, Richmond, the North Shore and communities in the coastal region, including: Squamish, Whistler and Pemberton in the Sea-to-Sky corridor; Gibsons and Sechelt on the Sunshine Coast; and Powell River. Through denominational service agreements with non-profit societies, the Health Authority serves the residents of Bella Bella, Bella Coola and other communities on the Central Coast. The Health Authority also partners with Providence Health Care in Vancouver.

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. <u>Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.</u>

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality and management of clinical services to achieve effective, appropriate, efficient and safer care.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by

Government (some of this information is included in annual reports and does not need to be otherwise displayed);

- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and
- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;

- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;
- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;
- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in

the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	Kip Woodward Chair of the Board Vancouver Coastal Health Authority
Date	Date

pc: Honourable Christy Clark
Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Dr. David Ostrow
President and Chief Executive Officer
Vancouver Coastal Health Authority

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Vancouver Coastal Health

2012/13 – 2014/15 SERVICE PLAN

August 2012

For more information about
Vancouver Coastal Health
see Contact Information on Page 18 or contact:

Vancouver Coastal Health
Corporate Office
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Vancouver, BC, V5Z 4C2
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www.vch.ca

1 Message from the Board Chair & Accountability Statement

On behalf of the Board of Directors of Vancouver Coastal Health (VCH), I am pleased to present the 2012/13 – 2014/15 Health Service Plan. The plan was prepared under the Board's direction in accordance with the *Health Authorities Act* and B.C. Reporting Principles. It is consistent with the Government's strategic priorities and plan, and the Ministry of Health goals, objectives and strategies. The VCH Board of Directors is accountable for the contents of this plan.

All significant assumptions, policy decisions, and identified risks have been considered in preparing this plan, as of the date of submission. The performance measures presented are consistent with VCH's mandate and goals, and focus on aspects critical to the health authority's performance. Our performance targets have been determined based on an assessment of VCH's operating environment, forecast conditions, risk assessment, fiscal realities and past performance.

This service plan advances VCH's ***People First*** strategy which shapes how we approach our vision, mission and goals. ***People First*** is our commitment to our patients and public. It is the lens with which we encourage shared responsibility with people in their own care and the improvement of our services. It is the lens through which we foster respectful collaboration among health care professionals, staff, the people we serve and our communities.

VCH recently celebrated its tenth anniversary – a decade marked by new treatments, procedures and programs which are now part of the daily life of our services and facilities. Every day, our experience with patients and clients drives new thinking and innovation about what we can do differently, and better, as we strive to be a ***People First*** organization.

Delivering health care is a complex endeavour. Behind every emergency department visit, home care visit, every birth and even every water quality inspection are the men and women of health care, their partners, the volunteers and other generous individuals who give back to their community and to the well-being of others.

But despite our successes and commitment, challenges persist. Inequities in health status across populations remain, and service demands continue to grow, while resources become increasingly tighter. Our capital infrastructure requirements grow daily and a commitment is needed to ensure our gains are not compromised by failing buildings, equipment and technology. VCH can demonstrate strong health outcomes when compared to other settings (including those that spend more money) because making health dollars go further is part of our dedication and focus on efficiency and innovation at every level.

While VCH is fully committed to the Ministry of Health *Innovation and Change Agenda* and actively supports strategies to improve population health, enhance the patient and provider care experience, and reduce costs, we cannot do this alone. We must see ongoing value from consolidation of services with our Lower Mainland and provincial partners, as well as stronger support for the vital provincial and tertiary services provided by VCH.

Demand and funding pressures have grown significantly in these provincial programs as a result of innovation, increased survival rates and life expectancy. Because of this, VCH continues to work with the Ministry to address these provincial program pressures - particularly for the Solid Organ Transplant and Bone Marrow Transplant programs - to ensure we can fulfill the provincial mandate and provide service to this population.

Patient Focused Funding (PFF) is a key facilitator of targeted transformation but requires a consistent governance process which enables health authorities to innovate across the continuum of care to foster truly positive change. VCH supports steadily increasing the share of operating budgets being determined by PFF and strongly believes that hard-won gains through innovation in one year should continue to attract incentive funding in following years rather than becoming the new performance baseline.

Demand drives innovation. As these past 10 years have shown, there is no end to patient demand or need, and certainly no end to the thinking and innovation that VCH staff demonstrates each and every day which makes a difference in the lives of people from all walks of life. That's a cause for confidence in us all.

C.C. (Kip) Woodward
Board Chair, Vancouver Coastal Health

August 2012

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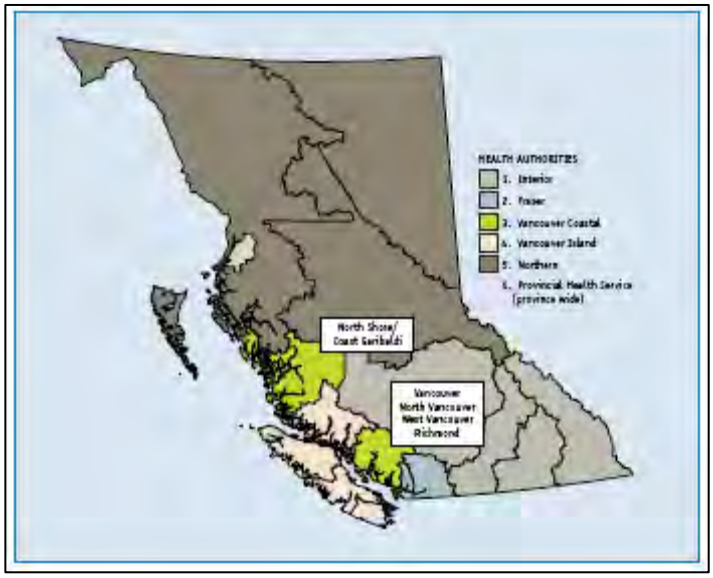
Organizational Overview

VCH delivers health services to more than one million people, or one quarter of British Columbia's population. The geographic area covered by VCH includes 12 municipalities and four regional districts in the coastal mountain communities, Vancouver, North Vancouver, West Vancouver, Richmond and 14 Aboriginal communities. VCH also delivers health services to many people from across the province, and is the main centre for academic health care (clinical service, teaching, research) in BC. The following describes some of the unique and complex populations served by VCH:



- A sizeable homeless population, burdened by a higher degree of mental health and substance use issues;
- Nearly 60% of new positive HIV tests in BC are reported in VCH[1]; compared to other provinces and territories, BC has the third highest number of positive tests in Canada[2];
- Non-VCH residents often require primary/secondary services as well as specialized services (i.e. tertiary/quaternary) offered by VCH such as complex cardiac, renal care and rehabilitation services. This means that VCH provides a large number of acute and rehabilitation beds that are utilized annually by non-VCH residents. Population growth and aging in other health authorities increases the demand for VCH resources and services;
- VCH serves one of the most culturally, economically and geographically (rural and urban) diverse populations in the province, and
- VCH is the main centre for academic health care (clinical service, teaching, research) in BC. Working with many partner organizations, the research and teaching programs are deeply integrated with the provision of general, complex and specialized care to patients from across VCH, BC and other parts of Canada.

Corporate Governance

Vancouver Coastal Health is committed to being open and accountable to the public we serve. VCH reports to a Board of Directors and its sub-committees. VCH's financial and operational information and results are reported to the Ministry of Health which provides the majority of our funding. The Board of Directors oversees operations, works with management to establish overall strategic direction for the organization and ensures appropriate community consultation. More information about the board members, board committees and the senior executive team can be found at http://www.vch.ca/about/.

We are committed to taking part in a continual review and updating process that follows the Board Resourcing and Development Office (BRDO) provincial best practice guidelines. The status of VCH's governance practices is available at http://www.vch.ca/about/board/.

For more information on specific services, please see www.vch.ca.

[1] BC Centre for Disease Control Annual Supplement Report: HIV and Aids 2009.
[2] Public Health Agency of Canada Surveillance Report to December 31, 2009

2 Strategic Context

VCH encompasses a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system – prevention to end-of-life care – in the context of significant growth in demand. VCH is the main centre for academic health care (clinical service, teaching, research) in BC. Working with many partner organizations, research and teaching programs are deeply integrated with the provision of general, complex and specialized care to patients from across VCH, BC and other parts of Canada.

VCH continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to the frail elderly, a rising burden of illness from chronic diseases, mental illness, and cancer and advances in technology and pharmaceuticals driving new costly procedures and treatments. The pressure is compounded by the need for new health service delivery models which help to support the sustainability of the system, and the need to maintain and improve the health system's physical infrastructure (i.e. buildings and equipment).

VCH also faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved significantly in several respects over the past few decades, the Aboriginal population in VCH continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other residents. Health inequities are also particularly pronounced for people with low socioeconomic status. VCH is committed to tackling health inequities and continues to work with First Nations, Métis and other partners to improve Aboriginal people's health and to close this gap in health status.

Meeting Provincial Demands

In addition to the highly specialized services (such as complex cardiac and renal services, specialized rehabilitation services, solid organ & bone marrow transplantation, deep brain stimulation, etc.) provided by VCH to people from across BC, VCH also supports residents of other health authorities through many primary and secondary services. This means that VCH provides a large number of acute and rehabilitation beds that are utilized annually by non-VCH residents. Population growth and aging in other health authorities increases the demand for VCH resources and services.

Population Diversity

VCH serves one of the most culturally, economically and geographically (rural and urban) diverse populations in the province. Vancouver, Richmond, and Coastal communities have some of the highest number of visible minorities in the province and many recent immigrants live in the large VCH urban centres. Residents in some of the local health areas within VCH have the longest life expectancies in the province, while residents in other local health areas have amongst the shortest[3]. Likewise, VCH has some of the lowest ranked local health areas on the BC regional socio-economic index, as well as some of the highest ranked areas[4].

Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis and asthma. People with chronic conditions represent approximately 35% of the VCH population[5] and consume a significant portion of the available resources. Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions across BC could increase 58% over the next 25 years[6] and be a significant driver of demand for health services. With risk factors such as obesity, tobacco use and inactivity, it is projected that the prevalence of chronic conditions will increase in the future, even more so than predicted by the aging population alone. According to the World Health Organization[7], 80% of some chronic conditions can be prevented. Specific research has found that moderate exercise and diet control among overweight people with pre-diabetes

[3] BC Stats Vital Statistics Life Expectancy at Age 0 by BC Local Health Area 2007-2011 Accessed June 2012
[4] BC Stats Overall Regional Socio Economic Index by Local Health Area 2010 Accessed June 2012
[5] BC Ministry of Health Medical Services Economic Analysis Branch Verified June 2012
[6] BC Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis,* March 2007, (2007-064); as cited in Primary Health Care Charter: a collaborative approach (2007), Ministry of Health
[7] World Health Organization, *Preventing Chronic Diseases a Vital Investment* 2005

(impaired glucose tolerance) reduces the likelihood of developing diabetes by more than 50%[8]. Targeted effective prevention strategies are therefore critical to the overall strategy.

Aging Population

VCH's older population is growing quickly, with the population over 65 years of age expected to increase from about 13% to nearly 22% of the VCH population over the next twenty years.[9] The aging population is a significant driver of demand because the need for health services rises dramatically with age. People over 65 years of age make up about 13% of the VCH population, but use nearly 33% of physician services, nearly 49% of acute care services, almost 46% of PharmaCare expenditures, over 75% of home and community care services and nearly 92% of residential care services.[10] The need to help seniors to stay healthy, independent and in the community for as long as possible continues to grow.

Population Assessed as Frail

About 1% of the overall VCH population is considered as "frail"[11]. However, among the nearly 80,000 people currently over 75 years of age in VCH, this portion increases to about 12% - and continues to increase significantly as individuals move into their 80s and 90s. Various types of dementia also become more prevalent as individuals move into these later decades of life. A significant portion of available resources are directed towards supporting frail persons – both in care and community settings. This includes resources for hospital services – and it is likely that much of the spending occurs for a hospital episode that *precedes or precipitates* the frailty requiring residential care.

Patients with Severe Mental Illness and/or Substance Use Requiring Hospitalization

Nearly 22,000 people in VCH suffer with a severe mental illness[12]. In addition, a significant homeless population, burdened by a higher degree of mental health and substance use issues, represents an important obligation for VCH. VCH is the hub for many specialized mental health and substance use services, drawing clients with significant needs from around the province.

HIV Patients

Nearly 60% of new positive HIV tests in BC are reported in VCH[13]. Compared to other provinces and territories, BC has the third highest number of positive tests in Canada[14].

Advances in Technology and Pharmaceuticals

New treatment and technology development over the past ten years has included less invasive surgery, increased use of diagnostic imaging and the introduction of biological and tailored drug therapies that have made health care more efficient and effective, but also led to a significant increase in demand for products and services. As the main centre for academic health care (clinical service, teaching, research) in BC, and its role in developing and disseminating new treatments and technologies, the continued impact on VCH is significant.

Health System Infrastructure

VCH continues to face a significant challenge to maintain and improve the physical infrastructure for delivering health services. VCH has an urgent need to update or expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to residents. In 2005, the government provided a one-time increase of $250 million to the Lower Mainland health authorities to compensate for the loss of capital funding associated with the Greater Vancouver Regional Hospital District being dissolved, with the VCH share being $132 million. VCH believes that there is an ongoing obligation by the Ministry to replace this source of capital funding.

[8] Tuomilehto J, Lindstrom J, Eriksson JG, et al *Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance*. New England Journal of Medicine 344 2001.
[9] PEOPLE Population Data, BC STATS
[10] Health System Planning Division, Ministry of Health Services; using MSP Expenditures 2008/09Acute Care: Inpt & Day Surgery workload weighted cases, DAD 2008/09; HCC community services by age group 2008/09, summed based on average unit costs; Residential care days 2008/09.
[11] BC Ministry of Health Health System Matrix Version 3(1).0
[12] BC Ministry of Health Health System Matrix Version 3(1).0
[13] BC Centre for Disease Control Annual Supplement Report: HIV and Aids 2009.
[14] Public Health Agency of Canada Surveillance Report to December 31, 2009

3 Goals, Objectives, Strategies & Performance Measures

This Service Plan has been developed within the context of the 2012/13-2014/15 Service Plan for the Ministry of Health. The MoH Service Plan has set out four goals for the health system. Applied to VCH, these goals are:

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of VCH residents.

Goal 2: VCH residents have the majority of their health needs met by high quality primary and community based health care and support services.

Goal 3: VCH residents have access to high quality hospital services when needed.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

The VCH objectives and strategies closely align to these goals and the designated key results areas articulated by the Ministry of Health. Together they will support the strategic vision to meet the sustainable population health and health care needs of the people of British Columbia.

VCH strives to be leaders in promoting wellness and ensuring care by focusing on quality and innovation. VCH is committed to supporting healthy lives in healthy communities with our partners through care, education and research. Dedicated to service, integrity and sustainability, VCH builds on patient/community focus, engaged teams, operational excellence and financial sustainability to:

- provide the best care;
- promote better health for our communities;
- develop the best workforce; and
- innovate for sustainability.

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of VCH residents.

VCH is committed to helping residents who do not enjoy good health or who are at risk of diminished health, along with supporting residents who enjoy positive health status. VCH will focus on reducing health inequities in the populations we serve. Through on promotion and prevention initiatives that have an impact on the overall health of residents, VCH will support the health of VCH families and communities by encouraging healthier lifestyles and choices and enabling self-management. There will be emphasis on key populations, including Aboriginal peoples, young children, people with mental illness and/or problematic substance use, people of low socio-economic status, and people with chronic conditions.

Objective: Promote better health for our communities.

Strategies:

- Support families and communities across the region to strengthen healthy living and choices opportunities, including informed dining and healthy eating, physical activity, reduced salt and sugary drink consumption, tobacco use reduction and responsible alcohol use to help reduce the burden of chronic diseases and obesity.
- Expand partnerships with First Nations communities across VCH through formal linkages, space sharing and co-location arrangements, clinic and health centre initiatives, Aboriginal patient navigators, staff training, case collaboration, and best practice knowledge exchange to generate greater emphasis on health promotion programming sensitive to Aboriginal culture, to increase access by Aboriginal people to culturally sensitive health services and to improve the delivery and evaluation of Aboriginal-specific programs. Grow the relationships with Aboriginal communities and schools across VCH to better support of the health status of Aboriginal children, including elevating the vision screening rate and service continuity for Aboriginal Kindergarten-age children.

- Commence implementation of the Nurse Family Partnership program to provide intensive nurse home visiting to young, low income first time mothers to improve pregnancy outcomes and influence health early childhood development, to help prevent disorders and development challenges, and to improve maternal well being, parenting skills and family economic self-sufficiency
- Support the provincial designation and implementation of standard public health perinatal, child and family services to help improve the infrastructure that promotes child health, to help reduce child vulnerability, and to foster healthy families in healthy communities.
- Increase collaboration between primary care and other health and social services, and remove barriers to primary health to enable greater access to care – particularly for target and disadvantaged populations across VCH.
- Strengthen food security for disadvantaged populations by helping to identify and address food security issues, supporting community-based food security initiatives and building capacity of disadvantaged populations to access, store and cook nutritious food.

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average sodium content of adult hospital diets	3580 mg	3200 mg	2900 mg	2500 mg

Data Source: Population and Public Health Division, Ministry of Health.

Discussion:

This performance measure focuses on the average sodium content of the general/regular diets for adults within VCH hospitals. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and asthma. According to the World Health Organization, interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective.[15]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease. Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. BC has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the *Guidelines for Food and Beverage Sales in BC Schools*.

VCH will progressively reduce the average sodium content of adult hospital diets towards achieving the 2016 goal of an average intake of 2300 mg of sodium per day.

Performance Measure 2: Health of Aboriginal Children

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of Aboriginal Kindergarten children receiving vision screening	85%	91%	92%	93%

Data Source: Population and Public Health Division, Ministry of Health.

[15] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21

Discussion:

This performance measure supports Aboriginal children's access to vision screening. Vision deficits such as amblyopia (lazy eye), strabismus (crossed eyes), and refractive errors (nearsightedness and farsightedness) are common problems in the preschool and school age population. Early detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child's opportunity for academic success and learning potential.

Goal 2: VCH residents have the majority of their health needs met by high quality primary and community based health care and support services.

VCH will deliver comprehensive, integrated primary and community care equitably across local health areas to improve the health outcomes of residents, enable positive impact on patient/family quality of life and satisfaction with the health system, and contribute to health system sustainability. VCH will advance health promotion and prevention to prevent or delay the onset of frailty, support clinical excellence at the community level to help support individuals to manage chronic disease, mental illness and/or problematic substance use, and integrate services to improve coordination of care, address gaps, improve transitions and reduce duplication.

Objective: Coordinate care across the continuum of primary, community, home and acute care.

Strategies:

- Partner with physicians through Collaborative Services Committees and Divisions of Family Practice to improve the coordination of services across setting and providers, and to develop and support shared care and care management strategies. This will help to increase the proportion of patient needs being met by primary and community based health services, and will serve to enhance the care experience for target populations – including people at the end of life, frail seniors and people with dementia, and people with chronic conditions.
- Expand home and community services that optimize patient focused funding arrangements and advance the "home is best" philosophy by supporting client and family independence and self management, by assisting people with aging in place for as long as possible, and by improving protocols for rapid access to specialist care for patients & their family physicians. This will enable greater system effectiveness for people with multiple needs, while helping to reduce avoidable reliance on hospitals and residential care.
- Increase the budget for non-acute services by 7% in 2012/13 while holding acute services to an increase of less than 3% (after removing the effect of Lower Mainland consolidation transfers). Through targeted allocation and strategic use of patient focused funding (non-acute services expenditures have increased by an average of 5.2% over past two years while acute expenditures have increased by 1.7% per year - after removing the effect of Lower Mainland consolidation transfers). VCH continues to demonstrate its commitment to having the majority of resident's health needs met by primary and community care.
- Within the integrated VCH Communities of Care (Coastal, Richmond and Vancouver), continue to implement integrated primary and community care strategies for target populations across eight designated community-based service delivery areas by advancing care management and "patient-as-partners" initiatives, by enabling family physician engagement and – most importantly – by increasing the proportion of patients receiving new or redesigned services at home and in the community.
- Build regional programs, departments and processes to improve clinical integration and quality, support prevention and early intervention, improve transitions between levels and locations of service, and advance the integration between primary, community, home and acute care.
- To ensure that home and community care services are sustainable and continue to meet the needs of VCH seniors, support and implement the *Improving Care for BC Seniors: An Action Plan* through comprehensive responsiveness to concerns and complaints, better access to information for making informed choices, consistent standards for residential care services, through Community Response Networks and elder abuse prevention and response strategies, and by ensuring the majority of senior care needs and support are provided within their own community.
- Support the evaluation of the integrated primary and community care strategy in collaboration with the Ministry of Health and other health authorities to enable consistent monitoring and reporting of progress

and to ensure alignment of care management, patient as partners, family physician engagement, and new or redesigned home and community services.

- In alignment with the *Healthy Minds, Healthy People: A Ten Year Mental Health Plan*, improve the health status and well being of individuals and families served by VCH at every stage of life through the provision of high quality, safe, integrated and comprehensive continuum of mental health services, supported by consultation with individuals, family members and community-based service providers. Ensure safe care and high quality outcomes through the adoption of optimal, evidence-informed guidelines, implementation of care standards, collaborative care initiatives, and measureable and accountable service delivery. Improve the care experience through an expanded family care model, patient and family advisory groups, regular care experience surveys and engagement with individuals and families partners.

Performance Measure 3: Managing Chronic Disease in the Community

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people under 75 years of age with a chronic disease admitted to hospital (per 100,000 people)	184	187	182	177

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health.
Note: The 2009/10 baseline has been restated according to the new CIHI methodology which determines the calculation of this rate nationally. The new methodology includes more people with diabetes. VCH already has a very low rate; therefore, reductions are possible at a pace slower than previously expected. The 2012/13 target has been adjusted accordingly.

Discussion:

This performance measure tracks the number of people with select chronic conditions, such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic conditions need the expertise and support of family physicians and other health care providers to manage their disease in order to maintain their functioning and reduce complications. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which helps to control the costs of health care. As part of a larger initiative of strengthening community-based health care and support services, VCH is working with family physicians and other health care professionals to provide more care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home Health Care and Support for Seniors

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of people 75+ years of age receiving home health care and support	14.5%	15.5%	16.0%	16.5%

Data Source: 1. PEOPLE 36, BC Stats. 2. Community Data Warehouse, VCH. 3. Home and Community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management Information Branch, Planning and Innovation Division, Ministry of Health. Note: The data for this measure may be restated at a later time when the new data reporting system is fully implemented. Targets may be revised accordingly.

Discussion:

This performance measure tracks the percent of seniors (aged 75+ years) who receive home health care such as home nursing and rehabilitative care, clinical social work, assisted living and adult day programs. While the majority of seniors experience healthy aging at home, there is growing need for community care options to support those who can no longer live independently. This support helps people manage chronic conditions and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community-based health care and support services, VCH is expanding home health care services and ensuring that high risk seniors are made a priority in

the provision of care. This focus, combined with the use of technology, can significantly improve health outcomes for seniors.

Goal 3: VCH residents have access to high quality hospital services when needed.

Acute care represents a critically important yet expensive part of the health services provided by VCH to its residents and to people from across BC. By furthering integration of acute care with expanding community and home based services, improving quality through innovation and expanded use of evidence-based guidelines, protecting capacity by continually improving patient flow, and realizing incentives embedded within patient centered funding, timely access for patients needing acute will be enhanced. These and other strategies will be underpinned by expanding use of evidence-based protocols across clinical services.

Objective: Reduce unnecessary variation in care by using evidence based protocols across VCH.

Strategies:

- Accelerate the implementation of evidence-based protocols – including provincial priority areas - to reduce unwarranted variation in the quality of care, and to improve care outcomes across settings by strengthening organizational structures and processes, and improving region-wide progress and outcome reporting.
- Complete implementation of a comprehensive system to coordinate information on medications used by VCH patients and clients in order to increase patient safety when patients are admitted and move through the system, and to increase system efficiencies when taking medication histories and ordering medications.
- Expand the provision of early (within 48 hours) medical assessment and intervention in six key areas (delirium/cognition, medication management, functional mobility, nutrition and hydration, bowel and bladder care and pain management) to help ensure meaningful and appropriate hospital care for seniors.

Objective: Optimize capacity, resource utilization and productivity.

Strategies:

- Enable access to enhanced home and community services through optimized application of patient focused funding to support independence and self management, assist people with aging in place for as long as possible, and reduce avoidable reliance on hospitals and residential care.
- Advance development of new mental health facilities and the transition of tertiary mental health beds and resources from Riverview Hospital to improve the care environment for patients and staff, and to further develop the continuum of services and settings for people living with serious and persistent mental health issues.
- Develop and implement cardiac sciences service priorities across VCH and quaternary services for BC to ensure patients have access to leading and comprehensive care within a provincial network of cardiac services, to ensure alignment with the changes taking place in other health authorities, to foster leadership in teaching, research and innovation, and to support advancements in clinical practice.
- Enable timely access for patients to surgery by providing patient-centred, efficient surgical services by expanding and coordinating services in areas such as rapid access breast diagnosis and treatment, sino-nasal, bariatric, and vascular surgery. Further improve patient outcomes by targeting interventions in specific areas as identified through the National Surgical Quality Improvement Program (NSQIP). Increase system efficiency through greater connectivity between surgeon's offices and OR booking, by optimizing waitlist management and by reducing costs of operating room supplies per case.
- Reduce the length of hospital stays when care is more appropriate in other settings and reduce unplanned readmissions to hospital to improve the patient care experience and optimize resource utilization through close and constant application of best practices in care management, aggressive use of operational tools, and continuous system alignment to ensure smooth transitions from acute to community settings.
- Increase access and improve efficiency in the delivery of diagnostic services across VCH through implementation of provincial guidelines for prioritization of CT studies, improved wait time reporting for all

modalities, and deployment of clinical guidelines and clinical support tools. Drive improvement across the health care delivery quality dimensions of appropriateness, access and safety, and support deployment of the approved provincial radiologist peer review system.

Performance Measure 5: Access to Surgery

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of non-emergency surgeries completed within the benchmark wait time	75%	75%	80%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Planning and Innovation Division, Ministry of Health.

Discussion:

In the last several years, VCH has successfully reduced wait times for cataract, hip and knee replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding - combined with continuous effort to foster innovation and efficiency in VCH hospitals - will improve the timeliness of patients' access to an expanding range of surgical procedures. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times. These benchmark wait times are new and give a priority rating for each surgical patient, based on individual need. Due to the need to 'catch up' on surgeries for patients without a priority rating who have already been waiting, surgery for some patients with the new priority rating may be delayed. The target for 2012/13 will allow for this 'catch up' period, after which wait times for patients with priority ratings should gradually decrease, although OR capacity may become a limiting factor.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

Through efficiency and productivity improvements and focused alignment with provincial strategies, VCH is able to maintain service levels and manage effectively within available resources. From this solid footing, VCH will continue to push for improvements in quality, productivity and efficiency across the continuum. These improvements will be leveraged through clinical and systems transformation, LEAN culture and expectations, through workforce optimization, by service sharing and consolidation across the Lower Mainland & BC, and through the improved provision of information for decision-making. To support better care for patients and residents – and to optimize productivity in the use of current and new capacity - VCH will continue to press for increased access to capital resources. In addition, VCH will do the most with the least environmental impact.

Objective: Accelerate clinical and system transformation to optimize care and improve system performance.

Strategies:

- Design and implement a clinical electronic health information system that ensures high quality, integrated care. Work closely with PHSA and Health Shared Services BC in the design, implementation and maintenance of information technology solutions and services which are enable by system and process transformation and serve to optimize care for patients/clients and improve system performance.
- Support the development, integration and deployment of eHealth technologies and systems, and new information tools to support high quality, integrated care, improve system accuracy and efficiency, and help optimize the resource available for improving the health of populations across the region.

Objective: Continuously improve using LEAN thinking at all levels.

Strategies:

- Accelerate LEAN education for staff and organizational leaders to further embed LEAN thinking with the VCH organizational culture and enable system-wide strategic improvement in the delivery of services to patients and clients.
- Implement a standard approach to LEAN-based improvements to enhance coordination and translation of activities across settings, to improve the delivery of quality outcomes, and enable sustainment of gains over time.
- Apply LEAN-based approach to regional and community of care strategy deployment to ensure focus and alignment on activities that are most important to patients and clients, and are supported by the tracking and reporting of "true north" metrics.

Objectives: **Maximize staff potential so they can do their best every day. Encourage a culture of respect, engagement, safety and accountability. Strengthen leadership and management capacity. Partner with physicians to improve quality and implement performance accountability.**

Strategies:

- Complete implementation - supported by staff training - of three major human resource systems:
    - staff forecasting to enable optimal matching of staff to clinical volumes to help enhance workforce productivity, reduce overtime and support relief staffing, and optimize bed and operating room utilization and flow;
    - staff timekeeping and scheduling to provide more proactive and consistent scheduling practices across VCH to reduce overtime and better deploy our human resources; and
    - nurse resource pools to provide experienced help on medical/surgical units, support VCH's long term relief staffing needs, and create more unit-based positions for new nursing graduates.
- Accentuate the VCH-wide Attendance Promotion Program, hire vacation relief positions, and convert bed capacity from temporary to permanent to help reduce overtime and manage sick time.
- Building on our experience as the first BC health authority to regularly post a balanced scorecard on its' public website, further develop and align comprehensive and consistent health services reporting to foster quality improvement, improve governance and leadership capacity, help guide decision-making, and assist in the achievement of health system objectives.
- Collaborate with provincial partners to strengthen the assessment and support for performance of medical staff members, and support deployment of initiatives to monitor and enhance the quality of medical care across VCH.
- Grow organizational capacity to provide care and services to patients and clients across VCH by strengthening leadership and management capacity through education and training and by enabling inter-professional team-based care, supporting health professional to practice to their full scope, and supporting staff through service redesign.
- Recruit and retain the best people across VCH by fostering a culture of excellence, recognition and respect, regularly tracking and actively supporting staff engagement and safety, and enabling staff commitment to patients/clients and families and to the public and communities served by VCH.

Objective: **Encourage innovative service models and funding mechanisms. Secure increased capital funding.**

Strategies:

- Consistent with VCH's role in providing many provincial services to residents from across BC, engage the Ministry of Health and Provincial Health Services Authority (PHSA) to fully resource key services – including solid organ and leukemia/bone marrow transplantation, deep brain stimulation, and amyotrophic lateral sclerosis services – and ensure sustained, coordinated and appropriate service delivery to patients in need.
- Rejuvenate residential care capacity across VCH in light of the pressing situation around the age and condition of many residential care facilities. This will help ensure that those clients who cannot be safely

cared for at home or in the community and for whom residential care is the appropriate option will have access to settings which enable quality of life and quality of care.

- Engage the Ministry of Health and other partners to secure access to adequate capital funding to meet pressing current and future infrastructure needs, and to ensure appropriate settings and equipment to deliver safe and effective care and services.
- Deliver further value through partnership and knowledge transfer across Lower Mainland health organizations by promoting innovation, consolidating resources, and pursuing new opportunities in the delivery of administrative and support efficiencies in support of patient care. Achieve stronger buying power and economies of scale through strategic consolidated sourcing of the services and products needed to support the delivery of health care services.
- Incent improved quality, efficiency and effectiveness of services to patients and clients by fully optimizing current activity-based and pay-for-performance patient-focussed funding arrangements, as well as by implementing funding arrangements that support integrated primary and community care under the principle that "home is best". Expand the proportion of incentive-based funding received by and allocated within VCH to encourage innovation and support system sustainability.
- Accelerate the integration of primary and community care by enhancing home-based services to replace or delay residential care, by supporting early appropriate hospital discharge for patients with chronic diseases, by screening and following up with older adults who present at emergency, by enabling telephone support for patient self-management, and by improving specialist access for patients and GPs.
- Integrate and standardize business processes across VCH and in partnership with other health authorities through the application of appropriate technologies to increase efficiencies and minimize waste and to ensure that resources are optimized in support of patient care and service delivery.

Performance Measure 6: Nursing Overtime

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Nursing overtime hours as a percent of productive nursing hours	4.0% (2010 calendar year)	No more than 3.5%	No more than 3.4%	No more than 3.3%

Data Source: Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC). The VCH figures include Providence Health Care.

Discussion:

This performance measure compares the amount of overtime worked by nurses to the amount of time nurses work. Overtime is a key indicator that is used in assessing the overall health of a workplace. High rates of overtime may reflect inadequate staffing or high levels of absenteeism, resulting in workload issues and increased costs. Reducing overtime rates by addressing the underlying causes not only assists in reducing direct (e.g. labour) and indirect (e.g. unengaged staff) costs to the health system, it also helps promote both patient and caregiver safety. As noted above, VCH will apply a comprehensive combination of strategies – including Attendance Promotion Program, staff forecasting, staff timekeeping and scheduling, hiring of vacation relief positions, converting bed capacity from temporary to permanent, etc. to help reduce staff overtime.

Resource Summary

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Plan	2014/15 Plan
Operating Summary:				
Provincial government sources	3,082.9	3,185.0	3,265.0	3,315.9
Non-provincial government sources	204.9	194.0	196.1	198.1
Total Revenue:	3,287.8	3,379.0	3,461.1	3,514.0
Acute Care	1,966.4	2,038.9	2,087.4	2,119.3
Residential Care	442.0	431.5	438.7	445.4
Community Care	196.8	212.3	219.5	223.2
Mental Health & Substance Use	269.6	291.3	298.0	302.7
Population Health & Wellness	117.0	118.1	121.5	123.5
Corporate	289.5	286.9	296.0	299.9
Total Expenditures:	3,281.3	3,379.0	3,461.1	3,514.0
Surplus (Deficit)	6.5	0.0	0.0	0.0
Funded by Provincial Government	61.4	79.2	37.5	19.2
Funded by Foundations, Regional Hospital Districts, and other non-government sources	38.4	37.6	25.6	6.2
Total Capital Spending	99.8	116.8	63.1	25.4

Notes:

1. Operating revenues and expenses are a consolidation of VCH and PHC information. They are consistent with what has been presented in past years. These amounts will not agree to any publicly available consolidated Financial Statements.
2. In 2011/12 there was a one-time expense of $12.8M in the Residential Care sector for the purchase of ceiling lifts and for one-time repairs and maintenance expenses.
3. Health authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

Capital Project Summary

Following is a list of VCH approved capital projects over $2 million in total capital cost:

Community (as applicable)	**Facility Location** (as applicable)	**Project Name**	**Total Project Cost** ($ million)
Facility Projects			
North Vancouver	Lions Gate Hospital	The HOpe Centre	58.1
Sunshine Coast	Sechelt	St. Mary's Hospital Redevelopment	43.7
Vancouver	Vancouver General Hospital	Tertiary Mental Health - Willow Pavilion	27.9
Vancouver	St. Paul's Hospital	SPH Electrical Control Systems	12.5
Vancouver	Youville Residence	Tertiary Mental Health - Youville Behaviour Stabilization	6.0
Vancouver	St. Paul's Hospital	UBC School of Medicine Expansion	5.7
Vancouver	St. Paul's Hospital	Critical System - Elevator Renewals - SPH	4.0
Sunshine Coast	Gibsons	Tertiary Mental Health - Gibsons Kiwanis Village	3.9
Vancouver	Vancouver General Hospital	Tertiary Mental Health - Willow Chest	3.0
Vancouver	Vancouver General Hospital	Critical System - Domestic Water Piping Systems - Jim Pattison North	3.0
North Vancouver	Lions Gate Hospital	LGH Endoscopy Unit Redesign	3.0
Vancouver	St. Vincent's Langara	Tertiary Mental Health - Langara Neuropsych	2.1
Medical & Diagnostic Equipment Projects			
Information Management/Information Technology Projects			
North Vancouver	Various facilities	Primary Access Regional Information System	7.2
Various communities	Various facilities	Electronic Staff Scheduling and Timekeeping Phase III	5.4
Various communities	Various facilities	Decision Support Infrastructure Expansion Phase II	2.7
Vancouver	Vancouver General Hospital	VA Nursing Documentation - Level 4	2.5

4 Contact Information

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GOVERNMENT LETTER OF EXPECTATIONS

BETWEEN

THE MINISTER OF HEALTH
(AS REPRESENTATIVE OF
THE GOVERNMENT OF BRITISH COLUMBIA)

AND

THE CHAIR OF THE VANCOUVER ISLAND HEALTH AUTHORITY
(AS REPRESENTATIVE OF THE HEALTH AUTHORITY)

APRIL 1, 2012 – MARCH 31, 2013

1. PURPOSE

This Government Letter of Expectations (GLE) between the Government of British Columbia (herein named the Government) and the Vancouver Island Health Authority (herein named the Health Authority) is an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority planning and performance reporting to Government.

This GLE does not create any legal or binding obligations on the part of Government or the Health Authority, but rather is intended to define and promote a positive and co-operative working relationship.

2. HEALTH AUTHORITY MANDATE

The mandate of the Health Authority, defined by the *Health Authorities Act*, is to plan, deliver, monitor, and report on health services, which include population and public health programs, high quality community based health care and support services and acute care, as well as improved productivity and performance.

The mandate for the Health Authority applies to the geographic region stretching from Vancouver Island, the Gulf and Discovery Islands and the mainland region located adjacent to the Mount Waddington and Campbell River areas.

3. HEALTH AUTHORITY ACCOUNTABILITIES

3.1 Appointment of Chief Executive Officer

The Health Authority is governed by a Board of Directors (the Board), which is appointed by, and accountable to, Government. The Health Authority Chief Executive Officer is selected in a collaborative process between the board of directors and Government, through the Deputy Minister of the Ministry of Health (the Ministry). The Health Authority Chief Executive Officer is appointed by the Board once approval of the selection is granted by the Minister of Health.

3.2 Alignment With Government Priority Initiatives

The Health Authority is accountable for ensuring its planning, business operations and service delivery activities are aligned with Government direction and contribute to the successful achievement of Government goals and priorities. The Health Authority must also ensure its services support the health of the population and promote public confidence in health system performance. The Health Authority will communicate its planning, business operations and service delivery activities clearly and in terms easily understood by the public.

Government provides direction through various means, including: ministerial directives, health authority funding letters, policy communiqués, executive member communication, and through the legislative, regulatory and policy framework that governs the health sector.

The progress of the Health Authority toward achieving Government's health sector priority initiatives in this GLE and other Ministry instructions that may be issued to the Health Authority during the term of this GLE will be monitored on an ongoing basis.

The Health Authority must reflect the priorities of Government, including key result area deliverables as outlined by Government, in all relevant aspects of its operations, plans and reports.

a) Government Health Sector Strategic Agenda

The British Columbia health system is guided by four overarching goals: effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; having the majority of health needs met by high quality primary and community based health care and support services; access to high quality hospital care services when needed; and improved innovation, productivity and efficiency in the delivery of health services. The focus of priorities for 2012/13 is on continuously improving quality and efficiency in the health system, which will contribute to improved health for British Columbians. Additional details of the strategic agenda are conveyed to health authorities through the Health Authority Deliverables and Performance Measures 2012/13 document.

1. <u>Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.</u>

   Government is committed to supporting the health status of British Columbians, reducing risk factors for chronic disease and the overall burden of illness in the population.

   In addition to continuously improving public health core programs, the Health Authority will undertake specific initiatives that increase, at a population level, healthy eating and moderate exercise as a basis for lower obesity rates, reduce risk factors and the incidence of chronic diseases against projected levels, and ensure a healthy start for families. These initiatives will be targeted toward the individuals most at risk.

2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.

   As British Columbia's population ages and the incidence of chronic disease increases, there is a need to more effectively support and manage the health of people with chronic diseases, mental illnesses and problematic substance use, women during pregnancy and childbirth, and the frail senior population.

   The Health Authority will provide integrated care through a system of community based health care and support services built around attachment to a family physician and an extended health care team with links to local community services, with the overall goal of reducing the need for hospitalizations and residential care. This includes the implementation of Government's *Improving Care for BC Seniors: An Action Plan*, as well as implementation of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*.

3. British Columbians have access to high quality hospital services when needed.

   Government is committed to building on the excellent care provided in B.C. hospitals, continually improving patients' experience of care and ensuring hospital care is effective, patient-centred, safe, accessible and appropriate.

   The Health Authority will ensure high quality, cost effective emergency and hospital services are available when needed, and will engage in efficiency and quality improvement activities aimed at improving care and the patient experience. The primary approach is the implementation of a provincial Clinical Care Management System to improve the quality and management of clinical services to achieve effective, appropriate, efficient and safer care.

4. Improved innovation, productivity and efficiency in the delivery of health services.

   A high performing health system manages its resources in the most effective and efficient manner, ensuring they are used where they will have the greatest impact on health outcomes for patients and the broader population. The Ministry of Health and the Health Authority will continue to drive improvements in innovation, productivity and efficiency, using human, financial and physical resources in the best possible way to meet British Columbians' needs.

   The Health Authority will collaborate with Government to develop, track and implement initiatives for cost reduction, cost avoidance and improved efficiencies to minimize waste and maximize the focus on quality outcomes. Initiatives include, but are not limited to: expanding patient-focused funding, using Lean processes, supporting administrative cost savings through shared services and supply consolidation, improving diagnostic medical care, strengthening performance assessment systems for medical professionals, expanding use of paramedic skills in health delivery, implementing provincial eHealth solutions, and realizing cost savings for drugs, equipment and supplies.

b) Other Government Health Sector Priorities

5. Aboriginal Health

   The Health Authority will take action to improve health outcomes for Aboriginal peoples and communities and provide culturally safe health services to all Aboriginal peoples, by supporting and guiding strategic directions outlined in the Tripartite First Nations Health Plan and respecting commitments in the Métis Nation Relationship Accord.

The Health Authority will work with tripartite partners to implement the BC Tripartite Framework Agreement on First Nation Health Governance, including supporting the creation of a new First Nations Health Authority with strong linkages to the provincial health system. This includes working collaboratively with BC First Nations in the region to better coordinate health planning and services, entering into partnership accords with First Nations Health Council Regional Tables, and participating on the Tripartite Committee on First Nations Health.

6. Green Health Care

Government is committed to taking action on climate change. The Health Authority will comply with the requirement to make the public sector carbon neutral. Achieving carbon neutrality will require that the Health Authority accurately define, measure, verify and report all greenhouse gas (GHG) emissions from its operations, implement aggressive measures to reduce those GHG emissions, report publicly on these reduction measures and reduction plans consistent with requirements of the *Greenhouse Gas Reduction Targets Act* (2007), and offset any remaining emissions through investments in the Pacific Carbon Trust, which will invest in GHG reduction projects.

3.3 Operational Management Accountabilities

The Health Authority will conduct its affairs to achieve its mandate and the performance expectations and objectives of Government. This includes establishing and implementing corporate strategies, policies, programs, plans and financial outcomes that are consistent with Government's direction and consistent with principles of efficiency, effectiveness, and customer service.

The Health Authority will conduct its operations and financial activities in a manner consistent with the legislative, regulatory and policy framework established by Government, including ensuring a balanced budget (i.e. no deficits).

The Health Authority shall not borrow, raise or secure the payment of monies without the prior approval of the Minister of Health and the Ministry of Finance. Requests for ministerial approval to borrow are to be accompanied by a resolution of the Health Authority's Board and rationale. Capital lease obligations are considered to be a form of borrowing.

The Health Authority is required to operate in a manner consistent with Government's policies for all projects over $50 million, which require that where the provincial contribution to a capital investment is greater than $50 million, a public-private partnership must be considered as the base case for procurement. Projects with provincial funding of between $20 million and $50 million will still be screened to determine whether a more comprehensive assessment of the project as a public-private partnership is warranted. This includes information management and information technology projects or delivery of services.

a) Planning and Reporting

The Health Authority will:

- Produce an annual a service plan and a service plan report consistent with the guidelines and priorities outlined by Government;
- Attend regular meetings of the Health Authority Board Chair and executives with the Minister of Health and other Government representatives to examine achievements to date, initiatives underway and anticipated accomplishments for the upcoming quarter;
- Display all annual Statement of Financial Information Schedules prepared under the *Financial Information Act* in an easily accessible location on its website as directed by

Government (some of this information is included in annual reports and does not need to be otherwise displayed);

- Provide Government with comprehensive, accurate and timely program/contract-related reporting, including financial and statistical service and utilization information on an individual, group and/or population basis as required by Government;
- Submit annually to Government, Board-approved budget working papers consistent with the instructions and funding parameters supplied by Government, and consistent with the requirement for a balanced budget. The budget working papers should reflect the Province's priorities set out in this GLE, and the Ministry of Health's capital plan approved by Treasury Board;
- Submit quarterly to Government, Board-approved forecast and year-to-date spending updates, material underlying assumptions, significant variances from previous forecasts, and other financial and budget reports, as required by Government; and
- Submit capital planning proposals to Government, including information management/ information technology plans, quarterly forecasts on major capital project spending, consistent with Government's capital/debt targets and other reports as required by Government.

b) Labour and Health Human Resources

The Health Authority will:

- Deliver services through Health Authority employees or enter into agreements with the Government or other public or private bodies for the delivery of those services within the statutory constraints applicable;
- Adhere to the agreements signed by Government with the British Columbia Medical Association (BCMA). This includes ensuring that any new contracts, service salary and sessional arrangements with physicians, including remuneration and terms and conditions, do not exceed the established rates and are otherwise consistent with the Provincial Service Agreement, the Provincial Salary Agreement and the Provincial Sessional Agreement, as negotiated between Government and the BCMA. Approval from the Ministry is required prior to implementing exceptions to this policy standard;
- Adhere to the agreements and policy commitments agreed to by Government and the Health Employers Association of British Columbia on behalf of the Health Authority with bargaining units including: Facilities Bargaining Association, Nurses Bargaining Association, Health Sciences Professionals Bargaining Association, Community Bargaining Association, and the Provincial Association of Residents of B.C.; and
- Ensure any changes to compensation plans receive prior approval of the Minister responsible for the Public Sector Employers' Council. For detailed information please contact the Public Sector Employers' Council Secretariat.

c) Risk Mitigation

The Health Authority will:

- Maintain compliance with the Ministry direction on the *Protocol for the Health System Response to Adverse Events and Service Issues* and communicate potential risk issues in a timely manner;
- As appropriate, develop and provide to Government strategies to be implemented by the Health Authority to manage risks to its service delivery;

- Collaborate with the Ministry and, where necessary, seek Government direction before making final decisions on corrective actions; and
- Deliver an emergency and business continuity management program consistent with the general standards and requirements outlined in Chapter 3.2 of the Health Services Management Policy for Health Authorities, Core Public Health Functions Model Core Program for Health Emergency Management, Accreditation Canada Standards (Effective Organization), Canadian Standards Association Z1600 and the National Framework on Health Emergency Management.

4. GOVERNMENT RESPONSIBILITIES

Government is responsible for the legislative, regulatory and public policy framework within which the Health Authority operates. In order to meet these responsibilities and support achievement of performance expectations, Government will:

- Establish, review, revise and communicate the Health Authority mandate;
- Advise the Health Authority in a timely manner of Government's priorities, strategic decisions, public policy and performance objectives and expectations that may impact the Health Authority;
- Establish the overall and Health Authority-specific financial frameworks under which the Health Authority operates;
- Provide to the Health Authority annual operating and capital funding allocations for inclusion in the Health Authority planning activities;
- Work collaboratively with the Health Authority to develop performance measures, targets and goals for annual performance monitoring to support the implementation of Government's strategic priority initiatives;
- Issue directives or orders, or sponsor submissions on behalf of the Health Authority that may be required to seek decisions or policy direction by the Executive Council or its committees, in order to facilitate the Health Authority in fulfilling its mandate and achieving its performance targets;
- Provide the Health Authority with guidelines and timelines for the preparation of required plans and reports based on a predetermined schedule; and
- Provide comment, advice and approval of required plans and reports, as appropriate.

During the term of this GLE, Government may provide further policy direction to the Ministry of Health. The Ministry will communicate any such direction, including implementation expectations, to the Health Authority as decisions are made.

Government has developed policies for ministries and crown agencies (including Health Authorities) for Capital Asset Management (see http://www.fin.gov.bc.ca/tbs/camf.htm) and board remuneration polices. Government has also issued Best Practice Guidelines for board governance and disclosure (see http://www.fin.gov.bc.ca/brdo/governance/index.asp).

5. SHARED ACCOUNTABILITIES

5.1. Communications

It is agreed by both Government and the Health Authority that, to ensure effective and efficient day-to-day communication and relationship building, officials representing both parties will be tasked with implementing the contents of this GLE and ensuring the Minister of Health and the Health Authority Board of Directors are informed of progress in a timely fashion.

Health Authority communication activities will be managed within the specific terms and conditions set out in the Ministry of Health's Government Communications and Public Engagement (GCPE), Health Authority Communications Protocol. Key elements of the Protocol specify that:

- Health Authority capital, policy and program announcements and events are subject to the approval of the Minister of Health or his/her designate;
- The content and timing of Health Authority news releases will be subject to the approval of the Minister of Health or his/her delegate;
- The Health Authority will conduct regular meetings with the Minister to advise him/her of upcoming media and event opportunities, and to discuss potential issues;
- The Health Authority will keep GCPE (Ministry of Health) apprised of upcoming communications opportunities, and will advise Government Members of the Legislative Assembly (MLAs) via newsletter and regular e-mail updates of Health Authority decisions and information updates;
- The Health Authority will designate a senior Health Authority staff person to deal with MLA concerns and questions;
- Health Authority senior executives will assume the lead in responding to significant regional media issues, in a timely, proactive manner and inform the Minister;
- The Health Authority will provide issue alerts to GCPE (Ministry of Health) and Government MLAs in a timely manner, to ensure messaging reflects Government strategic goals and gives MLAs advance notice on breaking issues; and
- The Health Authority will include in any public print or visual materials the provincial logo (as an integrated mark), in addition to the local Health Authority logo.

5.2. Monitoring

Monitoring performance is fundamental to continuous quality improvement and to determining whether adjustments must be made to ensure maximum effectiveness and efficiency in service delivery and financial management. Government and the Health Authority will monitor the performance and outcomes of the Health Authority on a regular basis to determine whether the Health Authority is meeting or not meeting performance expectations.

Government and the Health Authority will review the risks and challenges related to unmet expectations. The Health Authority, in consultation with Government, will develop plans to ensure measurable improvements are made.

5.3. Reporting

Government and the Health Authority are committed to enhanced transparency and accountability to the public. Government has put in place a public reporting structure set out in

the *Budget Transparency and Accountability Act*, the *Financial Administration Act* and the *Financial Information Act*. Government has provided the Health Authority with a reporting calendar that sets out financial performance reporting requirements (see http://admin.moh.hnet.bc.ca/regfin/rham/index.html).

The Health Authority agrees it will meet these financial and performance reporting requirements. If Government determines that changes to the reporting requirements are necessary, Government will communicate with the Health Authority in a timely manner.

It is agreed by both Government and the Health Authority that there will be advanced discussion and review of key strategic documents, such as, quarterly financial and service activity reports and annual reports. These discussions will be completed in advance of deadlines to ensure effective and timely input by Government and the Health Authority.

In addition to these financial, service and performance reporting requirements, the Health Authority agrees to provide information to Government related to risks and opportunities anticipated in achieving financial forecasts, as well as the actions proposed by the Health Authority to meet these targets while preserving health services to the public.

Government and the Health Authority agree that, as a matter of course, each will advise the other in a timely manner of any issues that may materially impact the business of the Health Authority or the interests of the Government, including information on any risks to achieving financial forecasts, priority deliverables and performance targets. The Ministry of Health and the Health Authority will designate a senior staff member for this purpose.

6. REVIEW AND REVISION OF THIS GLE

In addition to coordinating the overall process for preparing this GLE, Government is accountable for undertaking reviews of this GLE and monitoring its implementation. The Government Letter of Expectations will be reviewed annually and updated to reflect Government's priorities and direction to the Health Authority. If deemed necessary by either party, Government and the Health Authority will discuss any issues and may agree to amend this GLE on a more frequent than annual basis.

Honourable Michael de Jong, Q.C. Minister of Health	Don Hubbard Chair of the Board Vancouver Island Health Authority
Date	Date

pc: Honourable Christy Clark
Premier

John Dyble
Deputy Minister to the Premier and Cabinet Secretary

Peter Milburn
Deputy Minister and Secretary to Treasury Board
Ministry of Finance

Graham Whitmarsh
Deputy Minister
Ministry of Health

Howard Waldner
President and Chief Executive Officer
Vancouver Island Health Authority

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Vancouver Island Health Authority

2012/13 – 2014/15 SERVICE PLAN

2012

For more information on the
VANCOUVER ISLAND HEALTH AUTHORITY
see Contact Information on Page 16 or contact:

Vancouver Island Health Authority
1952 Bay Street
Victoria British Columbia, V8R 1J8

or visit our website at
www.viha.ca

Message from the Board Chair and Accountability Statement

On behalf of the Board of Directors of the Vancouver Island Health Authority (VIHA), I am pleased to submit our *2012/13 – 2014/15 Service Plan* which is aligned with our broader Five-Year Strategic Plan. Both plans are "living documents" which allows us to be adaptive to the changing needs of our communities while remaining accountable and transparent to the public. The plans support our continued commitment to providing high quality services that are accessible and sustainable to the region"s residents in a thoughtful, responsive manner.

As Board Chair, I am constantly impressed with the hard work and dedication our staff and physicians demonstrate on a daily basis. Thanks to their commitment, VIHA achieved a number of significant milestones over the past year including approval to construct three key projects (a new hospital in each of the Comox Valley and Campbell River as well as the innovative Oceanside Health Centre). In addition, work continues on the new Emergency Department at Nanaimo Regional General Hospital (NRGH). As part of VIHA"s ongoing strategy to better coordinate the care of our residents and clients, both the Oceanside and NRGH projects will provide a strong link to primary care services and will incorporate a VIHA-wide electronic health record.

Our health region faces a growing and a dramatically aging population, more so than any other in the province. Beyond the impact on services, we also face looming staff shortages with an aging workforce. That is why VIHA is planning now to ensure we continue to provide high quality health services to the population we serve into the future. Our continued focus on quality improvement ensures all areas of our health system work together to provide patients with the care they need. This includes:

- Improving the health of our residents and high needs populations through community partnerships and client-centred delivery models;
- Focusing on clinical best practices, including: improving infection prevention and control, and medication safety;
- Implementing strategies to improve patient access to services;
- Continued application of lean design processes to improve efficiency and effectiveness;
- Improving staff engagement, safety, and work life balance; and
- Strengthening physician partnerships as well as improving credentialing processes;

The *2012/13 - 2014/15 Vancouver Island Health Authority Service Plan* was prepared under the Board"s direction in accordance with the *Health Authorities Act* and the British Columbia Reporting Principles. The Service Plan is consistent with Government's strategic priorities and Strategic Plan, and the Ministry of Health"s goals, objectives and strategies. The Board is accountable for the contents of the Plan.

Achieving better health outcomes for all VIHA residents is the priority for our Board. We will continue to seek innovative solutions to provide sustainable and accessible quality healthcare to the region.

Sincerely,

Don Hubbard
VIHA Board Chair
June 13th, 2012

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Organizational Overview

The Vancouver Island Health Authority (VIHA) is one of five regional health authorities established by the province of British Columbia under the *Health Authorities Act 2001*. VIHA provides health services to over 774,000 people across a widely varied geographic area of approximately 56,000 square kilometres. This area includes Vancouver Island, the Gulf and Discovery Islands and part of the mainland opposite northern Vancouver Island. An important part of our mandate is to serve the many remote and isolated communities in our region accessible only by water or air.

Population We Serve

VIHA"s population represents approximately 17 per cent of the entire population of British Columbia. Approximately half our population lives in the Victoria and Gulf Islands area. By 2018, our population is projected to grow by more than 7 per cent, or approximately 56,000 people. The most significant growth is expected in Sooke, Qualicum, Nanaimo, Courtenay and the Gulf Islands. Not only is our population growing, but it is aging as well. Currently, almost 19 per cent of our population is over the age of 64 (compared to 15 per cent for British Columbia) and this age group is expected to increase by 30 per cent over the next 20 years[1].

Services We Provide

We provide a full range of dynamic and progressive health programs and services: public and environmental health, maternal and family health, home care and supports, primary health care, residential care, hospital care, mental health and substance use services, rehabilitation, and end-of-life care. We are able to meet virtually all health needs of people who live on Vancouver Island; only rarely must people seek services outside of VIHA for highly specialized needs.

VIHA has…

- ***~1,800 physicians***
- ***~18,000 staff***
- ***Over 150 facilities***
- ***~1,500 acute care & rehab beds***
- ***~ 6,300 residential care beds & assisted living units***

Governance and Leadership

A nine-member, government-appointed Board of Directors (the Board) governs VIHA. The Board"s primary responsibility is to foster the Health Authority"s short and long-term success, consistent with the Board"s responsibility to the Government and the stakeholders the Health Authority serves. More information on the role of the Board is available at http://www.viha.ca/about_viha/board_of_directors/.

Working with the Board, and headed by our President and Chief Executive Officer (CEO), the Executive team provides leadership in planning, delivering and evaluating health services in VIHA in collaboration with the Government. The VIHA Board and Executive team are responsible for meeting the health needs of the population in an effective and sustainable manner. Under their leadership, we have an Integrated Health Services Model with five clinical portfolios, each co-led by an Executive Medical Director and an Executive Director who have joint responsibility for the delivery of programs and services. These services are supported by a number of corporate services such as quality and patient safety, capital, finance, planning and human resources (See http://www.viha.ca/about_viha/organization).

[1] PEOPLE 36 Population Data, BC STATS

Strategic Context

The health system in British Columbia is a complex network of skilled professionals, organizations and groups that work together to provide value for patients, the public and taxpayers. The key challenge facing the health system is to deliver a high performing sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand.

Although the British Columbia health system effectively meets the majority of the population"s health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of demand are the aging population; a rising burden of illness from chronic diseases, mental illness and cancer; and advances in technology and pharmaceuticals driving new costly procedures and treatments. The pressure is compounded by the need for new care delivery models by health professionals and health care workers, and the need to maintain and improve the health system"s physical infrastructure (i.e. buildings and equipment). In the current economic climate it is even more important for the health system to find new and creative ways to ensure the resources available for health care services are used effectively and in ways that most benefit the people of British Columbia.

British Columbia also faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved significantly in several respects over the past few decades, the Aboriginal population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other British Columbia residents. Government is working with First Nations, Metis and other partners to improve Aboriginal people"s health and to close this gap in health status.

The Aging Population

British Columbia"s senior population currently makes up 15 per cent of the total population and is expected to nearly double within the next 20 years, making it one of the fastest growing senior"s populations in Canada.[2] The proportion within VIHA"s catchment area is higher than the provincial average at just over 19 per cent. Roughly 3 per cent of our region"s population is over the age of 84 and the number of people in this age cohort is growing, especially in the Nanaimo, Parksville/ Qualicum, and Courtenay areas[3]. The aging population is a significant driver of demand because the need for health services rises dramatically with age. In 2006/07 people over age 65 made up 14 per cent of the British Columbia population, but used 33 per cent of physician services, 48 per cent of acute care services, 49 per cent of PharmaCare expenditures, 74 per cent of home and community care services and 93 per cent of residential care services.[4] There is also an increasing need to provide appropriate care for those with frailty or dementia and to help seniors stay healthy, independent and in the community for as long as possible.

[2] PEOPLE 35 Population Data, BC STATS
[3] PEOPLE 36 Population Data, BC STATS
[4] Planning and Innovation Division, Ministry of Health; using MSP Expenditures 2006/07; Acute Care: Inpatient and Day Surgery workload weighted cases, DAD 2006/07; HCC community services by age group 2005/06, summed based on average unit costs; Residential care days 2006/07.

A Rising Burden of Chronic Disease

Chronic diseases are prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis and asthma. People with chronic conditions represent approximately 38 per cent of the British Columbia population and consume approximately 80 per cent of the combined physician payment, PharmaCare and acute (hospital) care budgets.[5] Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions could increase 58 per cent over the next 25 years[6], becoming an even more significant driver of demand for health services. Chronic diseases can be prevented or delayed by addressing key risk factors, including physical inactivity, unhealthy eating, obesity, alcohol consumption and tobacco use.

Advances in Technology and Pharmaceuticals

New treatments and technology development over the past decade include less invasive surgery, increased use of diagnostic imaging and the introduction of drug therapies that have made health care more efficient and effective. However, they have also led to a significant increase in demand for products and services. For example, the expansion of technology has seen the provincial number of CT exams increase by approximately 120 per cent and the number of MRI exams by almost 249 per cent between 2001/02 and 2011/12.[7] VIHA is also actively developing an electronic health record which will coordinate care across facilities and providers to increase the quality, efficiency and experience of patients and clients.

Human Resources and Health System Infrastructure

Although attrition rates have decreased recently, looming retirements in the health workforce combined with the rising demand for services are still key challenges that will impact the Province"s ability to maintain an adequate supply and mix of health professionals and workers. It is still important to plan and ensure that the health system has the required number of qualified healthcare providers entering the workforce. However, there is also need to continue focusing on redesigning care delivery models so that the skill sets of health care professionals are optimized and multidisciplinary teams supported. Healthy, supportive workplaces that enhance work and promote education will attract and retain the workforce we need to provide high quality services.

Another challenge in delivering health services is the need to maintain and improve the health system"s physical infrastructure. The average age of VIHA facilities across the island is approximately 30 years. Substantial improvements occurred recently within our region with the opening of the new Patient Care Centre at Royal Jubilee Hospital, the expansion of the Cowichan District Hospital pharmacy, and renovations to Tofino General Hospital which improved patient care and the staff working environment. However, other acute and residential care facilities, as well as medical and information technologies, will require significant investment over the next number of years. VIHA is moving forward with a number of important projects in this area.

The health system is faced with the continuous need to update or expand health facilities, medical equipment and information technology to ensure it provides high quality and safe health care to British Columbians.

[5] Discharge Abstract Database (DAD), Medical Service Plan (MSP) and PharmaCare Data 2006/07

[6] British Columbia Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis*, march 2007, (2007-064); as cited in Primary Health Care Charter: a collaborative approach (2007), Ministry of Health

[7] HAMIS/OASIS, Management Information Branch, Planning and Innovation Division, Ministry of Health as of October 12, 2010

Goals, Objectives, Strategies and Performance Measures

Goal 1: Improved health for Island residents through strong partnerships.

Objective 1.1: Work with community partners and stakeholders to improve the health and wellness of our population by focusing on the most vulnerable residents (seniors, persons with mental and/or chronic illness, Aboriginal peoples and youth).

Objective 1.2: Engage our residents, staff and healthcare partners to achieve better health outcomes.

Strategies

- Implement targeted healthy living and disease prevention initiatives to address the needs of high risk populations.
- Continue to develop partnerships with all communities to improve the health of residents by addressing the broad determinants of health. Focus will be on vulnerable populations (e.g., seniors, people with mental and/or chronic illness, Aboriginal people and youth.
- Develop a client centered model for delivering services to a geographic population to best meet its needs with physician partnerships. This will include a focus on better coordinating and managing the care a client receives using an inter-disciplinary team approach and optimizing technology.
- Collaborate with Aboriginal partners to develop and implement annual plans to support health needs as identified by the VIHA Aboriginal Health Plan.
- Develop and introduce a more effective and evidence-based case management approach for patients and clients with persistent mental illness with the aim of reducing acute hospital admissions, enabling them to be safely be cared for and supported in a community setting.
- Continue to review current assessment, care and service options for seniors on Vancouver Island to ensure that services provided are the most effective and responsive for patients and clients in hospital and community settings. A key focus area is the advancement of the residential care bed plan, including dementia care.

Performance Measure 1: Sodium Reduction

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Average sodium content in adult hospital diets	3650 mg	3300 mg	2900 mg	2500 mg

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure focuses on the average sodium content of the general/regular diets for adults within health authority owned and/or operated hospital and residential care facilities. Medical evidence links high sodium intake to elevated blood pressure, which is the leading preventable risk factor for death worldwide. High blood pressure is the major cause of cardiovascular disease and a risk factor for stroke and kidney disease. There is also evidence to suggest that a diet high in sodium is a risk factor for osteoporosis, stomach cancer and asthma. According to the World Health Organization, interventions to reduce population-wide salt intake have been shown repeatedly to be highly cost-effective. [1]

The Sodium Reduction Strategy for Canada recommends that publicly funded institutions follow consistent guidelines related to sodium levels in foods to ensure public funds are not contributing to the burden of disease. [1] Sodium guidelines have the potential to drive system change within the food industry and create a demand for lower sodium food items. British Columbia has seen the food industry reformulate food items in response to the trans fat regulation and the implementation of the Guidelines for Food and Beverage Sales in British Columbia Schools.

Health authorities are required to reduce the average sodium content of the general/regular diet for adults to the population goal of an average intake of 2300 mg of sodium per day by 2016.

Performance Measure 2: Health of Aboriginal Children

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of Aboriginal Kindergarten children receiving vision screening	88%	89%	91%	93%

Data Source: Population and Public Health Division, Ministry of Health

Discussion

This performance measure supports Aboriginal children"s access to vision screening. Vision deficits such as amblyopia (lazy eye), strabismus (crossed eyes), and refractive errors (nearsightedness and farsightedness) are common problems in the preschool and school age population. Early detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child"s opportunity for academic success and learning potential.

[1] From Sodium Reduction Strategy for Canada at http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php#a21

Goal 2: High quality client and patient centered care based on a culture of safety and excellence.

Objective 2.1: Provide quality health care guided by best practice and evidence.

Objective 2.2: Ensure the safety of clients and staff at all times.

Objective 2.3: Improve access to our health care services to ensure timely and appropriate care.

Strategies

- Implement evidence-based clinical best practices in eleven priority areas as identified by the Ministry of Health and expand the use of evidence to develop, implement and monitor use of guidelines to improve practice and to inform the next generation electronic health record.
- Continued implementation of the Next Generation Electronic Health Record (EHR) plan with a focus on ambulatory care and physician offices.
- Develop and approve a Quality Plan which includes strengthening governance structure for quality, optimizing Quality Councils to monitor performance and quality, and expand quality capacity throughout VIHA.
- Develop a medication safety strategy which includes implementing unit dose packaging and bar-code labelling using the concept of a "hub and spoke" for all acute and residential care sites.
- Reduce the spread of infectious disease through hand hygiene and antimicrobial stewardship programs.
- Introduce a significant shift in health care thinking, which assumes that most seniors who enter a hospital from home can and will ultimately return to their home with appropriate supports. This will involve significant improvements in the continuity of care, patient flow and care transitions.

Performance Measure 3: Managing Chronic Disease in the Community

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Number of people under 75 years with a chronic disease admitted to hospital (per 100,000 people)	235	220	210	201

Data Source: Discharge Abstract Database, Management Information Branch, Planning and Innovation Division, Ministry of Health
Note: The 2009/10 baseline has been restated from 222 to 235, according to the new methodology of the Canadian Institute for Health Information, which determines the calculation of this rate nationally. The new methodology includes more people with diabetes.

Discussion

This performance measure tracks the number of people with selected chronic diseases, such as asthma, chronic obstructive pulmonary disease, heart disease and diabetes, who are admitted to hospital. People with chronic diseases need the expertise and support of family doctors and other health care providers to manage their disease in the community in order to maintain their functioning and reduce complications that will require more medical care. Proactive disease management reduces hospitalizations, emergency department visits, some surgeries and repeated diagnostic testing, all of which help to control the costs of health care. As part of

a larger initiative of strengthening community-based health care and support services, family doctors, home health care providers and other health care professionals are working to provide better care in the community and at home to help people with chronic disease to remain as healthy as possible.

Performance Measure 4: Home Health Care and Support for Seniors

Performance Measure	2009/10 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of people aged 75+ receiving home health care and support	16.8%	17.2%	17.4%	17.6%

Data Source: P.E.O.P.L.E. 35, population estimates, BC Stats 2. Continuing Care Data Warehouse, Management Information Branch, Planning and Innovation Division, Ministry of Health. A small amount of baseline data is currently unavailable due to the transition to new reporting mechanisms. 3. Home and community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Management information Branch, Planning and Innovation Division, Ministry of Health.
Note: The data for this measure may be restated at a later time when the new data reporting system is fully implemented. Targets may be revised accordingly.

Discussion

This performance measure tracks the percent of seniors (aged 75+ years) who receive home health care such as home nursing and rehabilitative care, clinical social work, light housekeeping, assisted living and adult day programs. While the majority of seniors experience healthy aging at home, there is growing need for community care options to support those who can no longer live independently. This support helps people manage chronic disease and frailty, and may prevent falls or other incidents that can potentially result in hospital care or require a move to a residential care setting. As part of a larger initiative of strengthening community-based health care and support services, the health authorities are expanding home health care services and ensuring that high risk seniors are made a priority in the provision of care. This focus, combined with the use of technology, can significantly improve health outcomes for seniors.

Goal 3: A healthy, caring and engaged workforce supported by collaborative practice and strong leadership.

Objective 3.1: Develop leaders who are visionary and who can facilitate critical health system change.

Objective 3.2: Improve collaboration and support team work to ensure excellent service delivery.

Strategies

- Develop evaluation capacity for major projects. This will include retrospective analysis of our system-wide initiatives to determine the lessons we can carry forward, as well as a prospective evaluation of the integrated care model at the newly-approved Oceanside Health Centre.
- Continue to improve existing issues with staff scheduling and payroll that are negatively impacting staff satisfaction.
- Continue to focus on a safe workplace for staff with an emphasis on violence prevention and psychological safety.
- Continue to develop and implement a strategy that enables consistent, island-wide physician credentialing.

Performance Measure 5: Nursing Overtime

Performance Measure	2010/11 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Nursing overtime hours as a percent of productive nursing hours	3.5% (2010 calendar year)	No more than 3.5	No more than 3.4	No more than 3.3

Data Source: Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

Discussion

This performance measure compares the amount of overtime worked by nurses to the overall amount of time nurses work. Overtime is a key indicator to assess the overall health of a workplace. High rates of overtime may reflect inadequate staffing or high levels of absenteeism, resulting in workload issues and increased costs. Reducing overtime rates by addressing the underlying causes not only assists in reducing direct (e.g. labour) and indirect (e.g. unengaged staff) costs to the health system, it also helps promote both patient and caregiver safety.

Goal 4: Affordable health care that is sustainable through sound fiscal management and enhanced performance.

Objective 4.1: Ensure that our health services are delivered efficiently and effectively.

Objective 4.2: Employ sound fiscal management and strategic planning to ensure the best use of resources.

Strategies

- Continue to advance Lean methodology throughout the health authority in priority areas.
- Leverage HSSBC to find opportunities to further our collaborative relationships, including participation in the new provincial consolidation committee.
- Continue to manage the operating budget carefully and optimize funding potential through activity-based funding.
- Demographic and service analyses and forecasting to refresh *Strategic Plan 2013-18* for a fall 2013 consultation.

Performance Measure 6: Access to Surgery

Performance Measure	2011/12 Baseline	2012/13 Target	2013/14 Target	2014/15 Target
Percent of non-emergency surgeries completed within the benchmark wait time	69%	72%	79%	85%

Data Source: Surgical Wait Times Production (SWTP), Management Information Branch, Planning and Innovation Division, Ministry of Health. Notes:
1. The total wait time is the difference between the date the booking form is received at the hospital and the report date (end of the month). The day the booking form is received at the hospital is NOT counted.
2. This measure uses adjusted wait times that are calculated by excluding periods when the patient is unavailable, from the total wait time.

Discussion

In the last several years, British Columbia"s health system has successfully reduced wait times for cataract, hip and knee replacement, hip fracture and cardiac surgeries. Expanded surgical activity and patient-focused funding, combined with continuous effort to foster innovation and efficiency in British Columbia"s hospitals, will improve the timeliness of patients" access to an expanding range of surgical procedures. This performance measure will track whether non-emergency surgeries are completed within established benchmark wait times. These benchmark wait times are new and give a priority rating for each surgical patient, based on individual need. Because of the need to „catch up" on surgeries for patients without a priority rating who have already been waiting, surgery for some patients with the new priority rating may be delayed. The target for 2012/13 will allow for this „catch up" period, after which wait times for patients with priority ratings should gradually decrease.

Financial Summary

($ millions)	2011/12 Actual[1]	2012/13 Budget	2013/14 Plan	2014/15 Plan
Operating Summary				
Provincial government sources	1,820.8	1,864.8	1,937.2	1,964.0
Non-provincial government sources	126.1	112.8	113.0	113.5
Total Revenue	**1,946.9**	**1,977.6**	**2,050.2**	**2,077.5**
Acute Care	1,047.8	1,063.4	1,099.2	1,105.3
Residential Care	340.0	341.0	349.0	354.3
Community Care	213.9	226.6	236.2	245.5
Mental Health & Substance Abuse	142.5	141.5	150.2	154.2
Population Health & Wellness	54.3	56.2	60.9	60.9
Corporate	142.6	148.9	154.7	157.3
Total Expenditures[2]	**1,941.1**	**1,977.6**	**2,050.2**	**2,077.5**
Surplus (Deficit)	**5.8**	**-**	**-**	**-**

($ millions)	2011/12 Actual	2012/13 Budget	2013/14 Plan	2014/15 Plan
Capital Summary				
Funded by Provincial Government	45.9	39.6	14.7	12.3
Funded by Foundations, Regional Hospital Districts, and other non-government sources	42.6	84.4	20.7	22.6
Total Capital Spending	88.5	124.0	35.4	34.9

Note 1: 2011/12 total revenue and expenditures are per audited financial statements.
Note 2: Health authorities are implementing Public Sector Accounting standards for the 2012/13 fiscal year and have made adjustments to sector expenditure reporting to improve consistency, transparency and comparability. Expenditures for 2011/12 have been adjusted accordingly.

Capital Project Summary

Capital investment ensures health infrastructure is maintained and expanded to meet a growing population with increasing needs for health services. Capital assets such as buildings, information systems and equipment are key components of health care delivery and must be acquired and managed in the most effective and efficient manner possible. Funding for these assets is primarily provided through the Provincial government and through partnerships with Regional Hospital Districts, Hospital Foundations and Auxiliaries. Recognizing the significant cost and lifespan of most capital investments — both in acquisition and use — the Ministry of Health and health authorities prepare three year capital plans annually, aligned with other health sector planning.

VIHA bases the development of its Capital and Information Management/Information Technology (IM/IT) Plans on the following principles:

- Capital investments must support the strategic direction of the organization;
- Investments must be backed by a rigorous examination of service delivery options and a thorough business case analysis;
- Our use of existing infrastructure must be maximized and non-capital alternatives must be explored before new investment; and
- Our spending on capital assets must be managed within fiscal limits.

The following list is VIHA"s approved capital projects over $2 million currently underway:

Community Name	Facility location	Project Name	Total Project Cost ($ million)
Facility Projects			
Campbell River/Comox Valley	Campbell River and District General Hospital and Comox Valley Hospital	North Island Hospitals Project	600.000
Parksville	Parksville	Oceanside Health Centre	15.795
Nanaimo	Nanaimo Regional General Hospital	Emergency Department/ Psychiatric Emergency Service/Psychiatric Intensive Care Expansion	36.850
North Cowichan	Cowichan Lodge	Riverview Redevelopment Upgrade	9.000
Victoria	Royal Jubilee Hospital	Patient Care Centre (P3 & Traditional)*	348.535
Victoria	Seven Oaks	Riverview Redevelopment Upgrade	2.000
Victoria	Saanich Peninsula Hospital	Operating Room and Electrical System Redevelopment	9.936
Equipment Projects			
Various	Campbell River, St. Josephs, West Coast and Cowichan District Hospitals	Mobile Magnetic Resonance Imaging Equipment and Trailer Pads	2.920
IM/IT Projects			
Ambulatory Clinical Systems Foundation			3.392
Business Systems Foundation			6.706
Clinical Documentation, Communication and Care Planning			10.842
TeleHealth			2.516

*Includes demolition of outdated buildings.

Contact Information

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Fax: 250.519.3441

VIHA BOARD OF DIRECTORS

Board Liaison:
Janet Shute - Email: janet.shute@viha.ca

Hyperlinks to Additional Information

VANCOUVER ISLAND HEALTH AUTHORITY

HOMEPAGE www.viha.ca

FINDING CARE http://www.viha.ca/finding_care/

HEALTH INFORMATION http://www.viha.ca/health_info/

FIVE-YEAR STRATEGIC PLAN http://www.viha.ca/about_viha/strategic_plan/

BOARD OF DIRECTORS http://www.viha.ca/about_viha/board_of_directors/

ORGANIZATIONAL CHARTS http://www.viha.ca/about_viha/organization/

PERFORMANCE MEASURES
http://www.viha.ca/about_viha/accountability/goals_and_performance_measures/

NEWSLETTERS AND CEO UPDATE http://www.viha.ca/about_viha/news/newsletters/

DEPARTMENTS AND SERVICES http://www.viha.ca/about_viha/departments_and_services/

OTHER CONTACTS

HEALTHLINK BC http://www.healthlinkbc.ca/kbaltindex.asp or dial 8-1-1 to look up non-emergency health information and find publicly funded health services near you.

COLLEGE OF PHYSICIANS AND SURGEONS to find a physician https://www.cpsbc.ca/

BRITISH COLUMBIA MINISTRY OF HEALTH http://www.gov.bc.ca/health/index.html

BRITISH COLUMBIA HEALTH AND SENIORS INFORMATION LINE 1-800-465-4911

MEDICAL SERVICES PLAN OF BRITISH COLUMBIA 1-800-663-7100

PHARMACARE 1-800-663-7100

OTHER HEALTH AUTHORITIES

FRASER HEALTH AUTHORITY www.fraserhealth.ca

INTERIOR HEALTH AUTHORITY www.interiorhealth.ca

NORTHERN HEALTH AUTHORITY www.northernhealth.ca

PROVINCIAL HEALTH SERVICES AUTHORITY www.phsa.ca

VANCOUVER COASTAL HEALTH AUTHORITY www.vch.ca