Interior
Health Authority

2012/13 – 2014/15
SERVICE PLAN

July 2012

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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

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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:

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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