2008/2009 : Report 8

OFFICE OF THE
Auditor General
of British Columbia

Follow-up Report:
Updates on the implementation of recommendations from recent reports

October 2008

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The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
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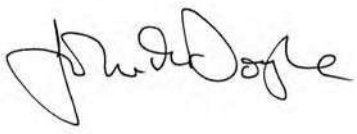
Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2008/2009 Report 8: Follow-up Report: Updates on the implementation of recommendations from recent reports.



John Doyle, MBA, CA
Auditor General of British Columbia

Victoria, British Columbia
October 2008

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

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Auditor General's Comments

John Doyle
Auditor General

I have been told by legislators from both sides of the house that following-up on the recommendations contained in our reports, and endorsed by the Public Accounts Committee, is extremely important. I could not agree more. Following-up on recommendations closes the loop on our reports, and is a critical step in ensuring our work has a positive influence on British Columbia's public sector.

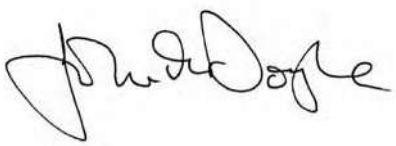
Following-up on previous audit recommendations can be a labour intensive process. Detailed follow-up is something I do not believe is justifiable or appropriate in all cases. However, in other cases it is. I rely on Members of the Legislative Assembly — members of the Public Accounts Committee in particular — to provide me with feedback about the areas that should receive the most attention.

To facilitate discussions with Legislators, my office obtains updates from the organizations we have audited about their progress to date in implementing our recommendations. This document is a compilation of updates we have received from a number of organizations. To be clear, these are management's representations. Although we have read each update, and in some cases discussed them with their respective authors, we have performed no audit work in relation to them and offer no assurance concerning their fairness, completeness or accuracy.

Some organizations have reported that they have fully implemented our recommendations — an outcome that we, obviously, find satisfactory and hope to see most of the time. In other cases, management adopts alternate approaches that address the issues underlying our recommendations, albeit in ways that were not anticipated. This too is a satisfactory outcome. To be fair, there are also times where, due to the passage of time or changes in circumstance, it no longer makes sense to implement recommendations as originally written — although we hope these occasions are few and far between. Unfortunately, there are some recommendations that are not implemented either because they have not been given priority or management finds them in some way unsatisfactory.

Most of the updates in this report appear satisfactory and will likely result in no further work. However, there are others that cause me concern because either they do not appear to address the original recommendations, do not appear consistent with other known facts or describe progress that appears unreasonably slow. Going forward, we will discuss these factors with legislators and the organizations themselves as my office develops its ongoing work plan.

This report is the first of what will be a semi-annual publication. I offer my thanks to the organizations that provided updates to us. In some cases, updates have gone well beyond the summaries we requested, providing considerable detail on actions taken and progress to date. These we have published in their entirety, except where they refer to other publicly available documents. I encourage legislators and other interested parties to review these responses and offer any comments they may have.



John Doyle, MBA, CA
Auditor General of British Columbia

Victoria, British Columbia
October 2008

Section 1

Update on the implementation of recommendations from:

Province of British Columbia Audit Committees: Doing the Right Things

December 2006

October 2008

Auditor General recommendations – December 2006

We recommend that:

Consistent with their intended evolutionary nature, the Board Resourcing and Development Office governance guidelines for government organizations be revised to fully incorporate current best practice for audit committees; and

Compliance with these guidelines be required of all government organizations in the government reporting entity, including the SUCH sector.

Audit Committees - Doing the Right Things Response

General comments about progress since the report release:

Crown Agencies Secretariat and the Office of the Auditor General co-sponsored an Audit Committee workshop for Board and Audit Committee Chairs on February 1, 2008. Workshop speakers included private sector experts, Audit Committee Chairs, Office of the Auditor General and Crown Agencies Secretariat staff, and the Auditor General. Attendees at the Audit Committee Workshop included approximately 80 Board and Audit Committee Chairs from Crown Corporations, Health Authorities, Universities and Colleges and a sample of School Districts, as suggested by the Office of the Auditor General.

Crown Agencies Secretariat has also completed a Good Practices for Crown Agencies Audit Committees Checklist which was distributed at the Audit Committee Workshop, and is being reviewed before being distributed more widely. This document is based on the Board Resourcing and Development Office guidelines, the Office of the Auditor General audit criteria from this report, and private and public sector best practices, and includes updated information on internal audit oversight and whistleblower responsibilities of Audit Committees.

Government Response	Actions Taken Since Report Issued	Results of Actions	Self Assessed Progress (I/P/AA/NA)
Recommendation 1 Government has committed to ensuring the governance guidelines are reviewed and updated from time to time in response to the changing needs, experience and new developments in the art of good governance. Government is further committed to ensuring that this is the case for its other governance guidelines and documents.	Crown Agencies Secretariat and the Office of the Auditor General Audit Committee co-sponsored a workshop for Board and Audit Committee Chairs. Crown Agencies Secretariat has also completed a Good Practices for Crown Agency Audit Committees Checklist which	A better understanding by Crown agency Audit Committees of their responsibilities	I

	was distributed at the Audit Committee Workshop and is being reformatted for general distribution.		
Recommendation 2 Government has applied these guidelines to a wide range of government organizations, including the SUCH sector. The guidelines are not extended, at this time, to some of the smaller SUCH sector organizations, such as school boards of trustees and denominational hospitals. Government's approach has been to ensure that the most material and significant organizations (health authorities, universities and colleges) are addressed as a first priority.	Attendees at the Audit Committee Workshop included Board and Audit Committee Chairs from Crown corporations, Health Authorities, Universities and Colleges and several School Districts. The Good Practices Checklist will be distributed to all Crown agencies, including the entire SUCH sector.	A better understanding by SUCH sector Audit Committees of their responsibilities	I

I – substantially or fully implemented
P – partially implemented
AA – alternative action taken
NA – no substantial action has been taken

Section 2

Update on the implementation of recommendations from:

Financial Framework Supporting the Legislative Assembly

April 2007

October 2008

Auditor General recommendations – April 2007

We recommend that:

A suitable internal audit provider be engaged to examine and report periodically to senior management on the operation of financial controls across all Vote 1 expenditure areas, including constituency offices.

Clearer procedures, policies and guidelines for financial control be put in place, covering:

- types and frequency of financial procedures to be performed, and financial control reports to be produced and reviewed by the senior management team; and
- procedures for identifying, documenting and following up significant variances or changes to financial plans.

Business Continuity and Disaster Recovery Plans covering financial systems in the Legislative Assembly be completed and periodically tested.

Financial reporting requirements to the Legislative Assembly Management Committee be established and include regular reporting and discussion of actual and budget spending, as well as publicly available audited annual financial statements for Vote 1.

A more clearly documented process be put into place for the production and approval of the annual operating and capital budget, including the respective roles of senior management and Legislative Assembly Management Committee members.

E. GEORGE MacMINN, Q.C.
CLERK OF THE
LEGISLATIVE ASSEMBLY
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LEGISLATIVE ASSEMBLY
PROVINCE OF BRITISH COLUMBIA

ROOM 221, PARLIAMENT BUILDINGS
VICTORIA, BRITISH COLUMBIA
V8V 1X4

August 5, 2008

Malcolm Gaston, MA, CPFA
Assistant Auditor General
8 Bastion Square
Victoria, British Columbia
V8V 1X4

Dear Mr. Gaston,

Re: Follow-up of your Special Audit Report to the Speaker on the *Financial Framework Supporting the Legislative Assembly*

In response to your letter of May 30, 2008, attached is the Legislative Assembly's self-assessment monitoring report relative to the recommendations contained in your Special Audit Report of April 2007.

I trust this is to your satisfaction.

Sincerely,

E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

Cc: Hon. Bill Barisoff, MLA, Speaker of the Legislative Assembly
Dan Arbic, Legislative Comptroller

Pro Forma Format for Monitoring Management Progress:

Special Audit Report to the Speaker on the Financial Framework Supporting the Legislative Assembly

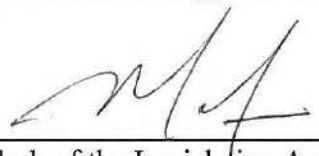
OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I/P/AA/NA[1]
Recommendation 1: A suitable internal audit provider be engaged to examine and report periodically to senior management on the operation of financial controls across all Vote 1 expenditure areas, including constituency offices.	• The Legislative Assembly Management Committee (LAMC) understands its responsibilities, under subsection 5(4) of the LAMC Act. It remains satisfied with the assurances provided by the Office of the Legislative Comptroller relative to the operation of financial controls across Vote 1.	• LAMC continues to rely on the established financial controls of the Office of the Legislative Comptroller, which the Auditor General judged to be, in all material aspects, sound.	AA
Recommendation 2: Clearer procedures, policies and guidelines for financial control be put in place, covering: • **Types and frequency of financial procedures to be performed, and financial control reports to be produced and**	• Branches and caucuses are provided with their respective financial reports on a monthly basis, and great scrutiny is exercised by branch leads and staff. Nothing of significance has recently materialized that would affect branches' financial plans. All branch directors understand the importance of managing within	• In the relatively small environment of the Legislative Assembly, current processes, well understood by senior management, continue to be applied, and significant financial matters can be addressed more expeditiously than in, say, a much larger public body.	AA

[1] **I – Recommendation has been fully or substantially implemented**
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I/P/AA/NA[1]
reviewed by the senior management team; and • **Procedures for identifying, documenting and following up significant variances or changes to financial plans.**	their respective allocations. Matters of considerable financial significance normally originate from the House or LAMC, without input from administrative Branches. Generally, at the branch level, processes are firmly in place to monitor financial position.		
Recommendation 3: Business Continuity and Disaster Recovery Plans covering financial systems in the Legislative Assembly be completed and periodically tested.	• The Office of the Legislative Comptroller will endeavour to complete its financial business continuity and disaster recovery plan in conjunction with Computer Systems branch.	• The development of the plan will address the Auditor General's finding.	P (in process)
Recommendation 4: Financial reporting requirements to the Legislative Assembly Management Committee be established and include regular reporting and discussions of actual to budget spending, as well as publicly available audited financial statements for Vote 1.	• LAMC has had other pressing matters affecting services to Members to deal with during the last year. This recommendation has yet to be discussed at a LAMC meeting. In the meanwhile, it remains satisfied with the assurances provided by the Office of the Legislative Comptroller relative to the operation of financial controls across Vote 1. LAMC is also satisfied with the public information provided in the annual Public Accounts.	• LAMC continues to rely on the established financial controls of the Office of the Legislative Comptroller, which the Auditor General judged to be, in all material aspects, sound.	NA

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I/P/AA/NA[1]
Recommendation 5: A more clearly documented process be put into place for the production and approval of the annual operating and capital budget, including the respective roles of senior management and Legislative Assembly Management Committee members.	• The Assembly has a documented process for the production and approval of the annual operating and capital budgets, in the form of instructions from the Office of the Legislative Comptroller to all branch directors and Clerks accompanying the schedules request to be filled. The instructions point out what is expected to be provided, timelines, and the review process by the Legislative Comptroller and the Clerk Assistant, then by the Clerk of the Legislative Assembly, followed by the Speaker's review, culminating in a presentation to LAMC as a whole.	• In the relatively small environment of the Legislative Assembly, current processes, well understood by senior management, continue to be applied.	AA

Reviewed and Approved:



Clerk of the Legislative Assembly

Section 3

Update on the implementation of recommendations from:

Preventing and Managing Diabetes in British Columbia

December 2007

October 2008

June 13, 2008 726919

Mr. Morris Sydor
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Mr. Sydor:

Re: **Follow-up Review of the Report from the British Columbia Office of the Auditor General on *Preventing and Managing Diabetes in British Columbia***

As requested by the Office of the Auditor General, I am pleased to enclose an update on the significant progress the British Columbia Ministry of Health has made in implementing the Auditor General's recommendations from their report titled *Preventing and Managing Diabetes in British Columbia* as of March 2008

The Auditor General's recommendations included:

1. Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia
2. Develop and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.
3. Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.

The update has been additionally organized around the areas of primary prevention and secondary prevention with most recommendations being partially implemented and ongoing.

…2

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

The recommendations were directed both to the Ministry of Health for action and the Government of British Columbia to impact the underlying determinants of health, such as: income, transportation, and levels of education. Diabetes is a multifaceted, societal problem and requires action by government, public institutions, communities, and individuals, as well as the health system.

Sincerely,

Gordon Macatee
Deputy Minister

Attachment

P:\Chronic Disease Management\Diabetes Measures\726919 oag cover letter 08.doc

Cliff # 726919

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION

THE PREVENTION AND MANAGEMENT OF DIABETES IN BRITISH COLUMBIA

June 13, 2008

In October 2004, the British Columbia Office of the Auditor General issued the report, the *Prevention and Management of Diabetes in British Columbia*. In 2008, the Office of the Auditor General (OAG) requested an update on the status of the implementation of the recommendations issued in the report. Below is a summary of status of implementation by recommendation:

	Implementation Status				
Auditor General's Recommendations: We recommend that the provincial government engage in an organized process to:	Fully	Substantially	Partially	Alternative Action	No Action
1. Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia (BC).			✓		
2. Develop, and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.			✓		
3. Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.			✓		

The prevention and management of chronic conditions involves two main approaches. Primary prevention involves broad population health initiatives focused on helping British Columbians to avoid developing a chronic condition to begin with. Secondary prevention involves strategies for helping British Columbians who do develop chronic conditions to cope with their condition and to avoid complications resulting from the condition. Responses to each of the Auditor General's recommendations are documented in each of these two categories since the approaches are different.

Recommendation #1: Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia (BC).

Recommendation #1 - Primary Prevention Strategies: Preventing Diabetes

Diabetes is a chronic condition that results from the body's inability to sufficiently produce or use insulin. Of the three types (Type 1, Type 2, and gestational diabetes), the most common is Type 2, which accounts for more than 90 per cent of diagnosed cases. Risk factors include individuals being overweight or obese, and physical inactivity. [1]

The BC Ministry of Health addresses the prevention of diabetes, and other prevalent chronic disease categories including Type 2 diabetes, cardiovascular disease, chronic respiratory disease and cancer, through an integrated, cross government, cross sector, risk factor-based population health and wellness strategy targeting the risk factors that are common to these health conditions: tobacco use, physical inactivity, poor nutrition, and overweight/obesity.

The Ministry's role in chronic disease prevention is one of stewardship: the Ministry sets direction and provides a framework of legislation, regulation, monitoring and evaluation to ensure a robust system of investment, program delivery and awareness-raising is in place to help British Columbians make healthy lifestyle choices, and avoid the chronic diseases that impact quality of life, increase morbidity and mortality, and threaten the sustainability of the health care system.

The following are three significant initiatives that support Government's population-based approach to promotion of health and wellness and chronic disease prevention, including prevention of diabetes:

i. A Framework for the development, delivery, measurement and evaluation of evidence-based core public health functions in BC;

ii. An integrated, cross government, cross sector, risk-factor based, chronic disease prevention strategy (ActNow BC); and

iii. First Nations Health Plan is a tripartite agreement between the province, the First Nations and the federal government to support the health of First Nations in British Columbia.

Core Public Health Functions in BC

Core public health functions are the primordial, primary and early secondary prevention activities of a comprehensive health system. Since 2002/03, the Ministry has been working with the Health Authorities to redefine and implement the core public health functions in BC. In March 2005, A Framework for Core Functions in Public Health was released (http://www.health.gov.bc.ca/prevent/#core), identifying 21 core public health programs that would lead to a renewed and modern public health system in British Columbia. The following core public health programs are specifically related to the risk factors most commonly linked with diabetes prevention: Healthy Communities, Healthy Living that includes healthy eating, physical activity and tobacco use, and Food Security, a program that looks at access to safe healthy foods in key settings. The implementation of these core programs by Health Authorities, in collaboration with key partnering organizations such as the Canadian Diabetes Association, will create supportive

[1] Food, Health and Well-Being in British Columbia, Provincial Health Officer's Annual Report 2005

environments where British Columbians are supported and can make choices to be more active and eat healthier foods, leading to a reduction in diabetes and other chronic diseases.

The core public health programs are being implemented through a performance improvement process over a number of years. Health Authorities are participating in the definition of model core programs for all program areas, based on best available evidence and best practice. Once the model core programs are approved, the Health Authorities will develop their own public performance improvement plans, with targets, tailoring their actions to the unique needs of their populations. These plans will be reviewed by the Ministry, and made public to ensure the Health Authorities are accountable to their communities and citizens.

In 2006/07, Health Authorities developed performance improvement plans for Food Security. Food Security is a concern as diabetes is more prevalent in food insecure populations.[2] Obesity occurs at a higher rate in low income children and adults and in Aboriginal populations.[3] Food-insecure diabetics have more costly and life-threatening complications to their illness and require greater levels of care.[4] The Food Security performance plans are tailored to Health Authority needs and priorities, but focus on components such as development of regional food policy frameworks, and an appropriate array of programs and services at the community level to assist residents to have greater access to safe healthy food. The Food Security Performance Improvement plans are now in the second year of implementation.

Health Authorities will identify how best to address the next two core programs, Healthy Living and Healthy Communities. The process is to undertake a needs assessment, gap analysis and performance improvement planning of policies and services related to Healthy Living and Healthy Communities. The focus is on increasing systemic supports for "making the healthy choice the easy choice" at the individual, family and community level, preventing and reducing the high-risk behaviours of unhealthy eating and physical inactivity, particularly in young people and vulnerable populations, and enhancing surveillance, monitoring and evaluation of healthy living trends and interventions. It is anticipated that the Health Authorities' performance improvement plans will include strategies such as development of partnerships to create healthy schools and workplaces, and strategies to engage in advocacy within communities to promote involvement in addressing these issues. The Ministry has facilitated the work to support healthy communities and healthy living through ActNow BC initiatives such as Healthy Communities, Active Communities and Action Schools! BC.

ActNow BC: Government's integrated, Cross Ministry, Cross Sector Health Promotion and Chronic Disease Prevention Strategy

ActNow BC is an integrated, cross government, cross sector, risk factor-based population health and wellness strategy targeting the risk factors that are common to these health conditions: tobacco use, physical inactivity, poor nutrition.

ActNow BC adopts a best practice approach that is comprehensive, multi-sectoral, partnership-based, results-focused and measurable. By engaging British Columbians where they live, learn, work and play, ActNow BC extends responsibility for population health beyond the healthcare sector and takes advantage of the reach and resources and active participation of non-traditional sectors like transportation, agriculture, forests and labour.

[2] Vozoris, N.T., and Tarasuk, V.S. 2003. Household food insufficiency is associated with poorer health. *Journal of Nutrition* 133 (1):120-126.

[3] Riches, G., Budkingham, D., MacRae, R, and Ostry, A. 2004. *Right to food case study: Canada.* Rome: Food and Agricultural Organization of the United Nations.

[4] Vozoris, N.T., and Tarasuk, V.S. 2003. Household food insufficiency is associated with poorer health. *Journal of Nutrition* 133 (1):120-126.

ActNow BC has both a social marketing campaign assisting British Columbians to have the information and access to programs and resources that will support and assist citizens to make healthier choices in a variety of key settings. The ActNow BC website (www.actnowbc.ca) has been developed, and specific promotions for physical activity and healthy eating occurred in 2007 and will again in 2008. The ActNow BC Road to Health Community Tour visited 18 communities in 2007. The tour included fun, free activities to promote active, healthy living, and health screening including height, weight, BMI, waist circumference and blood glucose monitoring. The tour will occur again in 2008.

The following are examples of programs, delivered in partnership with other ministries or key partnering organizations that are helping British Columbians make healthier choices to be more physically activity and eat more nutritious foods, thereby reducing their risk of developing Type 2 diabetes:

- Action Schools! BC is a best practices model designed to assist schools in creating individualized action plans to promote healthy living. Action Schools! BC provides **more** opportunities for **more** children to make healthy choices **more** often. There are 1,486 schools registered to participate affecting 406, 350 students in these schools.
- Active Communities is an initiative that assists communities to create programs and resources for their residents to have more opportunities to be active. There are 161 registered active communities.
- The School Fruit and Vegetable Nutrition Program provides a fresh B.C. grown vegetable or fruit to students twice a week, raising awareness of the importance of healthy eating. By 2010, all interested elementary schools will have participated in the program. There are currently 364 participating schools.
- The Sales of Foods and Beverages in BC Schools (2007) are guidelines developed to create healthier choices for sales of foods and beverages to students in the school environment. Elementary schools have implemented the guidelines. Middle and Secondary schools require full implementation by September 2008. The Nutrition Guidelines for Vending Machines in Public Buildings (2007) extends the policy to public buildings including recreation centres. These guidelines create an environment where the healthy choice is the easy choice; reducing the availability of high calorie, low nutrient foods that contribute to poor nutrition and unhealthy weight gain.
- The Community Food Action Initiative is implemented through all health authorities across the province to support communities to take action on increasing access to safe healthy foods in their local communities. Grants are provided to communities based on their needs and specific plans. In 2007/08, 155 specific projects were funded in communities across BC. Projects included community gardens or kitchens, school programs, food policies and bringing residents together to plan.

ActNow BC's success will be measured in terms of the 2010 targets: reducing tobacco-use by 10%; increasing the percentage of BC adults who are moderately or physically active by 20%; increasing the percentage of BC adults who eat five or more servings of fruit and vegetables per day by 20%; reducing the percentage of BC adults who are overweight or obese by 20%; and increasing the percentage of women counselled on the dangers of alcohol use in pregnancy by 50%.

Measuring Our Success (2006), the ActNow BC baseline document, identifies the baseline measures as of 2004/05. Regular published reports will monitor progress toward the targets. A discussion of the monitoring and evaluation framework for ActNow BC and its programs and services is documented in the report "Measuring Our Success".

First Nations

The First Nations Health Plan is a tripartite agreement between the province, the First Nations and the federal government to support the health of First Nations in British Columbia. There are four distinct areas for collaboration, one of which is Health Promotion/ Disease and Injury Prevention.

The First Nations Health Plan has recognized that prevention and management of diabetes in First Nations is a priority and many of the actions in the plan are intended to reduce the incidence in this vulnerable population.

The Ministry of Health is working with the National Collaborating Centre on Aboriginal Health (the Centre), located at the University of Northern BC, to develop an Aboriginal-specific ActNow component.

The Centre is working with the First Nations Health Council, the BC Association of Aboriginal Friendship Centres, and the Métis Nation British Columbia to promote wellness and support chronic disease prevention; promote physical activity in communities; promote wellness and healthy lifestyles in British Columbia; increase the capacity of Aboriginal communities to create and sustain health promoting policies, environments, programs and services; and enhance collaboration between Aboriginal communities, government, non-government and private sector organizations.

The Honour Your Health Challenge is funded by the BC Ministry of Health – Aboriginal Health Branch. This Challenge is a province-wide, community-based health initiative which uses small grants, incentives, and provincial grand prize draws to mobilize individuals and communities to live active, healthy & strong lifestyles, free from tobacco misuse. This year 187 community grants were provided.

Under the Honour Your Health Challenge umbrella, this year, the Province of BC (Ministries of Health and Tourism, Sport and the Arts) and Health Canada (First Nations and Inuit Health Branch, Aboriginal Diabetes Initiative) have partnered with Sportmed BC to offer an Aboriginal specific in-training program to prepare participants for the Vancouver Sun Run. The goal of this program is to improve the health and fitness of Aboriginal communities in British Columbia. Over 300 participated in the Sun Run event through this training program.

Prevention Support Program

The Prevention Support Program, a province-wide initiative that included 50 physicians and 35 nurses with 13 Nurse Facilitators/Coordinators, was piloted in 2005/06 through an evidence-based "Prevention" Structured Collaborative. A clinical guideline on primary prevention of cardiovascular disease – including guidelines for providing advice, counselling and referral regarding diet and physical activity – was distributed to family physicians in March 2008 by the Guidelines and Protocols Advisory Committee (GPAC, co-chaired by the BCMA and the Medical Services Plan). In addition, a prevention fee was launched by the General Practice Services Committee in April 2007. By supporting individuals to reduce their risk factors and therefore their risk of cardiovascular disease in particular, this initiative supports government's work to address chronic disease in general, including diabetes.

Recommendation #1 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

In order to close gaps in care between recommended diabetes care and the care that patients actually receive, the BC Ministry of Health adopted the Expanded Chronic Care Model for province-wide implementation. The research literature has reported that implementation of all the model's components invariably results in improved care and ultimately patient outcomes. British Columbia has embedded the components of the model into BC health care system as follows:

Decision Support:

The following tools have been distributed to BC physicians across the province, and are publicly available on both the Ministry of Health and the BCMA websites:

Clinical Guidelines Development - The BC Diabetes Management Guidelines (developed through the MSP/BCMA Guidelines and Protocols Advisory Committee) identify recommended diabetes care based on the best scientific evidence currently available

Patient Flow Sheet – The Diabetes Care patient flow sheet (which is part of the BC Diabetes Management Guideline) is a useful tool for summarizing clinical information important in effective diabetes management.

The BC Diabetes Management Clinical Guidelines and Patient Flow Sheets are periodically reviewed and updated by the Ministry of Health/BC Medical Association Guidelines and Protocols Advisory Committee to ensure consistency with the current state of evidence based medical knowledge.

Information Technology

The Diabetes Patient Register was developed through administrative data to identifying the population of patients with diabetes, and to accurately monitor of the quality of patient care and population health status. The Diabetes Patient Register has been updated yearly as the latest data becomes available.

The chronic disease management (CDM) toolkit information technology gives general practitioners easy access to BC Clinical Guidelines, and a patient reminder and recall system. It also includes electronic versions of the BC Diabetes Patient Flow Sheets, the CDM Toolkit enables members of practice networks to securely share information (including consult notes and referral letters) needed to ensure continuity of patient care. In 2008/09 1307 family physicians are using the CDM Toolkit to organize patient care.

The Physician Information Technology Office (PITO) is an outcome of the Government/BC Medical Association 2006 Agreement where the provincial government and the BCMA agreed to work collaboratively to co-ordinate, facilitate and support information technology planning and implementation for physicians, including the development and implementation in British Columbia of standardized systems of electronic medical records" (EMR). 1,000 BC family physicians are involved PITO in 2008/09. Chronic disease management is a business requirement for the six PITO vendors of EMRs.

Patient Self-Management

Since 2003, the Ministry's Primary Health Care Branch has funded the University of Victoria Centre on Aging to make the evidence-based Chronic Disease Self Management Program available across the Province since 2003. This program helps people develop the self-efficacy skills needed to care for their own health, and better cope with emotional, social and physical effect of chronic illness, including diabetes. In 2008/09, the Ministry provided $500,000 to Centre on Aging to continue this valuable service in the community.

In 2008, the Ministry's Primary Health Care Branch hired a Director of Patients as Partners. This portfolio is working with stakeholders across the health system and non-governmental organizations to develop a strategy to make patients more informed and activated partners in their health care and well-being.

Also in 2008, in collaboration with the Fraser Health Authority, the GP Services Committee (a joint committee of the Ministry of Health and BC Medical Association) is pilot testing the distribution of patient passports to patients – the patient passport provides a record of the patient's health concerns, medications, and other important health information required by health professionals for informed diagnosis and treatment.

Often patients with chronic illness (including diabetes) also suffer from depression. It is often the case, patients cannot get their diabetes under control until their depression has been addressed. In June 2008, the Ministry in partnership with the Canadian Mental Health Association launched the Bounce Back Program – this program provides depression self-help to patients via telephone (toll free to patients) by a community-based coach. The coaches will provide patients with motivational support and instruction to work through a series of self-help modules that are part of a structured program called "Overcoming Depression, Low Mood, and Anxiety". This program is available in both workbook and web-based format.

Delivery System Design/Re-Orient Health System

Practice redesign focuses on supporting family physicians, their practice staff and other health professionals to be innovative, improve and sustain practice changes that result in better improved patient health outcomes. Activities implemented in BC to support practice re-design were:

Alignment of physician compensation for improved chronic disease management: Through the *Full Service Family Practice Incentive Program*, BC GPs are eligible to receive a $125 per patient/per year payment for each patient with diabetes managed to best practice guidelines. This payment remunerates GPs for the non-direct patient care involved in reviewing the patient's chart and undertaking a planned, proactive approach to diabetes management.

In addition, in May 2007 a *complex care fee* was introduced to better support family physician care for their patients with two or more chronic illnesses – diabetes is one of the co-morbid chronic illnesses eligible for the complex care payment.

Structured Collaboratives: The MoH, with the health authorities, has used best practice quality improvement methodology of Plan/Do/Study/Act, to implement guidelines based diabetes care through a structured collaborative process, to enhance management of chronic disease at the primary care level. The initial pilot collaborative that focused on congestive heart failure resulted in improved processes of care for patients, as shown below. The success of this initial structured collaborative led to the implementation of ten collaboratives involving approximately 1100 practitioners across the province in diabetes management quality improvement.

The Practice Support Program (launched May 2007) is funded through the 2006 Ministry of Health/BC Medical Association Agreement. This is a provincially coordinated, two year practice enhancement program in which physician champions will work in partnership with local family physicians and health authority staff in realigning health care services to attain better patient health outcomes, and improve practitioner professional satisfaction. Through this program, GPs can access training in the following areas of practice redesign which are relevant in the management of all chronic illnesses, including diabetes:

1. Advanced Access - a new way of scheduling appointments that ensures patients see their physicians closer to the time they need an appointment
2. Group visits - GPs and their office staff can offer care, education and advice in a group setting that is efficient for the practice, and supportive for patients. Patients benefit from the opportunity to learn from, and share their experiences with their peers
3. Chronic disease management – developing patient registers to help identify patients with chronic conditions; using a planned recall approach to proactively monitor the care provided based on the clinical guidelines recommendations; and using the CDM Toolkit to help track progress and patient outcomes
4. Patient self-management - Helping GPs support patients to set and work toward their own health goals, in addition to managing the medical aspects of the patients' illnesses.

As of March 30, 2008, 1207 general practitioners and their medical office assistants participated in the Practice Support Program (this is approximately, 40% of all BC general practitioners).

In 2008/2009, twenty five *integrated health networks* have been funded for development. The purpose of the integrated health network approach is to formalize the linkages between family practice, specialist services, health authorities, and community based services for improved health outcomes of complex patients. An integrated health network will serve a geographic community that links patients and family physicians with existing health authority and community-based resources. It will also add other key resources to improve coordinated community care through an integrated team of providers organized around high-need priority patient populations—chronically ill patients with diabetes are one of these high-need priority populations.

In June 2008, the *Quality Improvement Network* will be launched as a partnership of the Ministry, BC Medical Association, BC Health Authorities, and IMPACTBC. The Quality Improvement Network's goal is to enhance regional health authority staff knowledge, skills, and cultural shift toward primary care practice improvement and integration of services (in particular extending the quality improvement strategies used in the practice support program to integrated health networks) for improved patient health care, especially chronic disease management. Community development to improve the health status of target populations and communities, as opposed to only the individual patient is also the mandate of the Quality Improvement Network.

Recommendation #2: Develop, and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.

Recommendation #2 - Primary Prevention Strategies: Preventing Diabetes

- In 2006/07, approximately 4.8 percent of British Columbians were diagnosed with diabetes. Complications of diabetes include cardiovascular disease, kidney disease, damage to sight, and limb amputation[5] (see attached appendix A).
- In 2006/07, approximately 6.7 percent of Status Indians (the proportion of First Nations population for whom data is available) in British Columbia were diagnosed with diabetes[6]. The prevalence rate of diabetes is 1.3 times higher among Status Indians than other BC residents. On average, each year, more than 100 Status Indians with diabetes die in British Columbia[7].
- The estimated direct costs for diabetes to the healthcare system in BC including hospitalization, Medical Services Plan and PharmaCare costs were approximately $1.04 billion in 2003/04. These costs could rise to $1.9 billion by 2015/2016[8].
- In 2005, the Ministry of Health Services, Population Health Surveillance and Monitoring, estimated that through the implementation of a Lifestyles Modification program, the BC government could reduce the incidence of diabetes by 25% and save $200 million in health care dollars[9]. A 50 per cent reduction would decrease annual costs for persons with diabetes by $400 million.[10] See also response to Recommendation 1: Strategic Population Health Initiatives.
- The 2004 Provincial Health Officer's Report "The Impact of Diabetes on the Health and Well-being of People in British Columbia" reinforces that for prevention programs to be successful, governments and communities need to work together to provide effective, aligned, multi-sectoral strategies as well as committed resources and funds to maintain programs for a long period of time.

Responding to the changing demographics and increased incidence of chronic illness in BC, the Chronic Disease Prevention Framework provides a broad strategic overview of the factors that lead to chronic diseases and the range of interventions needed to prevent or reduce their occurrence. This framework together with the Chronic Disease Evidence Paper, documenting costs and benefits, informed the ActNow BC framework which was announced by Government in the throne speech of 2005. The goal of ActNow BC is to improve the health of all British Columbians by addressing the common risk factors for chronic diseases, including diabetes, rather than focusing on one disease, or risk factor, at a time. ActNow BC has been designed to support Government's second great goal to counteract the broader societal trends linked to poor health outcomes, and to set hard targets for improvements. These initiatives will make an important contribution to the primary prevention of diabetes.

[5] Population Health Surveillance and Epidemiology, Ministry of Health, 2008
[6] Population Health Surveillance and Epidemiology, Ministry of Health, 2008
[7] The Impact of Diabetes on the Health and Well-being of People in British Columbia, 2004 Provincial Health Officer's Report.
[8] Follow-up of 2004/05 Report 3:Preventing and Managing Diabetes in British Columbia, Office of the Auditor General, December 2007
[9] Population Health Surveillance and Epidemiology, Ministry of Health Services, 2005.
[10] *ibid*, pg 37

In 2005, Premier Campbell announced the launch of ActNow BC, the health promotion and chronic disease prevention initiative aimed at encouraging British Columbians to make healthier lifestyle choices to improve their quality of life, reduce their risk of developing preventable chronic disease, and reduce the burden on our health care system. See response to recommendation #1 for information on the implementation of ActNow BC.

Recommendation #2 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

Improving Chronic Disease Management: A Compelling Business Case for Diabetes was developed in 2001 to identify the potential costs savings that could be accrued through the province-wide identification of people with diabetes and the implementation of the expanded chronic care model for the management of diabetes. Preventing the complications of diabetes was addressed in the business case, along with projections of health system burden of disease expected if action is not taken to effectively manage diabetes.

Effective management of chronic diseases is pivotal to an overall sustainable health system. To this end, the Ministry launched the BC Primary Health Care (PHC) Charter in May 2007. The PHC Charter outlines primary health care challenges, identifies priorities and actions, and establishes outcome measures to set the strategic direction of the Ministry of Health with the regional health authorities. One of the seven priorities identified in the Charter is chronic disease management, which includes the prevention of the complications of diabetes. The PHC Charter sets out a strategic agenda for other health system key stakeholders who want to align their efforts with a systems approach, and in 2008 a consultation was taken with BC health system stakeholders to re-state the PHC Charter – the revisions arising from the consultation will be completed in Fall 2008.

MoH initiated the Chronic Disease Management Initiative in January 2002, and since then has been implementing the components of the Chronic Care Model on a province-wide basis to realize the business case. In order to move providers and patients to a chronic care model that optimizes prevention, empower self-management, and support providers to manage care to best practice recommendations, the work of the Ministry has been to align:

- Compensation Strategies: Through the joint Ministry of Health/BC Medical Association Full *Service Family Practice Program,* general practitioners receive compensation for providing diabetes care according to the BC Diabetes clinical guidelines.
- Information Technology Strategies: BC's E-health Strategy will ensure that provincial funded electronic medical records include CDM Toolkit functionality (e.g., register of diabetes patients, diabetes guidelines and flow sheets, patient recall reminders).
- Legislation: Bill 29 (enacted March 2007) introduced changes to the Freedom of Information and Protection of Privacy legislation to authorize indirect collection of patient personal health information for the following purposes of managing chronic disease, and for use in health service development, management, delivery, monitoring and evaluation.
- Policies: The Ministry of Health developed a BC Primary Heath Care Charter (launched May 2007) to set a Province wide strategic direction for the re-design of primary health care that emphasized patients as partners in their own care.

- Service Delivery Models: Through the implementation of structured collaboratives and the Practice Support Program, Integrated Health Networks, and the Quality Improvement Network, BC GPs and other health care professionals are receiving training and support in
- re-designing their practice to better enable a proactive, planned approach to chronic disease management including diabetes management.
- Patients As Partners: The Ministry is developing a comprehensive strategy to empower patients to be informed and activated partners in their own care.

Recommendation #3: Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.

Recommendation #3 - Primary Prevention Strategies: Preventing Diabetes

1. The Ministry facilitated, and is a funder and non-voting member of the BC Healthy Living Alliance (BCHLA), the goal of which is to improve the health of British Columbians through leadership that enhances collaborative action. The BCHLA has developed four distinct strategies for supporting government's agenda of healthy living: healthy eating, physical activity, tobacco reduction and community capacity building. BCHLA is also working from an evidence based approach of focusing on common risk factors to chronic diseases such as diabetes, cardiovascular disease and certain types of cancer.

   The BCHLA, formed early in 2003 under the leadership of the BC Ministry of Health. There are nine voting members including the Canadian Diabetes Association, Heart and Stroke Foundation, Canadian Cancer Society,BC Lung Association, British Columbia Recreation and Parks Association, Dietitians of Canada, Public Health Association of BC, Union of BC Municipalities, and the BC Pediatric Society. Non-voting members include the Ministry of Health, the Public Health Agency of Canada, and the six Health Authorities. In February 2005 the Alliance released their strategic document The Winning Legacy – A Plan for Improving the Health of British Columbians by 2010 containing 29 recommendations for actions government could take. In March 2006, Government responded with a $25 million grant to the Alliance to support action on their recommendations. The Alliance has undertaken extensive strategic planning and is also working from an evidence based approach of focusing on common risk factors to chronic diseases such as diabetes, cardiovascular disease and certain types of cancer, aligned with the ActNow BC targets and Government's prevention targets in coming weeks. Investing in BCHLA and supporting strategic action across the large disease related organizations will support sustainability and action on promotion of health and wellness and prevention of chronic diseases such as diabetes.

2. In March 2005, the Premier launched ActNow BC, a multi-sector, partnership-based initiative that draws upon the reach and resources of all levels of government, non-government organizations, communities, schools and the private sector to create a assist British Columbians in making healthy lifestyle choices to improve their quality of life, reduce their risk of preventable chronic disease, and help create a sustainable health care system in BC. By engaging all sectors of society in creating a health-supporting environment where the healthy choice is the easy choice, ActNow BC broadens responsibility for population health beyond the traditional health care sector and creates a more sustainable network of health promotion and prevention initiatives that will ensure BC meets its goal of improved population health over the long term. A list of ActNow BC partners is available at www.ActNowBC.gov.bc.ca.) See response to recommendation # 1 for more information on implementation of ActNow BC.

3. MoH has a comprehensive framework for monitoring progress towards ActNow BC targets. Logic models have been developed for ActNow BC and for each ActNow BC target.

4. As part of its renewal strategy for public health, the MoH has adopted A Framework for Core Functions in Public Health, which will form the basis for a new Public Health Act. Health authorities will be required to reflect the "Healthy Living - core program paper" in their service delivery system beginning in the 2007/08 fiscal year. See response to recommendation # 1 for more information.

5. The MoH is involved nationally with diabetes surveillance. The diabetes probabilistic patient register developed from the case definition and work developed through participation in the National Diabetes Surveillance System, has been verified through a series of patient surveys.

Recommendation #3 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

1. The Ministry facilitated, and is a funder and non-voting member of the BC Healthy Living Alliance, the goal of which is to improve the health of British Columbians through leadership that enhances collaborative action to promote physical activity, healthy eating, and living smoke free, thus focusing on a wide range of chronic illness including diabetes.

2. In March 2005, the Premier launched ActNow BC, a multi-sector, partnership-based initiative that draws upon the reach and resources of all levels of government, non-government organizations, communities, schools and the private sector to create and assist British Columbians in making healthy lifestyle choices to improve their quality of life, reduce their risk of preventable chronic disease, and help create a sustainable health care system in BC. By engaging all sectors of society in creating a health-supporting environment where the healthy choice is the easy choice, ActNow BC broadens responsibility for population health beyond the traditional health care sector and creates a more sustainable network of health promotion and prevention initiatives that will ensure BC meets its goal of improved population health over the long term. A list of ActNow BC partners is available at www.ActNowBC.gov.bc.ca.)

   An important and active partner in supporting government's chronic disease prevention strategy (and helping to ensure its sustainability) is the BC Healthy Living Alliance (BCHLA). The BCHLA, formed early in 2003 under the leadership of the BC Ministry of Health, is an alliance of health sector stakeholders who are working together to prevent chronic disease. The nine voting members include the Heart and Stroke Foundation, Canadian Cancer Society, Canadian Diabetes Association, BC Lung Association, British Columbia Recreation and Parks Association, Dietitians of Canada, Public Health Association of BC, Union of BC Municipalities, and the BC Pediatric Society. Non-voting members include the Ministry of Health, the Public Health Agency of Canada, and the six Health Authorities. BCHLA members individually and collectively lobbied government regarding the need for investments in health promotion and chronic disease prevention. In February 2005 the Alliance released their strategic document *The Winning Legacy – A Plan for Improving the Health of British Columbians by 2010* containing 29 recommendations for actions government could take. In March 2006, Government responded with a $25 million grant to the Alliance to support action on their recommendations. The Alliance has undertaken extensive strategic planning and will be releasing plans for investments aligned with the ActNow BC targets and Government's prevention targets in coming weeks, specifically healthy eating and physical activity strategies.

3. MoH has a comprehensive framework for monitoring progress towards ActNow BC targets. Logic models have been developed for ActNow BC and for each ActNow BC target.

4. MoH supported the Provincial Health Services Authority (PHSA) in the planning and development of the BC Population and Public Health Data Evidence Network established to gather, coordinate and interpret key population and public health data and evidence.

5. As part of its renewal strategy for public health, the MOH has adopted *A Framework for Core Functions in Public Health,* which will form the basis for a new Public Health Act. Health authorities will be required to reflect the "Healthy Living - core program paper" in their service delivery system beginning in the 2007/08 fiscal year.

6. The MoH is involved nationally with diabetes surveillance. The diabetes probabilistic patient register developed from the case definition and work developed through participation in the National Diabetes Surveillance System, has been verified through a series of patient surveys.

7. Emerging evidence published in the New England Journal of Medicine June 2008, indicates previous evidence-based chronic disease management measures appear to be dangerous in some populations, causing higher mortality and morbidity. This evidence contributes to the complexity of approaches for the MoH and clinicians. We are currently reviewing our strategies to ensure the art as well as the science of clinical practice is well supported in BC.

The MoH/BCMA 2006 Agreement has identified significant additional resources to support expanded activity. It has increased the annual incentive payment for appropriate management of diabetes per patient per year from $75 to $125. It has also introduced a payment to better support family physicians care for patients with complex co-morbid conditions (of which diabetes is an eligible condition). The agreement has included new resources to address hypertension supported by new clinical practice guidelines. The guideline includes a management flow sheet, which is shared with the patient. It is anticipated that a focus on hypertension will make an important contribution to diabetes prevention, because high blood pressure is often associated with the onset of diabetes.

The Government/BCMA 2006 Agreement includes significant investment in BC's e-health strategy, designed to support clinical improvements across the system. e-Health will take the successes of the CDM electronic toolkit, which enables substantial improvements in patient care for people with diabetes and other diseases, and will embed these critical functionalities into Electronic Medical Records, which will be available to all general practitioners and specialists in the province.

Section 4

Update on the implementation of recommendations from:

In Sickness and in Health:
Healthy Workplaces for British Columbia's Health Care Workers

June 2004

October 2008

May 1, 2008 722749

Mr. Morris Sydor, CA
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V9V 1X4

Dear Mr. Sydor:

Thank you for this opportunity to provide a second follow-up on outstanding recommendations from the Report entitled ***"In Sickness and in Health: Healthy Workplaces for British Columbia's Health Care Workers".***

I am pleased to provide a coordinated response to your March 12, 2008, letter of request on behalf of the Presidents and Chief Executive Officers for the Vancouver Island Health Authority, Fraser Health Authority, Vancouver Coastal Health Authority, Interior Health Authority, Northern Health Authority and the Provincial Service Health Authority.

The response is a collaborated effort between all the health authorities working to achieve best practices in promoting healthy workplaces for B.C. health care workers. Detailed updates can be found in the attached "Summary of Status of Implementation by Recommendation" and in the "Progress on Implementing the Recommendations".

The Ministry continues to work with the health authorities to ensure all recommendations are fully implemented. I appreciate the Auditor General's recognition of the importance and continuing interest in seeing that progress continues to be made in improving workplace health.

Sincerely,

Original signed by

Gordon Macatee
Deputy Minister

Attachments

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

pc: Honourable George Abbott, Minister of Health

Lynda Cranston, President and Chief Executive Officer
Provincial Service Health Authority

Howard Waldner, President and Chief Executive Officer
Vancouver Island Health Authority

Nigel Murray, President and Chief Executive Officer
Fraser Health Authority

Ida Goodreau, President and Chief Executive Officer
Vancouver Coastal Health Authority

Cathy Ulrich, President and Chief Executive Officer
Northern Health Authority

Murray Ramsden, President and Chief Executive Officer
Interior Health Authority

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	**Fully**	**Substantially**	**Partially**	**Alternative ction**	**No Action**	**Supporting Documentation or Comments**
Enhancing Leadership — Ensure that the health of the work environment is included into the performance appraisal of all senior and frontline managers.						
Interior Health	√					People Plan alignment of commitments and 2008 objectives agreed Fall 2007.
Northern Health	√					Imbedded in core competencies of performance management. Following the plan previously stated (2007) and on track with deadlines.
Provincial Health Services Authority	√					See supporting documentation.
Demonstrate in word and action that employee health and well-being are important to organizational success.						
Northern Health	√					Provincial wide development Health & Wellness Charter, enhanced Employee Family Assistance Program (EFAP), Wellness Committees. On going Health and Safety updates to Board and Executive Committees. Chief Operating Officers reporting at Board meeting on injury outcomes for their areas.
Develop costing information for the initiative in their human resource and occupational health and wellness plans in order to understand their return on investment.						
Northern Health		√				Built Evaluation systems: HSCIS reports, White Database Reports, Encon Reports, WCB/OHSAH – research completed.
Ensure in conjunction with partner agencies, that all initiatives are well coordinated to maximize both the funds and effort being directed to creating a healthy work environment.						
Northern Health	√					Integrated process with HBT on early Return to Work. Worksafe BC funding to promote employee Health & Safety Wellness. Health Canada to promote employee Health & Safety.

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	Fully	Substantially	Partially	Alternative ction	No Action	Supporting Documentation or Comments
Put in place appropriate mechanisms to gather data on employee health indicators and work environment conditions. The health authorities should then incorporate the information into their human resource plans.						
Vancouver Island Health Authority	√					See supporting documentation.
Provincial Health Services Authority	√					See supporting documentation.
Promoting a Healthy Environment						
Ensure that their actions are consistent with their communications to staff.						
Northern Health		√				Performance Management.
Review the extent of managers' control and ensure that it is not beyond a limit to be effective.						
Interior Health		√				Focus groups with managers on their roles and responsibilities have been undertaken at the direction of the CEO. Awaiting report May 2008.
Northern Health		√				Currently reviewing organizational design.
Vancouver Coastal Health Authority		√				Decreasing the span of leadership for manager's cannot be accomplished by increasing the number of managers given the current fiscal constraints. VCH has focussed on increasing front line supervision of employees (clinical resource nurses) who are available to staff to assist with problem solving and decision making, and introducing business support assistants to managers so that transactional work (scheduling, payroll) can be completed by the assistant rather than the manager, thus providing opportunity for the manager to respond to front line staff issues in a more timely manner. Note: April 2008: The evaluation of this strategy is not complete, but early indications are that this strategy has significantly improved the productivity, effectiveness and the satisfaction of managers with their workloads.

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	**Fully**	**Substantially**	**Partially**	**Alternative ction**	**No Action**	**Supporting Documentation or Comments**
Fraser Health Authority		√				See supporting documentation
Vancouver Island Health Authority		√				See supporting documentation.
Provincial Health Services Authority	√					See supporting documentation.
Assess the work environment for risks to staffs' mental health and develop an action plan to mitigate the risks.						
Interior Health			√			Two pilot seminars were held for managers within the past year to increase awareness of staff mental health issues and to provide education on early recognition. An action pan is currently being developed to replicate this learning in other sites across Interior Health in the coming year. The addition of Lifehub (web access for mental health assistance) as part of the overall Employee and Family Assistance Program for all staff has been very well received. In addition, Interior Health is involved with our EFAP partner, Interlock, in a research project on depression that supports staff through telephone counselling. Within HR, restructuring occurring in WHS. New position of Wellness Coordinator, once filled, will take lead on additional mental health initiatives for staff.
Northern Health	√					Respect in the Workplace Training. Conflict Resolution Training. Employee Family Assistance Program. Additional intervention request follow up.
Fraser Health Authority		√				See supporting documentation.
Vancouver Island Health Authority			√			See supporting documentation.
Provincial Health Services Authority	√					See supporting documentation.

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	**Fully**	**Substantially**	**Partially**	**Alternative ction**	**No Action**	**Supporting Documentation or Comments**
Consider ways to promote a healthy lifestyle among their employees						
Interior Health		√				Contracts with our vending machine companies have been altered to include healthy food and beverage choices. Local healthy lifestyle initiatives are being supported at the local levels e.g. walking clubs, onsite massage therapy, organized golf schedules, pot luck lunch events, corporate fitness accounts etc. The annual influenza campaign promotes health for staff and their patients. In 2008, a major focus will be on tobacco reduction strategies. Wellness Coordinator will take lead in broadening health promotion programs across IH where there is local support. Ongoing initiatives continue to be developed as opportunities present themselves.
Fraser Health Authority		√				See supporting documentation
Ensure that their appointees to the Joint Occupational Health and Safety Committees attend meetings regularly and recognize occupational health and safety as a part of their responsibilities.						
Vancouver Island Health Authority		√				See supporting documentation

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	**Fully**	**Substantially**	**Partially**	**Alternative ction**	**No Action**	**Supporting Documentation or Comments**
Assess the work environment for risk of violence to staff safety and security and develop an action plan to mitigate the risk						
Interior Health			√			A Violence Prevention Coordinator has been hired in spring 2007. A comprehensive program is currently under development including risk assessment tools, policy and procedure development and an education program beginning with staff in high risk areas. This will be rolled out across several of our high risk units in acute care this year. A parallel strategy is being developed for residential care sites. Significant work has been done since last report; Violence Prevention program substantially developed, training program pilot currently being provided & evaluated. Once pilot sites are completed a more global rollout across IH will occur, over the next 2 years.
Northern Health	√					108 Northern Health Sites – 85% risk assessments are complete with completion date target for March 2008. Risk Mitigation plans developed (such as new security system implemented at Prince George Regional Hospital)
Provincial Health Services Authority		√				See supporting documentation
Monitoring and Reporting on the Work Environment						
Implement a human resource information system that will provide data needed for developing a comprehensive picture of employee and workplace health						
Vancouver Island Health Authority	√			√		See supporting documentation
Provincial Health Services Authority		√				See supporting documentation

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	Fully	Substantially	Partially	Alternative ction	No Action	Supporting Documentation or Comments
Have senior management work with their board members to determine what employee health and work environment indicators are important to collect and report on a regular basis, and how to evaluate if current policies, programs and resources are meeting employee and workplace needs.						
Interior Health	√					Issues associated with work environment are built into the Terms of Reference of the HR Committee of the Board. Quarterly and annual Chart of Business Indicators, including HR, is in process of finalization and implementation.
Fraser Health Authority	√					See supporting documentation
Determine in conjunction with the Ministry of Health, what indicators of employee and workplace health should be reported publicly on a regular basis						
Interior Health	√					Chief Human resources Officer participates regularly @ Health Human Resources Strategy Council on the identification, monitoring and reporting of provincially-agreed indicators. Quarterly Human Resources report on IH-agreed indicators is distributed to IH Executive and Management for follow-up and action
Northern Health	√					Per GLE

Summary of Status of Implementation by Recommendation
In Sickness and in Health: Healthy Workplace for British Columbia's HealthCare Workers

	Implementation Status					
Auditor General's Recommendations	**Fully**	**Substantially**	**Partially**	**Alternative ction**	**No Action**	**Supporting Documentation or Comments**
Vancouver Coastal Health Authority	√					Performance measures reported to the Ministry of Health include: paid sick hours as a percent of productive hours; Nurse overtime hours as a percent of productive hours; Allied Health overtime hours as a percent of productive hours; difficult to fill nurse vacancies as a percent of Registered Nurse employees; difficult to fill Allied Health Professional vacancies as a percent of Allied Health Professional employees; Musculoskeletal Injuries per 100 FTE's; new long term disability claims per year; and percent of staff who receive the flu vaccine. These same indicators are reported through Open Board meetings and are available on the VCH website for the public to review.
Fraser Health Authority	√					See supporting documentation
Vancouver Island Health Authority	√					See supporting documentation
Provincial Health Services Authority	√					See supporting documentation

Supporting Documentation and comments as noted from Summary Table

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON
In Sickness and in Health: Healthy Workplaces for British Columbia's Health Care Workers
As at March 2008

Fraser Health Authority:

Recommendation: Review the extent of managers' control and ensure that it is not beyond a limit to be effective.
Implementation Status: *Substanially*

- Conducted a preliminary review of literature regarding effective span of control, including identification of span of control issues and optimal span of control factors.
- Established base-line data regarding current span of control in various nursing areas and other clinical manager portfolios.
- Developed discussion paper confirming necessary preconditions for successfully addressing issues related to span of control of health services managers, the scope of engagement for this initiative, current management infrastructure requirements and appropriate interventions, targeted investments and monitoring outcomes.
- Engaged senior leader stakeholders in discussions to determine executive sponsorship, effective implementation methodology, best-fit pilot sites and established a steering committee to guide implementation of action plan.
- Determined relevant metrics to measure outcomes, identified key risks and project resource requirements.

Recommendation: Assess the work environment for risks to staffs' mental health and develop an action plan to mitigate the risks
Implementation Status: *Substantially*

Two health risk assessment tools were piloted within Fraser Health. The @alive® pilot program was a confidential on-line health risk assessment tool supported by one-on-one nurse coaching. The FeelingBetterNow© tool was an anonymous, web-based mental health assessment system that address the full continuum of mental health care.

The pilots began in October 2006 and ran until October 2007. Over 2300 staff was offered the chance to participate and there was over a 20% response rate. The program has received funding to continue as an ongoing basis in the pilot sites and will be expanded to an additional 7,000 staff in 2008.

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@live® and FeelingBetterNow© provides member organizations with usable metrics to guide workplace health planning to prevent escalating long term disability [LTD] and extended health claims [EHC] costs.

Fraser Health is participating in a CHSRF Funded Grant entitled: Developing Healthy Workplace Environments within BC Healthcare.

"Within British Columbia there is a lack of information about the work stressors that have the greatest negative impact on the mental health of healthcare workers from which a business case can be developed for improving the workplace. Furthermore, no program exists that innovatively improves the work environment of healthcare workers at the unit and organizational level."

To address this gap, this study will test a model for initiating the development towards healthy workplaces through the implementation and evaluation of unit and organizational level preventative programs in the Fraser, Interior, and Vancouver Coastal Health Authorities.

This study has five objectives. They are:

1. to determine prevalence of mental health problems among BC HCWs;
2. to determine the level and nature of exposure to work stress by HCWs in British Columbia and the stressors [i.e. work-home balance stressors, work-related stress, organizational culture, etc.] that are negatively impacting HCWs mental health and retention;
3. to identify current preventative programs and services available within the health authorities that address risk factors, as well as facilitators and barriers to program implementation;
4. to identify, pilot, and evaluate interventions in each health authority that will address high priority mental health risk factors at the unit and organizational level as evidenced by the qualitative and questionnaire data from participants, and;
5. examine factors that impact the implementation and sustainability of healthy workplace initiatives.

Research collaborative: include FHA, IHA, NHA, PHSA, OHSAH, SFU, UBC, UNBC and VCHA.

Recommendation: Consider ways to promote a healthy lifestyle among their employees
Implementation Status: *Substantially*

- During 2006 and 2007, Fraser Health's Health Promotion and Prevention partnered with Workplace Health to launch a three-month healthy living pilot project with

employees in the Abbotsford/Mission area. This pilot project yielded a participation rate of approximately 25% of employees registered for the challenge. *"The Fraser Health Challenge pilot demonstrated how an action-oriented, participant-led health promotion program that is based on simple and clear messaging and layers of support [through senior administration, ambassadors, champions and the project team] can yield impressive participation, behavioural, satisfaction and perception outcomes."* [FH in motion Challenge Pilot Evaluation, 2007].

Fraser Health participated in the Act Now Challenge from February 1st to March 31st. Healthy Living activities at work sites included healthy potlucks, stair challenges, fit-break days, tobacco free days and more. Every Fraser Health site had some type of activity, including the virtual step challenge across British Columbia.

Ongoing partnership between Fraser Health's Health Promotion and Prevention and Workplace Health has generated an action plan for 2008/09 that includes quarterly campaigns at a site level with the following goals:

1. To educate employees on strategies to integrate healthy living into their daily lives.
    - Provide materials and information to encourage eating well, exercising and living tobacco-free.
    - Expose employees to a variety of presentations and activities focused on healthy living options.
2. To increase consumption of fruits and vegetables.
    - Provide a menu of activities that encourage employees to increase their fruit and vegetable intake.
    - Highlight options available to incorporate local food options.
3. To increase the frequency of daily physical activity.
    - Provide a team activity challenge to encourage the increase in daily physical activity.
    - Highlight local options that employees can access to support an increase in physical activity levels.
4. Decrease tobacco exposure
    - Provide current, evidence-based cessation options for staff.
    - Highlight materials and information designed to assist sites to become tobacco free.

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5. Aid in the recruitment and retention of employees.

    - Incorporate challenge information into recruitment materials to promote FH as a "Healthy Living Employer."

Recommendation: Have senior management work with their board members to determine what employee health and work environment indicators are important to collect and report on a regular basis, and how to evaluate if current policies, programs and resources are meeting employee and workplace needs
Implementation Status: *Fully*

In 2006, Workplace Health published the first annual "Healthy Workplace Profile" reports for Fraser Health leadership using data from the 2005 calendar year. This current report, using data from the 2007 calendar year, represents the on-going effort to provide Fraser Health leadership with data to facilitate evidence-based decision-making to improve the health of our workers and workplaces.

Fraser Health's project within this national Health Canada initiative is to develop a multi-factorial model of indicators that reflect the health of our organization and our employees. Reports have been prepared for each member of the Executive Team and Regional Director profiling the performance of the portfolios for which they are directly responsible. Reports exist for the 2005 and 2006 calendar years.

PerformanceLink – performance expectations and action plans for healthy workplace interventions are built into Fraser Health's PerformanceLink [Performance Management System].

Fraser Health has a business goal to reduce short term disability occupational injury claims duration to align with Provincial averages. WorkSafe BC [WSBC] has made reduction of STD duration a core strategic business objective for 2007. In 2007, Fraser Health and WSBC collaborated on a project using the LEAN Six sigma methodology to improve injury outcomes within a select area of Fraser Health by the end of 2007. Outcomes included: reducing injury recovery time through enhanced services for the worker; decreasing staffing pressures and costs by implementing light duties and modified work; reducing claim costs and complexity by developing a coordinated claims management system; and improving worker education and advocacy.

Project achieved a 9 day reduction in average duration for the sub-set of claims and geographic area within the select area.

Findings and best practices are now being shared and implemented provincially.

Recommendation: Determine in conjunction with the Ministry of Health, what indicators of employee and workplace health should be reported publicly on a regular basis
Implementation Status: *Fully*

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The Fraser Health Board receives as part of its reporting, quarterly reports on the following Key Performance Indicators that are related to Healthy Workplaces:

- Frequency of WorkSafe BC claims [rate]
- Duration of WorkSafe BC claims [days lost average per claim]
- Sick Time Utilization [rate]
- Flu immunization [% rate]

On annual basis, the Board receives a report outlining trends by portfolio of the following:

- Frequency of WorkSafe BC claims [rate]
- Duration of WorkSafe BC claims [days lost average per claim]
- Sick Time Utilization [rate]
- LTD Claims per Productive Hours [rate]
- LTD Hours as a % of Productive Hours
- Overtime
- Costs of LTD, WSBC and Sick time claims

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Vancouver Island Health Authority:

1. Has your organization undertaken specific follow up action in response to the 2007 Follow up Report of the Auditor General?

__X_ yes ___ no

Please report on your actions and activities that specifically respond to each recommendation made in the Auditor's report (complete the attached Appendix A):

2. Based on the OAG findings, are there other supporting initiatives or approaches that support the priorities identified by the Auditor: providing leadership, promoting a healthy work environment, monitoring and reporting etc.

In June of this year, VIHA's HR Strategic Plan (the People Plan) was approved by the Executive Management Committee (EMC) and endorsed by the Board. The Plan notes that the most significant risk to VIHA achieving its organizational goals and objectives is its ability to retain and recruit adequate numbers of health care professionals and support staff.

The People Plan stresses that if the organization relies on traditional or "status quo" workforce supply strategies, VIHA and its service delivery partners will find themselves in a potential shortfall – what we have termed "the GAP" – of up to 1200 health care professionals and support staff by the year 2010/11. While this gap is of significant concern, it is compounded by the fact that these shortfalls are more pronounced within certain programs, occupational groups and geographic locations.

Given the significance of this risk, the Board asked that a detailed implementation plan be prepared, setting out how the organization intends to address this pressing issue. Based on input from the People Plan Steering Committee, including a review of best practices, this Plan describes nine core projects that are complementary in nature and collectively, are designed to "close the GAP" including:

- Innovative Recruitment and Retention Strategies
- Re-engineered Staff Scheduling systems and Processes
- Redesigned Care Delivery Models
- Workforce Planning, Utilization and Forecasting
- Re-engineered vacancy management business processes.
- Commitments to continuous learning
- Community and Environmental Leadership
- Worklife Support Strategies.

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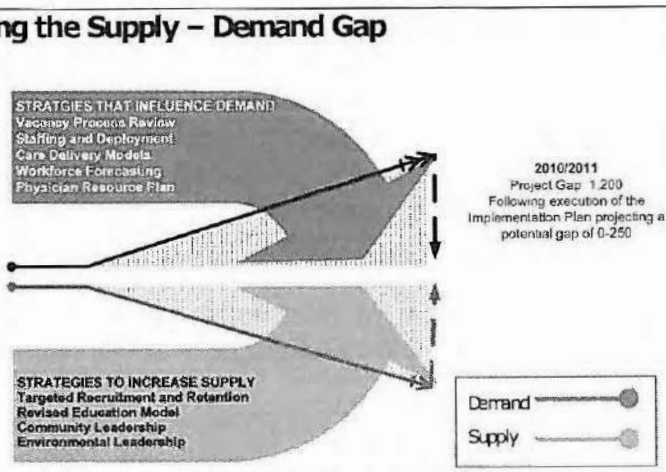
Although the Implementation Plan focuses on these core projects, this is not intended to be an exhaustive list of the activities required to close the supply/demand gap. A broad spectrum of additional strategies currently in place, or under development, will also contribute to achieving our stated goals.



Similarly, as we update the Plan, the consultation process will be expanded to include a greater number of employees, physicians and other stakeholders. Further, a regular report, website and other forms of communication to the organization will be developed to both heighten the awareness of our response to the workforce challenges, report out on our progress, and to solicit further input into future planning in this regard.

3. Do you undertake any formal monitoring or surveying of your staff with regard to workplace wellness/morale/engagement etc?

Our People Plan also recognizes the strategic value of engagement. Engaging or securing commitment from staff has become a key focus for employers, and as such, has been integrated into our performance-monitoring framework. Historically, employers have tended to focus on staff satisfaction as one of the indicators for organizational performance. However, research (Watson Wyatt, 2005, Gallup, 2003) has shown that unlike satisfaction, staff engagement (the degree to which employees are emotionally and intellectually committed to, and involved in their work) is a powerful predictor of work behaviour and overall performance. The degree to which staff is engaged can be linked to improved levels of staff/patient satisfaction and increased productivity. Towers Perrin (Global Workforce Study, May, 2006) conducted a study with over 80,000 employees worldwide and their data underscored another key learning---while there are a variety of elements involved in both retaining and engaging employees there is a significant link between staff engagement and retention.
The Towers Perrin Study also showed that there isn't a single solution for increasing employee engagement.

However, the study points to the fact there is a core set of workplace factors that employers should focus upon:

- Visible Senior Leader Involvement
- An emphasis on Learning, Skills Enhancement & Career Development
- Effective Frontline Management & Supervision
- Customized Rewards & Recognition Strategies

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- Organization's Reputation

Many of our strategies and the nine core projects touch on one or more of these factors. However, the Executive is of the view that more work should be undertaken to increase employee engagement. Specific strategies will be implemented to influence each of the above noted factors.

For example a President's Council, which involves the President meeting on a regularly scheduled basis with groups of staff to receive feedback on issues important to them. The first of these focus groups will be scheduled in January 2008.

The Celebration of Excellence Program will be expanded to include a new category that will acknowledge and honour individuals or teams for their Community Service.

A formal employee suggestion program will be implemented to solicit employee suggestions for improvement opportunities.

Of note, staff engagement on the new RJH patient care centre is well underway including gathering 'content expert' feedback through a variety of formats and means including: open houses, walkabouts, suggestion boxes, staff meetings, practice committees and interviews. This project has adopted, as a core objective, the concept of a "Magnet Hospital" to assist with attraction and retention.

Finally, we will continue to use best practice survey instruments to assess and measure engagement. Using the Gallup Q12 survey tool in 2006, we surveyed a broad cross-section of staff across programs and geography. A resurvey of these workgroups has just completed and, at the same time, we have brought forward a recommendation to our Board of Directors concerning the go-forward instrument of choice based on a best practices review conducted in and early 2008.

Vancouver Island Health Authority

Recommendation: Put in place appropriate mechanisms to gather data on employee health indicators and work environment conditions. The health authorities should then incorporate the information into their human resource plans
Implementation Status: *Fully*

VIHA has introduced several processes designed to gather data and report on indicators of employee health and work environment conditions including:

1. Gallup engagement survey (Q-12).
2. Continued roll-out of the WHITE database – (see #5 below).
3. On-line Management Reporting via our web-based **IDEAS** management information system. Managers across VIHA have access to statistical information through **IDEAS**, which is an on-line decision support tool which integrates clinical and administrative data. Each manager has a personalized Balanced Scorecard containing indicators relevant

to the program in which they work, and their scope of responsibility. The system allows managers to 'drill down' into the data to facilitate further analysis.

4. Patient Safety rounds – Executive rounds with individual departments and staff includes "worklife" as a dimension of quality and safety.

These systems help to inform both individual department performance (and thus front line performance in this regard), but also HR Planning. As such, responsibility for Workplace Health and Wellness is now found in the performance plans of all management staff.

Similarly, VIHA's five-year strategic Human Resources Plan (People Plan) is informed by and evaluated against, among other things, healthy workplace indicators. While the People Plan Implementation Plan largely focuses on the achievement of assigned FTE values to close the projected supply/demand GAP, it should be noted that the assigned values are predicated on realizing improvements in a number of measurable outcomes. VIHA continuously monitors and tracks health care data and other information to assess how well the organization is meeting its goals and objectives. Performance measures are used to monitor performance throughout the health authority with respect to the achievement of these goals and objectives.

To this end, the Plan will initiate multiple concurrent, complementary and interdependent activities that will each impact several performance measures. As such, the Plan sets out a number of core performance measures and targets, including employee health indicators, which we will continue to monitor and report against throughout the execution of the Plan.

As the Plan unfolds, these activities and initiatives may generate unique key performance indicators (KPI's) that will be incorporated into the monitoring and reporting of the individual projects. Similarly, it is anticipated that these core performance measures and targets will be reviewed/adjusted annually and new measures may emerge and be incorporated into the broader People Plan monitoring process.

Recommendation: Review the extent of managers' control and ensure that it is not beyond a limit to be effective
Implementation Status: *Substantially*

To meet the changing and increasing demand for health care, VIHA is implementing a broad range of changes including:

- New care delivery models;
- Improved access and patient flow;
- New clinical and diagnostic technologies;
- New and updated facilities; and,
- Optimizing scope of practice.

To realize the quality of care and productivity improvements such transformations promise require significant organizational design support from the HR Portfolio to implement staffing models that take into consideration:

- Organizational structure;
- Staff mix (full-time/part-time);
- Staff configurations;

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- Shift design and non-traditional staff rotations; and,
- Best practices in work team design.

Organizational design strategies will significantly influence the organization's ability to attract and retain key talents and must address historic issues such as span of control to create a professional practice environment that has coaching, mentoring, and professional development as key characteristics. To this end, the Ministry of Health, the Health Authorities and the Nurses' unions agreed to dedicate some resources to addressing the span of responsibility issues. In 2007/08, VIHA introduced 16 such positions, including clinical education and clinical coordination support – all in the central and northern parts of the health authority that have been historically resource-challenged in this regard. More positions are being added in 2008/09 with the input of management and union representatives.

At the same time, as part of the People Plan, VIHA has embarked on a three-year project to is redesign its care delivery models using a technique called Functional Analysis. The initiative is designed to replace current care delivery and staffing models (including leadership models) with new, innovative and sustainable approaches involving job and service model redesign and accountability frameworks.

Recommendation: Assess the work environment for risks to staffs' mental health and develop an action plan to mitigate the risks
Implementation Status: *Partially*

People Plan Implementation Plan has set out a number of complementary goals and work-life support strategies designed to support the well-being of our staff by adopting programs that improve the work environment and the overall work experience. In this regard, VIHA is in the early stages of creating a partnership with our Mental Health and Addictions Services and the Health Care Benefit Trust to address employee mental health. As part of an environment scan in 2007 in this regard, VIHA has identified that the work at the Provincial Health Services Association (PHSA) may serve as a suitable framework to begin to address employee mental health issues. Further scoping of this framework, including a resource plan, will be developed for 2008/09.

Recommendation: Ensure that their appointees to the Joint Occupational Health and Safety Committees attend meetings regularly and recognize occupational health and safety as a part of their responsibilities
Implementation Status: *Substantially*

The following describes how VIHA supports our 51 Joint Occupational Health & Safety (JOH&S) Committees and how the Wellness & Safety department, on behalf of the organization, promotes the effectiveness of these committees within the intent and spirit of our policy and legal/regulatory framework.

a. The requirement to have JOH&S Committees, and the roles/responsibilities for committee members are laid out in the *Workers' Compensation Act*. VIHA also has a formal Prevention & Health Promotion Program that details the organization's expectations for committees.

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b. The VIHA Wellness and Safety Department liaises with each Committee on a regular basis. In all cases, the committees are provided with monthly updates regarding statistics and other health & safety issues. In some cases, especially with the larger hospitals and/or the committees asking for assistance, a Safety Advisor and/or MSIP Advisor attends the monthly meetings to provide expert guidance and/or facilitation.

- As an example, the Occupational Hygienist and a member of the MSIP/PEARS Team attends the Victoria General Hospital and the Royal Jubilee Hospital JOH&S Committee Meetings on a regular basis to answer questions and to provide training/education in specific areas of expertise. As well, these health & safety experts liaise with the committees' management/union co-chairs on a regular basis to answer questions and provide assistance.

c. Each member on the committees is granted a minimum of 8 hours of training (as per the *Workers' Compensation Act*). This amount of training is provided in addition to any education/training mentioned above and is in addition to any education/training provided by a committee member's union.

- Training programs were developed, in cooperation with the Occupational Health and Safety Agency for Healthcare in BC. In April & November of 2007, courses were delivered in Victoria, Duncan, Nanaimo, Parksville, Campbell River and Port Hardy; another round of courses will be provided again starting in June of 2008.
- As part of that training, members are provided with a number of health & safety topics. This includes the basic requirements for JOH&S Committees (as outlined in the *Act*). Every member that attends this training is aware of their role/responsibility on the committees to ensure that these bodies are functional.

d. The W&S Department has conducted audits on JOH&S Committee performance. The last audit was conducted in 2007 and focused on the basic elements of a Committee (e.g. number of meetings held annually, the attendance at those meetings, etc.).

- As part of the audit, W&S also reviewed each committee's meeting minutes to review the topics that were discussed. It should be noted that committees are required to take meeting minutes at each of their monthly meetings.

e. VIHA's Wellness and Safety Department has formed a joint committee with WorkSafeBC (formerly, the "Workers' Compensation Board"). In this working group, members from both VIHA's W&S Department and WSBC's Prevention Division have been meeting since 2006 at regular intervals to review/address the efficiency and effectiveness of JOHS committees. The committee, co-chaired by a VIHA Wellness & Safety Representative and a WorkSafeBC Hygiene Officer (Bill McCaugherty), met with JOH&S Committees throughout VIHA. One of the objectives was to identify concerns of Committee members. A survey was conducted, identifying education and training needs and determining other JOH&S Committee concerns.

- The working group presented the results of the status survey to the four focus sites as well as to management groups at two of the four sites.

f. As part of the findings described in "e" above, the working group has developed a template for the JOH&S Committees' Terms of Reference, as well as for meeting agendas.

It is felt that by having these two documents standardized island-wide, that this will assist in individuals understanding their roles/responsibilities.

Recommendation: Implement a human resource information system that will provide data needed for developing a comprehensive picture of employee and workplace health.
Implementation Status: *Fully and Alternative Action*

VIHA continues pursue the replacement of its decommissioning legacy HR information systems. An RFP to replace these systems was issued in late 2006 but placed in abeyance with the introduction of the Health Authority Shared Services Organization (SSO). The SSO's goals will be to create extra value to the health system through increased efficiency, standardization, and stronger buying power; to enhance quality through the delivery of customer-focused services; and improve alignment and integration across the health authorities. The non-clinical services under consideration are common products procurement, warehousing and logistics, **payroll/transactional human resources,** and information technology (including data centre, desktop and contact centre/help desk). John Johnston, Vice-President of Human Resources with VIHA will be the executive lead on the provincial Payroll/Transactional HR business case review process.

In the interim, VIHA has continued to implement the OHSAH WHITE database. WHITE stands for Workplace Health Indicator and Tracking and Evaluation.

The WHITE Database is a web-based system that helps incident tracking and case management. Four of BC's six health authorities, including VIHA, are now using the system to centralize information that can be used to reduce and/or eliminate workplace injuries, provide prompt clinical and workplace interventions to reduce disability and time loss, and evaluate the effectiveness of health and safety programs. The system links all information entered into the Database. For a healthcare organization, this could mean determining, for example, that a specific education session has a major impact on reducing back injuries, or that introducing safer needles has reduced the total cost of needlestick injuries. Similarly, the Database can be used to identify immunized and non-immunized workers during an infectious disease outbreak such as influenza. The Database has five modules. Their key functionalities are:

Incident Investigation Module

- Recording of incident/injury details.
- Recording of the Investigator's Report (including identification of action items and corrective action timescales/completion)
- An electronic body map for the identification of injured/affected body parts

Case Management Module

- Electronic submission of WorkSafeBC Form 7
- Electronic retrieval of WorkSafeBC Claims Costs
- Recording/tracking of short term and long term disabilities

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- Modified Return to Work Planning/Management for time loss claims as well as short and long term disabilities

- Recording of immunization and vaccination against infectious diseases
- Recording/tracking of needlestick and BBF exposure information (EPINet)
- Recording of worker allergies and sensitivities
- Recording/tracking of chemical, heat and radiation exposures

Health and Safety Module

- Recording of facemask fit test results
- Training and education records
- Recording of audiometric test results

Prevention and Early Active Return-to-work Safely (PEARS) Module

- Tracking of MSI prevention strategies
- Healthcare worker assessments - clinical charting (i.e. SOAP notes)
- Workplace and equipment assessments
- Ergonomic assessments and workplace accommodation
- Interventions (including work programs and education)
- Reporting and follow up features for enhanced case management

Data Security/Confidentiality

The WHITE Database captures information about occupational health and safety concerns and personal information at each health authority using WHITE. The information that is collected is used for health promotion, case management, research and evaluation; for the purposes of improving the health of the local and, because of the provincial roll-up, British Columbia's healthcare workforce. The WHITE Database has many layers of security to ensure that information is only available to authorized persons. This is achieved through personal non-transferable login and passwords that determine the information to be displayed to each user (Occupational Health Professionals) of the system. This is in addition to health authority network security.

Data is used for research and analysis purposes by each health authority and OHSAH. Information collected and used by OHSAH is based upon the anonymity of individual healthcare workers. This is achieved by removing or encrypting personal information before it is analyzed.

Recommendation: Determine in conjunction with the Ministry of Health, what indicators of employee and workplace health should be reported publicly on a regular basis..
Implementation Status: *Fully*

VIHA actively participates in a number of inter-Health Authority forums where these metrics are being discussed and developed. The work is being lead by the Health Human Resource Strategy Council (Vice-President's of Human Resources) with the detailed work (indicator

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development/data mapping) being done by the provincial HR Data Committee. VIHA is actively involved in these discussions given its extensive experience reporting on a series of employee health indicators. Attached is the most current report to our Board of Directors on the current suite of health human resource indicators monitored at VIHA. These reports are publicly available and summarized on our internet web site (Accountability section).

GHR Nov 2007 Perf Rpt.pdf

Attached in hard copy form for review

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VANCOUVER ISLAND health authority

Performance Report
Introduction – November 2007

The Vancouver Island Health Authority has a strong commitment to monitoring, reporting and improving its performance. Each publication of the Performance Report focuses on select performance measures that together, provide a balanced assessment of our performance and progress in meeting our goals. This set of measures is not static nor is it inclusive of all the indicators monitored by VIHA. Rather, these indicators are the most relevant and informative with respect to our goals and the 2007/2008 Government Letter of Expectations (GLE) and the 2007/2008 Health System Performance Framework (PF).

Indicators added as a result of this ongoing assessment of indicators are:

A7	Screening Mammography – Rate of Participation
B3	Percent of VIHA Children Entering Kindergarten "Ready to Learn"
G5	Status Indian Mortality Rate
G7	Status Indian Youth Suicide Rate
G8	Status Indian Infant Mortality Rate
G9	Status Indian Diabetes Prevalence
K9	Surgical Wait Time – Hip Fracture Repair
K10	% CABG Surgeries Waiting Longer than 6 Weeks
N6	Satisfaction – Outpatient Cancer Care

VIHA Performance Scorecard

The Performance Report includes a VIHA scorecard as well as specific scorecards for Board Committees. Committee specific scorecards show shaded in yellow the indicators the Committee is responsible for monitoring and the other indicators lightly faded. This provides each Committee with the entire VIHA Performance Scorecard but focuses on indicators of particular interest to each Committee. The allocation of the indicators to the various Board Committees as not been reviewed and confirmed by the Board for the November 2007 report.

Indicator Pages

The indicator pages summarize the analysis for each performance measure, are sorted by responsible Committee and are located behind each Committee's Performance Scorecard.

Targets

VIHA has strived to establish realistic short-term annual targets for all indicators. In setting our targets, we have looked to many references including the 2007/2008 Government Letter of Expectations, the 2007/2008 Health System Performance Framework and the 2006/2007 Performance Agreement. Some indicators VIHA monitors internally and are not exactly the same indicator as in the government agreements. This is in large part to the timing of the measures. VIHA strives to monitor performance using both leading and lagging indicators. Many of the measures in the government documents cannot be measured until well after the end of the year.

Changes in Performance

The Performance Scorecard(s) highlights the trend of individual indicators, based on actual performance relative to previous performance and to targets. The trend arrows are literal interpretations of the trend. Improving and stable trends are noted for 76% of the indicators. VIHA continues to do well in the domains of health promotion, appropriateness, safety and overall patient satisfaction. We continue to have challenges with our special populations, specific areas of access / wait times and worklife. The following areas continue to be a challenge:

Committee of the Whole

- All of the Special Population Measures

Health Quality Committee

- Immunization Rates for Children at 24 Months of Age
- Screening Mammography – Rate of Participation
- % Community Based Clients Admitted to Residential Care within 30 Days
- Occupancy rate Level 2 and 3 Perinatal Beds
- Surgical Wait Time – Cataracts
- % Cases Admitted from Emergency within 10 Hours
- % of CABG Surgeries Waiting Longer than Six Weeks
- % of Cancer Deaths Occurring outside hospital
- Selected Hospital Infection Rates
- Food Satisfaction - Residential

Governance & Human Resources Committee

- Overtime Rate
- Staff Influenza Immunization Rates – Acute and LTC
- Difficult to Fill Rate

Finance and Audit Committee

- Working Capital Ratio
- Facility Condition Index
- Equipment Depreciation Index

Performance Monitoring Descriptors

VIHA goals are guiding the ongoing re-development of the performance monitoring descriptors. The descriptors define what needs to be measured to ensure that VIHA goals are being met. We continue to develop methodologies to collect a range of appropriate metrics on all these descriptors.

Goal 1 Improved health and wellness of VIHA residents

Prevention & Protection
Prevention and protection activities focus on reducing incidence of disease, injury and disability.

Promotion
Health promotion activities are targeted to support residents of VIHA in making positive lifestyle choices, which can reduce the burden of disease and promote wellness.

Special Populations
Health promotion, prevention and protection activities for VIHA's population priorities are focused where there is a clear need and an ability to influence health.

Goal 2 Quality, client-centered care and service

Access
Reasonable access to necessary services provided within our own communities and across a continuum of care is key to the provision of client-centered care.

Wait Times
The provision of services at the most appropriate time and timely diagnosis and treatment are vital to clients and health professionals. The reduction of wait times and waitlists is a priority.

Appropriate
The utilization of services and outcomes of care are considered appropriate when services meet the needs of the community and are proven to produce health benefits.

Safety
Health care is complex and inherently involves risk. By studying error and creating a safety culture, we can improve practice, reduce errors and improve patient safety.

Satisfaction
Client and patient satisfaction with the care provided in our health system is integral to the quality of the health care experience. Measuring satisfaction highlights successes as well as concerns.

Goal 3 A sustainable, affordable public health system

Worklife
Recruiting, supporting and retaining healthy and competent staff and physicians are necessary activities to achieve our goals.

Sustainability
An affordable and sustainable health system is dependent on the effective planning and use of financial resources, the workforce, innovation, and emerging technology.

VANCOUVER ISLAND health authority

GOVERNANCE & HUMAN RESOURCES COMMITTEE
PERFORMANCE SCORECARD November 2007

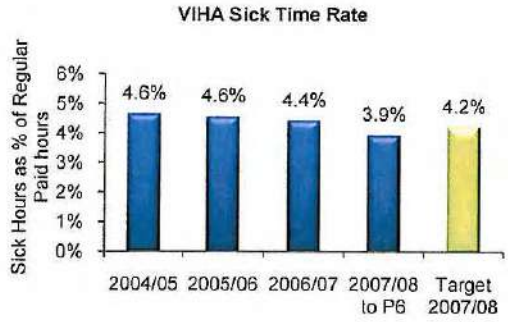
GLE	PF	CTTEE	WEB	REF	PERFORMANCE MEASURES	DATA DATE	LIGHT	TREND	TARGET	ACTUAL
GOAL 1: IMPROVED HEALTH AND WELLNESS OF VIHA RESIDENTS										
PREVENTION / PROTECTION										
	=	HQC	*	A1	Immunization Rate for Children at 24 Months of Age	March 2007	▲	⇧	76.7%	74.1%
	=	HQC	*	A2	Residential Care Influenza Immunization Rate	March 2007	■	⇧	90.0%	92.7%
=	=	HQC		A7	Screening Mammography - Rate of Participation	August 2007	▲	⇨	>55%	52%
HEALTH PROMOTION										
	=	CoW		B1	Tobacco Use Rates Ages 15 and Over	March 2007	■	⇨	18.1%	19.0%
	≈	CoW		B3	Percent of VIHA Children Entering Kindergarten "Ready to Learn"	June 2007	■	Set baseline		70.4%
	=	CoW		B6	Rate of Newly Reported HIV Infections	December 2006	■	⇧	8.3	7
SPECIAL POPULATIONS										
		CoW		G4	Status Indian Potential Years of Life Lost for External Causes	December 2005	●	⇩	<40.3	42.3
≈	≈	CoW		G5	Status Indian Mortality Rate	December 2005	●	⇩	<79.8	82.5
≈	≈	CoW		G7	Status Indian Youth Suicide Rate	December 2005	■	⇧	<6.6	5.7
≈	≈	CoW		G8	Status Indian Infant Mortality Rate	December 2005	●	⇩	<11.6	11.9
≈	≈	CoW		G9	Status Indian Diabetes Prevalence	December 2006	■	⇨	<6.5	6.6
GOAL 2: QUALITY, CLIENT-CENTERED CARE AND SERVICE										
ACCESS										
		CoW	*	J1	Health Services Self-Sufficiency	March 2007	■	⇨	95.0%	95.3%
	≈	HQC		J3	Alternate Level of Care Population Based Rate	March 2007	■	⇧	decrease	68.8
=	=	HQC		J6	Assisted Living, Supportive Living and Residential Spaces	September 2007	■	⇧	1259	1259
	=	HQC		J7	Riverview Replacement Units	October 2007	●	⇩	85	0
	=	HQC	*	J8	% of Community Based Clients Admitted to Residential Care within 30 Days	July 2007	●	⇩	58.5%	35.7%
		HQC		J9	Average Length of Stay Variance	March 2007	■	⇧	5.11	4.87
	≈	HQC		J10	Occupancy Rate Level 2 and 3 Perinatal Beds	September 2007	▲	⇧	decrease	NRGH 65% VGH 82%
=	=	HQC		J11	Mental Health Housing with Supports	September 2007	■	establish baseline		24
WAIT TIMES										
		HQC	*	K2	CT Wait Time	September 2007	■	⇧	7 weeks	5.3 weeks
		HQC	*	K3	MRI Wait Time	September 2007	■	⇧	12 weeks	10.5 weeks
=	=	HQC	*	K4	Surgical Wait Time - Total Hip Replacement	September 2007	■	⇧	<=41%	29%
=	=	HQC	*	K5	Surgical Wait Time - Total Knee Replacement	September 2007	■	⇧	<=54%	41%
=	=	HQC	*	K6	Surgical Wait Time - Cataracts	September 2007	▲	⇩	<=24%	26%
=	=	HQC		K8	% of Cases Admitted from Emergency Within 10 Hours	September 2007	▲	⇩	80%	70.9%
=	=	HQC		K9	Surgical Wait Time - Hip Fracture Repair	March 2007	■	⇨	95%	95%
=	=	HQC		K10	% of CABG Surgeries Waiting Longer than Six Weeks	September 2007	▲	⇩	17%	56%
APPROPRIATE										
	≈	HQC		L3	Ambulatory Care Sensitive Conditions Rate	March 2007	■	⇧	394	358
		HQC	*	L4	Readmission Rates	March 2007	■	⇧	<5.6%	5.2%
=	=	HQC		L6	Mental Health 30 Day Follow-up Rate	March 2007	■	⇧	80%	80.6%
	=	HQC		L8	Percent of Cancer Deaths Occurring outside Hospital	March 2007	▲	⇩	54.9%	50.1%
	=	HQC		L9	Percent of Non-cancer Natural Deaths Occurring outside Hospital	March 2007	■	⇧	50.0%	52.6%
	=	HQC		L10	Hospital Standardized Mortality Ratio	March 2007	■	⇨	<100	81.0
SAFETY										
		HQC		M1	Selected Hospital Infections Rates	September 2007	▲	⇩	5.8	12.4
		HQC		M2	In-Hospital Hip Fracture Rate	March 2007	■	⇨	1.2	1.2
		HQC	*	M3	Housekeeping Quality Audits	September 2007	■	⇨	85%	90.5%
		HQC	*	M4	Food Safety Audits	May 2007	■	⇧	80%	92%
SATISFACTION										
		HQC	*	N1	Food Satisfaction - Residential Care	September 2007	●	⇧	90%	79%
≈	≈	HQC	*	N3	Satisfaction - Emergency Services	September 2003	■	NA	85.8%	87.7%
		HQC		N6	Satisfaction - Outpatient Cancer Care	May 2006	■	NA	96.4%	97.1%
GOAL 3: A SUSTAINABLE, AFFORDABLE PUBLIC HEALTH SYSTEM										
WORKLIFE										
≈	≈	G&HR	*	U1	Sick Time Rate	September 2007	■	⇧	4.2%	3.9%
≈	≈	G&HR	*	U2	Overtime Rate	September 2007	▲	⇩	2.8%	3.0%
		G&HR	*	U3	Staff Injury Rate (time loss only)	September 2007	■	⇧	11.0	9.7
		G&HR		U4	Days Paid per Injury Claim	May 2007	■	⇧	25.0	24.1
		G&HR		U5	Long Term Disability Rate (own occupation only)	October 2007	■	⇧	2.5%	2.3%
	=	G&HR		U6A	Staff Influenza Immunization Rate - Acute Facilities	February 2007	▲	⇧	47.9%	45.3%
	=	G&HR		U6L	Staff Influenza Immunization Rate - LTC Facilities	February 2007	●	⇩	67.4%	62.4%
≈	≈	G&HR		U7	Difficult to Fill Rate	September 2007	■	⇩	1.10%	0.83%
SUSTAINABILITY										
	=	FAC	*	V3	Year End Surplus/(Deficit)	September 2007	■	⇨	$0	$0
	=	FAC		V4	Working Capital Ratio	September 2007	▲	⇩	0.8 - 1.0	.78
		FAC		V5	Facility Condition Index	August 2007	▲	⇩	0.132	.124 to .155
		FAC		V6	Return on Investments	October 2007	■	⇨	4.37%	4.46%
		FAC		V7	Equipment Depreciation Index	August 2007	■	⇧	See Indicator Page	
		FAC		V8	Revenue Generation	September 2007	■	⇨	$128M	$135M

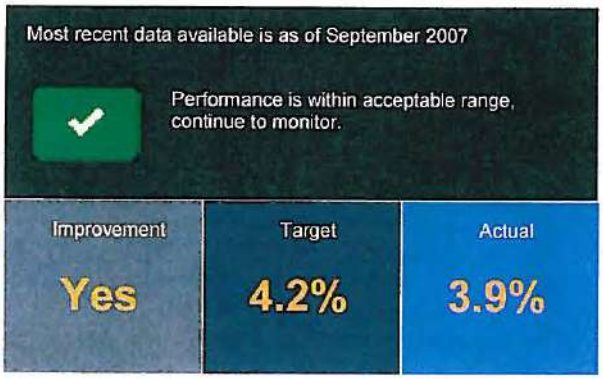
Trend	Light	GLE/Performance Framework
⇧ trend is improving	■ Green: Performance is within an acceptable range, continue to monitor	= measures exactly the same
⇨ trend is stable	▲ Yellow: Performance outside acceptable range, monitor and take action as appropriate	≈ measures vary slightly
⇩ trend is worsening	● Red: Performance significantly outside acceptable range, take action and monitor progress	

Section 4

Sick Time Rate

VANCOUVER ISLAND health authority





Data Source: VIHA Payroll Systems

WHAT IS BEING MEASURED?

The sick time rate is calculated as the number of hours paid for sick leave as a percent of total regular paid hours.

WHY IS THIS OF INTEREST?

The sick time rate is an indicator of the health and capacity of the workforce (including employee morale and engagement). It also provides an early warning indicator for potential Long Term Disability claims. Any reduction in the sick time rate infers avoidance of sick relief costs.

WHAT IS THE TARGET?

Sick time is a 2007/08 Government Letter of Expectations item. Because of the differences in data reporting times between the Ministry of Health and VIHA, the data used here is VIHA's internal measure, which is more current. The internal target for 2007/08 is 4.2% which is designed to achieve the target in the Government Letter of Expectations.

HOW ARE WE DOING?

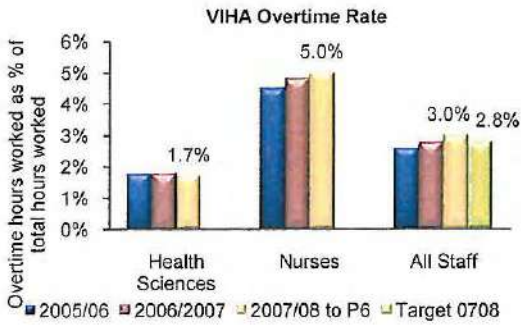
As at Period 6, the sick time rate is 3.9% which is less than the 2007/08 target. From April 2007 to September 2007 the sick time rate was 3.9%, or 9.8 days annually per employee. The year to date rate compares favourably to previous years.

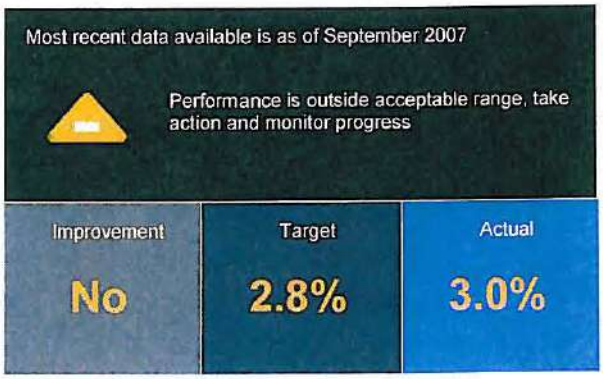
Communicable disease exposure claims are now accepted by WorkSafeBC which has resulted in a decrease to the number of hours paid for sick leave.

WHAT ACTIONS ARE WE TAKING?

- The education component of the Absence Management Program has had a complete rollout to the organization. A project team has been created to support the administration of the absence management program.
- Last year's handwashing campaign reminded staff that their hand-washing vigilance will protect them and their patients from illness.
- A health promotion brochure, "Wellness is within Reach" has been produced.
- The People Plan implementation will introduce supports that are meaningful to our staff's well-being and will improve the work environment and overall work experience. Supports may include daycare/elder care; wellness strategies, and alternative work arrangements.

Overtime Rate





Data Source: VIHA Payroll systems (extracted October 2007)

WHAT IS BEING MEASURED?

The overtime rate is calculated as the overtime hours worked as a percent of the total hours worked.

WHY IS THIS OF INTEREST?

The frequency that VIHA staff work beyond regular hours is linked to the physical and mental well-being of employees and their ability to provide high quality care.

A moderate amount of overtime is inevitable due to patient acuity, times when staff members are absent at short notice, or an unexpected increase in workload. Excessive amounts of overtime, however, can impact quality of care and contribute to staff illness, injury, poor morale and increased cost.

WHAT IS THE TARGET?

Overtime is a 2007/08 Government Letter of Expectations item. Because of the differences in data reporting times between the Ministry of Health and VIHA, the data used here is VIHA's internal measure, which is more current.

The internal target for 2007/08 is 2.8%, based on the prior year's experience and taking into account an environment where workload fluctuates (planned and unplanned), availability of casual workers is limited, and job vacancies continue to exist. This challenge is part of a national and international trend of shortages in certain specialties in health care.

HOW ARE WE DOING?

The 2007/08 overtime rate to September is 3.0% which does not meet the internal target of 2.8%.

Reasons for overtime continue to be workload (36%) (planned and unplanned), sick relief (16%) and job vacancies and turnover (10%). In addition, overcensus conditions often result in unscheduled workload increases that necessitate the use of overtime.

Overtime rates remain highest for registered nurses.

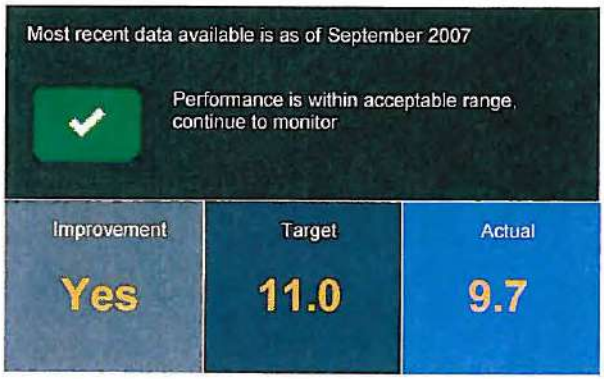
WHAT ACTIONS ARE WE TAKING?

VIHA has a variety of strategies in place and initiatives underway aimed at reducing overtime rates:

- Continuing efforts to improve patient flow should reduce the need for additional staffing at overtime rates;
- Planning for and construction of new residential care capacity;
- Developing appropriate care delivery models and staff mix strategies that will result in the most effective and efficient use of resources;
- Undertaking a project to re-engineer the staff scheduling model;
- Assigning a team to assist with responsive shift scheduling for nurses;
- Implementing the People Plan will ensure VIHA is able to attract new staff, retain existing staff, and develop and optimize our existing workforce.

Staff Injury Rate (time loss only)

VANCOUVER ISLAND health authority



Data Source: VIHA Claims Management and Payroll systems

WHAT IS BEING MEASURED?

The staff injury rate is a measure of the frequency of work related incidents that result in staff having to take time off work. The measure is calculated as the number of these incidents per 100 full time staff equivalents. The staff injury rate excludes claims for health care treatment only.

WHY IS THIS OF INTEREST?

This indicator provides information regarding the safety of the work environment such as adherence to safe work practices and availability of appropriate equipment. Injuries have an impact on employee morale, staff retention and the cost of providing service.

WHAT IS THE TARGET?

The target established by VIHA for 2007/08 is 11 incidents per 100 full time staff equivalents. This target factors in the increasing number of incidents attributed to occupational diseases, such as Noro-virus exposure which WorkSafeBC began accepting in 2006.

HOW ARE WE DOING?

The staff injury rate as at period 6 in 2007/08 is 9.7 which meets the target of 11. Communicable disease exposure accounts for 8% of time loss incidents thus far in 2007/08. 71% of timeloss incidents are musculo-skeletal in nature.

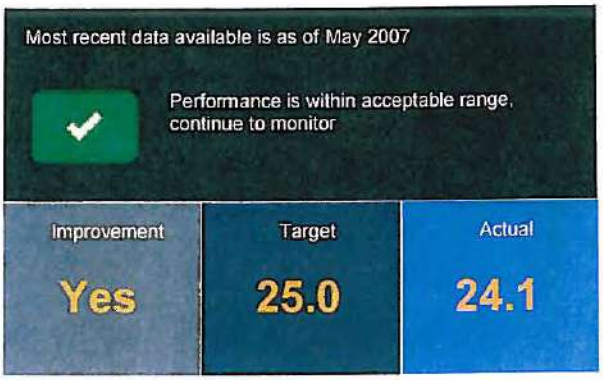
WHAT ACTIONS ARE WE TAKING?

VIHA has implemented a number of measures to reduce workplace injuries:

- Creation of a team to support targetted units with high injury rates via focused interventions by prevention and wellness staff.
- A handwashing campaign which has reduced the number of WorkSafeBC claims for communicable disease exposure from 111 last year to 44 this year.
- Enhancement of Violence Prevention Strategy and Initiatives including: regional violence prevention committee; Workplace Violence Prevention Program and Policy; violence prevention signage; social awareness initiatives; violence risk assessments and training to establish Code White teams at 10 VIHA sites.
- Increased investment in repositioning sheets and overhead ceiling lifts to reduce musculoskeletal injuries.
- Conversion to safety sharps and safety medical devices.
- Piloting a new blood and body fluid exposure control program beginning in 2008.
- Training of Joint Occupational Health and Safety committee members in accident investigation and safety monitoring.
- Increasing WorkSafeBC officer inspections at 11 sites.
- Conducting injury risk analysis in select departments and implementing controls for injury reduction.

Days Paid per Injury Claim

VANCOUVER ISLAND health authority



Data Source: WorkSafeBC (preliminary results for 2007)

WHAT IS BEING MEASURED?

The days paid per injury claim is calculated as the number of days paid by WorkSafeBC (WSBC) within the calendar year of injury, divided by the number of claims by year of injury. This is a lagging measure of severity which can only be accurately measured after the end of the calendar year.

WHY IS THIS OF INTEREST?

The severity of the incident and the efforts to return the employee to productive employment have a direct impact on the duration of a claim.

The longer the duration of a WSBC claim, the more likely that it will convert to a long term disability case making it more difficult to successfully manage.

Staff injuries which result in paid time off from work as approved by WorkSafeBC are unexpected absences, usually requiring replacement staff which impacts on overtime and on continuity of service.

WHAT IS THE TARGET?

The target is 25 days per claim which is a reduction of 5.2 days per claim from 30.2 in 2005.

HOW ARE WE DOING?

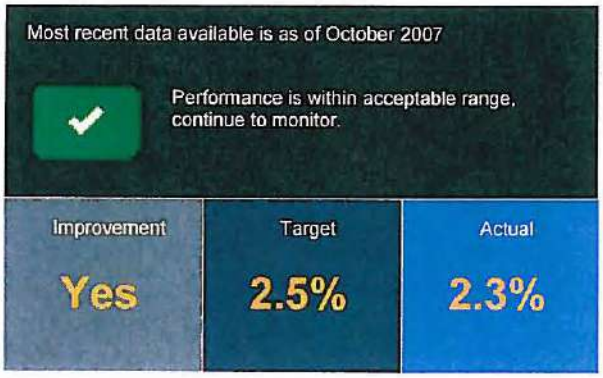
The trend continues to improve. The preliminary average for 2007 is 24.1 which meets the target. This improvement in claims duration will eventually contribute to reduced WSBC premiums and fewer conversions to long term disability.
If communicable disease claims (which are approximately 3 days in duration) are excluded, the average days paid per injury claim is higher.

WHAT ACTIONS ARE WE TAKING?

In addition to the Actions discussed in Staff Injury Rate (U3), these initiatives are being undertaken to reduce claim duration:

- Initiating joint working groups between Wellness & Safety and WSBC to improve timelines and processes for return to work planning;
- Promoting Prevention and Early Active Return-to-Work Safely (PEARS) programs to staff with musculoskeletal symptoms;
- Instituting the Peer Champion Program to improve safe patient lifting techniques used by staff. Champions are encouraged to support co-workers and provide instruction/coaching to those who require assistance;
- Producing a DVD on overhead lifts to educate front line staff;
- Focusing on transitional work opportunities and creative return to work solutions, through the Ability Management Team;
- Increasing communication to Joint Occupational Health & Safety committees about claims process and return to work (RTW) opportunities to increase awareness of services and uptake of RTW.

Long Term Disability Rate (own occupation only)



Data Source: VIHA Payroll and Wellness and Safety Systems

WHAT IS BEING MEASURED?

The Long Term Disability (LTD) rate measures the number of employees disabled from performing their own job and receiving LTD benefits, expressed as a percent of the employees with regular positions. For context only, the LTD rate for employees disabled from performing any occupation is shown.

WHY IS THIS OF INTEREST?

This measure is an indicator of the health and well-being of the workforce. As the rate increases, costs rise and staff capacity is reduced. LTD claims are a result of illness or injury and are usually not work related. VIHA can effectively influence the LTD rate where an employee can return to work in some capacity which is possible if the claim in still in the own occupation category. The any occupation rate is important because it reflects the number of conversions from disabled own occupation to the more complex any occupation category, where return to work is less likely.

WHAT IS THE TARGET?

The target for the LTD rate is 2.5% which is a 16% decrease from the September 2006 baseline.

HOW ARE WE DOING?

The rate at October 2007 is 2.3% which meets the target. This is due to VIHA's stronger organizational focus on LTD, proactive intervention strategies and partnership agreement with Healthcare Benefit Trust (HBT).

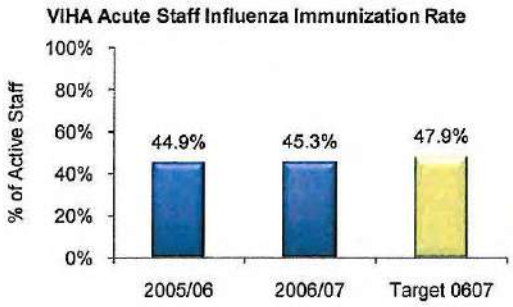
36 employees in the own occupation category returned to work between April and September. 54 staff are on rehab employment. 57% of all employees on LTD are also receiving Canada Pension Plan benefits which indicates they are unlikely to return to work at any point for any employer.

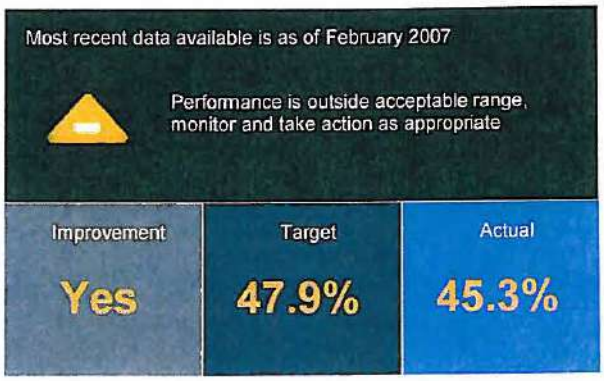
WHAT ACTIONS ARE WE TAKING?

The primary focus of managing LTD remains on the own occupation category. Management actions include:

- The Early Intervention Program pilot with HBT has been expanded to include all VIHA employees. The IHS project team identifies employees early in their absence and provides referral to EIP who offer medical case management to enable employees to return to work sooner and safer;
- The list of employees receiving LTD benefits are reviewed annually to identify people suitable for early retirement options;
- The IHS project team is reviewing all active LTD claims to identify transitional work opportunities and rehab employment;
- Workplace health and prevention efforts are focused on reducing musculoskeletal injury, one of main contributors to LTD.

Staff Influenza Immunization Rate - Acute Facilities





Data Source: British Columbia Centre for Disease Control (includes St. Joseph's)

WHAT IS BEING MEASURED?

The staff influenza immunization rate is an annual indicator that represents the number of staff immunized as a percent of the total number of staff working at acute care sites. It includes staff at "contracted" sites but excludes private facilities. Within VIHA, a record of immunization must be in Wellness & Safety's WHITE database to be included.

WHY IS THIS OF INTEREST?

Vaccination is an effective means to reduce transmission and prevent influenza infection. Immunization against influenza contributes to the health and well-being of employees and their family members and, most importantly, reduces the risk of transmission to clients and residents.

WHAT IS THE TARGET?

The 2006/07 Performance Agreement with the Ministry of Health set the target at 47.9% for acute care.

The 2007/08 Health System Performance Framework states a long term target of 60% but no timeframe has been stipulated to achieve this. For 2007/08, VIHA established an internal immunization rate target of 48.3%.

HOW ARE WE DOING?

In 2006/07 the rate was 45.3% which did not meet the target but was an improvement over the previous year. No other health authority in BC met the target for acute care in 2006/07.

The 2007/08 Flu campaign began on October 29 2007 so this year's results are not yet available.

WHAT ACTIONS ARE WE TAKING?

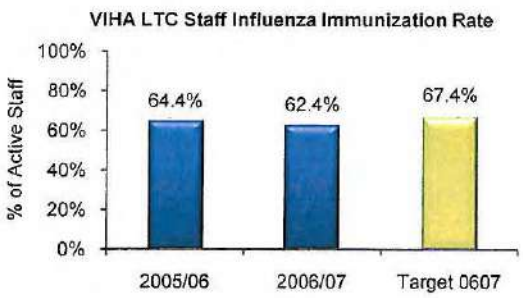
Staff can receive influenza immunizations either at a series of general clinics organized by Employee Health Nurses (EHNs) or directly from unit based nurses. The "nurse champion" program is a VIHA initiative aimed at further increasing awareness of the value and importance of staff getting their influenza immunization. In 2007/08, the number of Nurse Champions increased to 128 from 90 in 2006/07.

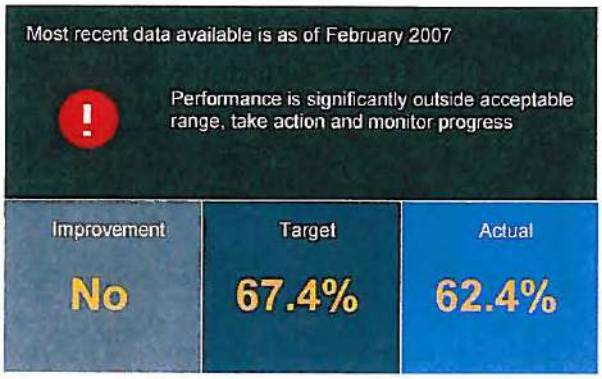
For 2007/08 VIHA has added a more comprehensive education and social marketing component to the campaign, including a "Manager's Toolkit" that outlines a variety of strategies to improve vaccine uptake.

Unit and program specific participation rates were reported to management during the campaign for the first time last year and will be enhanced this year.

Staff Influenza Immunization Rate - LTC Facilities

VANCOUVER ISLAND health authority





Data Source: British Columbia Centre for Disease Control (includes St. Joseph's and contracted residential care facilities)

WHAT IS BEING MEASURED?

The staff influenza immunization rate is an annual indicator that represents the number of staff immunized as a percent of the total number of staff working at residential care facilities. It includes staff at "contracted" sites but excludes private facilities. Within VIHA, a record of immunization must be in Wellness & Safety's WHITE database to be included.

WHY IS THIS OF INTEREST?

Vaccination is an effective means to reduce transmission and prevent influenza infection. Immunization against influenza contributes to the health and well-being of employees and their family members and, most importantly, reduces the risk of transmission to clients and residents.

WHAT IS THE TARGET?

The 2006/07 Performance Agreement with the Ministry of Health set the target at 67.4% of long term care staff.

The 2007/08 Health System Performance Framework states a long term target of 80% but no timeframe has been stipulated to achieve this. For 2007/08, VIHA established an internal immunization rate target of 65.4%.

HOW ARE WE DOING?

In 2006/07 the rate was 62.4% which did not meet the target. Only one health authority in BC met the target for long term care in 2006/07.

The 2007/08 Flu campaign began on October 29 2007 so this year's results are not yet available.

WHAT ACTIONS ARE WE TAKING?

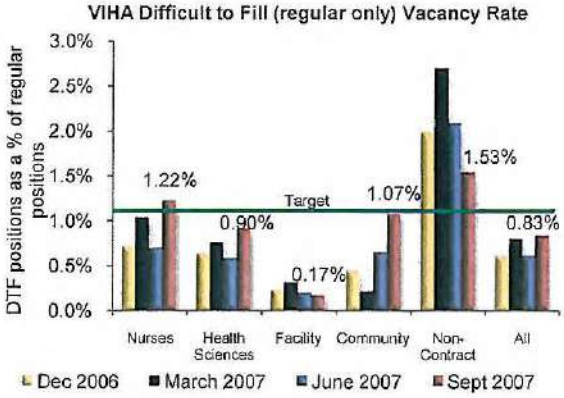
Staff can receive influenza immunizations either at a series of general clinics organized by Employee Health Nurses (EHNs) or directly from unit based nurses. The "nurse champion" program is a VIHA initiative aimed at further increasing awareness of the value and importance of staff getting their influenza immunization. In 2007/08, the number of Nurse Champions increased to 128 from 90 in 2006/07.

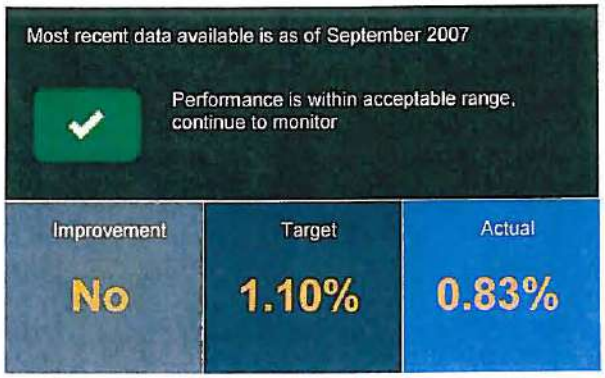
For 2007/08 VIHA has added a more comprehensive education and social marketing component to the campaign, including a "Manager's Toolkit" that outlines a variety of strategies to improve vaccine uptake.

Unit and program specific participation rates were reported to management during the campaign for the first time last year and will be enhanced this year.

Difficult to Fill Rate

VANCOUVER ISLAND health authority





Data Source: VIHA Employment Services and Payroll Systems

WHAT IS BEING MEASURED?

The difficult to fill (DTF) rate is the number of regular positions measured at the end of each quarter that remain unfilled for three or more consecutive months as a percent of total regular positions.

Previous reporting included temporary DTF vacancies and expressed the rate in full time equivalent staff. Historical values have also been restated to more closely align with the measure on the Government Letter of Expectations.

WHY IS THIS OF INTEREST?

VIHA's ability to meet the needs of our clients depends on availability of human resources. Positions that remain unfilled for an extended period of time cause additional staffing challenges such as increased use of overtime or working with less than the full complement of staff. This impacts on service delivery, morale and budget.

WHAT IS THE TARGET?

In the current labour market, there will continue to be difficult to fill positions. In many cases, DTF vacancies are not unique to VIHA as similar situations exist across Canada and internationally. In addition, there are some positions that will be difficult to fill due to reasons other than short supply, such as competition with the private sector; cost of accommodation on Vancouver Island; and professional regulatory requirements that are unique to each province. Given this environment, VIHA is striving to keep the DTF rate under 1.1%.

The long term target in the 2007/08 Government Letter of Expectations is 2% or less for Nurses and for Allied Health Professionals.

HOW ARE WE DOING?

The DTF rate is 0.83% as of September 30 2007 which meets the target. In total there were 89 DTF positions: 60% of these are regular full time positions; 53% are in Victoria; and 52% are newly created positions in VIHA.

The DTF rate is largely attributable to vacancies in nursing specialties, some paramedical positions such as pharmacy, and a growing number of non-contract vacancies.

WHAT ACTIONS ARE WE TAKING?

The following actions are underway:

- Continuation of the New Grad Transition Program (NGTP) which in 2007 resulted in the hiring of 212 new nursing graduates (87% of the 2007 Vancouver Island classes). Of the 2006 new grads hired, 98% were still working for VIHA after one year and of the 2005 new grads hired, 93% were still working for VIHA after two years.
- Ongoing recruitment initiatives, including journal and web advertising and attendance at Canadian job fairs; as well as targeted recruitment strategies.
- Continuing undergraduate nursing program.
- Partnering with Vancouver Island post-secondary institutions to target specific labor market needs.
- Ongoing nursing specialty training program offerings.
- Converting temporary positions to regular positions where appropriate.

Provincial Health Services Authority

Recommendation: Ensure that the health of the work environment is included in the performance appraisal of all senior and front line managers.
Implementation Status: *Fully*

In 2006 the PHSA included as a necessary competency of all non-contract leaders a requirement to demonstrate commitment to improving *wellness* and *quality and safety* in the workplace. Managers are reviewed annually against these competencies:

1. ***Wellness in the Workplace:*** Improving wellness in the workplace by supporting initiatives for employees that will enhance their working environment. Measures to determine the impact of sickness and absenteeism on their agency/portfolio are undertaken and have demonstrated actions that have been taken to improve overall wellness.

2. ***Quality & Safety:*** Demonstrates commitment to improving the quality of safety for the patients using the services. Regularly reports to the Quality and Access Committee of the Board and demonstrates corrective action to address issues.

Recommendation: *Put in place appropriate mechanisms to gather data on employee health indicators and work environment conditions. The health authorities should then incorporate the information into their human resource plans.*
Implementation Status: *Fully*

HR Metrics & Reporting
Commencing January 2007, the Human Resources Technology Solutions department began producing monthly metrics in the following areas: WCB Lost Time Accidents, WCB Day Paid for Active Claims, STIIP and Long Term Disability, Overtime and the Employee Family Assistance Program. Turnover statistics are produced on a monthly basis and analyzed based on reasons for termination and monthly grievance statistics are also produced and reviewed across PHSA agencies. Bi-weekly and monthly reports of employee short term sick leave are forwarded directly to the responsible manager. Similar data is produced on a quarterly basis for the Executive Leadership Council, semi-annual and annual Board reports.

Employee Surveys
Three key surveys were conducted in 2007: Patient Safety Culture Survey (see below), Employee Health Survey (see below) and the Employee Engagement Survey.

3. *Employee Health Survey* – In collaboration with Healthcare Benefit Trust (HBT), PHSA developed and launched an Employee Health Survey across PHSA agencies in June 2007.

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The survey was designed to collect valuable information on the physical and mental health needs of PHSA employees and to provide baseline data to help shape future employee health promotion initiatives, including the PHSA mental health and addiction strategy.

4. ***The Patient Safety Culture Survey*** - Intended to measure ten dimensions of culture pertaining to patient safety and four overall patient safety outcomes. A Patient Safety Culture represents "the way we do things around here" with respect to providing optimal patient care without harm. Safety culture surveys are used to measure organizational attitudes, behaviors, processes and decisions that can lead to patient harm in healthcare organization. Ten Dimensions of Culture:

    1. Supervisor/manager expectations & actions promoting patient safety
    2. Organizational learning – continuous improvement for patient safety
    3. Teamwork within units
    4. Communication openness
    5. Feedback & communications about error
    6. Non-punitive response to error
    7. Staffing
    8. Hospital management support for patient safety
    9. Teamwork across hospital units
    10. Hospital handoffs & transitions

The Survey on Patient Safety Culture was conducted under the direction of PHSA's Board to ensure that all PHSA agencies involved in purchasing, providing, studying, or regulating health care services are working together and toward a common goal of improving quality care.

Recommendation: Review the extent of managers' control and ensure that it is not beyond a limit to be effective.
Implementation Status: *Fully*

Span of Control
A review of the current span of control of the existing front line nursing leaders was conducted following bargaining in 2006. As a result, PHSA was allocated funding to introduce an additional 14 front-line operational, educational and clinical leadership positions across our agencies.

The span of control of front line leaders varies across the organizations but is currently approximately 35:1 at Children's and higher at BC Women's (50:1) and the BC Cancer Agency (60:1). While these spans of control might be reasonable in other settings and with experienced staff, the numbers of novice nurses and other clinicians, the complexity of the practice environments associated with academic teaching facilities, and the complexity of treatment processes and high intensity/acuity levels of patients – all serve to reduce the ability of the leader to manage these spans of control. These 14 front-line leadership roles are foundational to the creation and retention of a professional nursing workforce and to the delivery of safe, reliable health care services. The PHSA will monitor the impact of these roles on several process and outcome variables:

> Turnover; satisfaction of nurses with leadership support; overtime; numbers of outstanding performance reviews; numbers of Professional Responsibility Forms and Incident reports related to staffing levels and lack of leadership support; feedback from the nursing leadership group with regard to job satisfaction and workload; and ability to recruit and retain nurses in leadership positions.

imPROVE
After months of work by executive and leaders from across PHSA and all of its agencies, we commenced rollout (fall 2007) of **imPROVE** – PHSA's program to focus on patients and empower staff.

Just as it is front-line staff and physicians who see and experience the problems and inefficiencies within the system, it is these same individuals who hold the solutions. Empowering people within the system today with the time, skills, knowledge and support to examine and redesign their own work will create a high-quality and sustainable system for tomorrow. This is what **imPROVE** is about.

Over the last few months, executives and leaders from across PHSA and its agencies have investigated how we can adapt the principles of lean thinking to foster a culture of innovation and sustainability throughout our organization.

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We have decided to pursue this approach in order to:

- Improve patient safety and quality and, ultimately, outcomes and patient satisfaction.
- Empower staff, including physicians, to redesign their work environment, enabling them to better deal with continually increasing demands and HR shortages.
- Create more effective and efficient processes so as to build a sustainable system of care.
- Develop a culture of continuous improvement that aligns all of our agencies and services and is a means to achieving our vision of *'Province-wide solutions. Better health.'*

Within the name **imPROVE** is an acronym which represents PHSA's values:

P - Patients first
R - Results matter
O - Open to possibilities
V – Best Value
E – 'Excelling' through knowledge

Our goal in implementing imPROVE is to make a fundamental shift towards being more effective, efficient and quality focused in everything we do. This degree of transformational change requires unwavering commitment and leadership as well as new types of training, support and relationships.

Across PHSA, we recognize that engaging our people – creating an environment where you can do your best every day, you can voice your ideas, you feel respected and you know the work you do makes a difference – is fundamental for creating a healthy and productive work environment. While imPROVE will enable engagement by putting problem solving into the hands of those who do the work, other initiatives to strengthen engagement overall will also help us build the type of organization we're striving to be – one where engagement matters.

Recommendation: Assess the work environment for risks to staffs' mental health and develop an action plan to mitigate the risks.
Implementation Status: *Fully*

Leadership Charter
On October 12, 2006 the Chief Executive Officers of all Health Authorities signed a Healthy Workplace Leadership Charter intended to support the continuous improvement of a healthy workplace and employee health and well being. The charter was founded on the principle that optimal health, safety and wellness are closely linked to delivering high quality and patient centered care. The five guiding principle are: Leadership Commitment and Active Involvement, People Focused, Comprehensive Approach, Accountability and Stewardship. PHSA electronically communicated this charter to all employees in January 2007, and we continue to

promote the charter at all Employee Wellness and Safety educational workshops, road shows and on our portal.

Workplace Wellness and Active Living Program
In April of 2005, the PHSA Executive approved the creation of a Prevention Promotion and Protection (PPP) Workplace Wellness and Active Living project to address the physical and mental health of PHSA employees, demonstrate healthy behaviors to the public and patients, and to profile PHSA as a leader in influencing population health. This project was aligned with the Auditor General for BC's recommendation that all the Health Authorities develop and implement employee wellness programs. In the fall of 2006, *Life Works Health Systems* was contracted to complete a needs assessment, inventory of existing wellness programs, facilities & capabilities of the PHSA agencies, and also to recommend a workplace wellness pilot program for PHSA. Currently, this program consists of initiatives like onsite fitness classes, onsite shiatsu massage, health fairs, a Health Promotion Resource Centre on the PHSA portal, Health Promotion Bulletin Board, pedometer challenges, etc, and was presented to the Healthcare Benefit Trust and other Health Authorities at a conference in 2007.

The Health Promotion Resource Centre on the portal includes a calendar of events, information about on-site fitness programs, important links (to gym and recreation centres, disease and nutritional information, men, women and children's health) healthy living information and monthly recipes and tips.

Project Goals:
- To maintain and improve the physical and mental health of PHSA employees
- To reduce the cost of absenteeism, staff turnover and contain the costs of benefit programs
- For physically and mentally resilient employees to be attracted to and retained by our organization
- For our employees to demonstrate healthy behaviors to the public and our patients
- For PHSA to show its leadership by positively influencing population health starting with its own Employees

Workplace Mental Health Working Group
The PHSA has taken a leadership role in implementing activities associated with Depression in the Workplace. Activities included in our Mental Health and Addictions plan are: an Employee Health Survey, the development of the Anti-Depressant Skills at Work manual (disseminated both internally and externally to the business community), and an on-line depression screening tool FeelingBetterNow© launched in collaboration with Healthcare Benefit Trust. We commenced the development of a manager/leader training tool to address depression in the workplace entitled *Mental Illness First Aid (MIFA): Responding with Respect.* This training has been jointly created with the Canadian Mental Health Association and facilitated sessions will begin mid 2008. These initiatives have been shared with all Health Authorities through the Occupational Health and Safety Directors' meetings.

- ***Employee Health Survey*** – In collaboration with Healthcare Benefit Trust (HBT), PHSA developed and launched an Employee Health Survey across PHSA

agencies in June 2007. The survey was designed to collect valuable information on the physical and mental health needs of PHSA employees and to provide baseline data to help shape future employee health promotion initiatives, including the PHSA mental health and addiction strategy.

- ***FeelingBetterNow.com (Mensante)*** – PHSA partnered with Healthcare Benefit Trust to launch FeelingBetterNow®, an interactive, confidential, web-based self assessment tool that helps employees determine if they are at high risk for a number of common mental health disorders. This mental health tool is available to PHSA employees on a pilot basis until April 30, 2008.

- ***Anti-Depressant Skills Workbook: Dealing with Mood Problems in the Workplace*** – This workbook was developed by BCMHAS, in partnership with the Centre for Applied Mental Health and Addiction Research (CARMHA) at SFU. It is a self-care manual intended for staff who may be experiencing depression or low mood. Employees can use the workbook to identify whether they are experiencing depression or depressed mood, and apply practical strategies to reduce the effects on work satisfaction and performance.

Recommendation: Asses the work environment for risks of violence to staff safety and security and develop an action plan to mitigate the risk
Implementation Status: *Substantially*

We recognize there is a risk to our staff's safety and security from violence in the workplace which includes but is not limited to: violence from patients, visitors, and other staff – and we acknowledge that this varies widely across our agencies. We have formed a PHSA Violence Prevention Committee which is developing an action plan for this year to include:

- approved policy and program
- identify history of risk assessments at all PHSA sites in order to prioritize needs
- prioritize risk assessments to be conducted and recommend to JOHS committees for implementation
- review and evaluate risk assessments, controls implemented, current controls, develop training and education plan recommendations, including determining what is 'effective and appropriate' training based on evidence based best practice.

Recommendation: Implement a human resource information system that will provide data needed for developing a comprehensive picture of employee and workplace health
Implementation Status: *Substantially*

WHITE

PHSA is planning to implement WHITE (Workplace Health Incident Tracking and Evaluation System) as the management information system to support Employee Wellness and Safety functions through the PHSA. Some of the functions of WHITE include, but are not limited to: incident reporting, incident investigation, WCB claims, check points for steps in managing WCB and incident reports, and management decision making and prevention.

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In January 2007 we hired a Project Manager for WHITE who has been collaborating extensively with the Occupational Health and Safety Agency for Healthcare and our internal IMIT resources. To date, business requirements for this project have been identified and systems interfaces, configurations, test plans and scripts are underway. Communication to the Agencies and Joint Occupational Health and Safety committees regarding the new Incident form has been completed. Extensive training has taken place with the Users of the new system and we anticipate implementation no later than June 2008.

Recommendation: Determine in conjunction with the Ministry of Health, what indicators of employee and workplace health should be reported publicly on a regular basis.
Implementation Status: *Fully*

In February, PHSA completed our 2007/08 Influenza Immunization Report for the BC Centre for Disease Control (BCCDC) and the Ministry of Health. The BCCDC publicly reports results on all Health Authorities.

The PHSA Attendance Promotion Program includes a requirement to reduce sick time by 10% for December 31, 2008.

In addition, monthly statistics are produced and analyzed by Employee Wellness and Safety to report, monitor and reduce WCB, short term and LTD claims. These statistics are reported to individual agency management, Human Resources and the Executive Leaders Committee.

Additional initiatives supporting the priorities identified by the Auditor: Providing Leadership, Promoting a Healthy Work Environment, Monitoring & Reporting, etc.

Employee Recognition
An Employee Recognition Toolkit was created for managers and posted on the PHSA portal in the fall of 2007. Employee recognition is an effective and important way of showing appreciation to employees who contribute by sharing knowledge, thoughtfulness, consideration, teamwork and helpfulness. By acknowledging the every day contributions of employees we hope to build a culture of appreciation, foster individual pride in the workplace and reinforce the PHSA Workforce Strategy. We believe that formal and informal recognition programs and events are fundamental to retaining employees and reducing turnover.

imPROVE Employee Wellness and Safety Workforce Strategy
The key initiatives listed below have been incorporated into the 2007/2008 imPROVE Employee Wellness and Safety's (Health Promotion and Injury Prevention) workforce strategy.

- Implement an Early Intervention program across all bargaining units
- 10% sick time reduction by 2008
- Lost time incidents reduction by 10%

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- Reduce Long Term Disability claims by 10%
- In collaboration with OHSAH, implement White Database in early 2008
- Promote and expand upon the Workplace Wellness & Active Living Initiative
- BBF/Exposure Control Plan (safety engineered needle conversion, safety sharps)
- Influenza Immunization Campaign – meet MOH target of 60%
- PHSA Workplace Mental Health and Addiction Strategy (implementation of Mental Health Plan)

These initiatives all contribute to our objective of maintaining and improving employees' capacity to serve their patients and clients, to provide a physically and mentally safe work environment and to promote employee health and a healthy workplace. Our strategy in Employee Wellness and Safety is to develop and implement policies and procedures to prevent and reduce employee illness and injury at the workplace, to promote and support employee physical and mental wellness and to tightly control, monitor and reduce LTD, WCB and sick time rates.

Engagement Matters!
In addition to the Patient Safety Culture Survey completed in early 2007 and the Employee Health Survey (as above), PHSA conducted an Employee Engagement Survey (contracted through Gallup) in the fall of 2007. Results have recently been received by all Managers and action planning activities will take place early 2008.

The objectives for our engagement initiative are to cultivate an environment where staff thrive and perform to their best every day, establish a baseline for engagement and implement actions to improve engagement levels. As our organization responds to increasing demands and evolving expectations, investments must be made in creating and maintaining a healthy and productive work environment.

Leaders have received results for their work areas along with training on how to properly analyze the data. This information is on the portal "Action Planning: Leader's Facilitation Guide and Tools" and workshops are also being offered. Leaders have been asked to begin facilitating workgroups in the development of action plans, based on their results. The action planning phase of Engagement Matters is vital because it allows teams to openly discuss opportunities to create a more positive working environment, and identify activities that teams can work on together to make changes that will improve engagement. The PHSA will resurvey in approximately 18 months.

In order to address the morale issue, we believe that now, more than ever, working together as a cohesive team is critical to meeting the challenges and delivering safe, effective care. That's why Employee and Organizational Development (a division of Human Resources) is launching a new series of courses that will enhance individual and team effectiveness. In addition to helping employees address day-to-day challenges, these workshops will provide skills that can help both clinical and non-clinical employees support strategic initiatives like imPROVE and employee engagement. These workshops can be taken individually, or if one successfully completes the foundation workshop and three of the five electives, he or she will receive a certificate of completion for the series. A separate series of manager's only courses is currently being developed. Current course offerings on teamwork and collaboration include:

- *Foundations of Teamwork and Collaboration* - This course presents the basics on how to work well together, reduce wasted time, lessen conflict, and influence interactions in a positive way.
- *Electives Adapting to Change* - This course develops the confidence and skills needed to face change and welcome it as an opportunity to grow and learn. Building Trust In this workshop you will learn about your role in building or limiting trust, and examine hands-on, proven techniques to build trust within your sphere of influence.
- *Communicating with Others* - This interactive skill practice course will help you understand the impact of effective interaction skills and teach you to recognize and overcome communication barriers and interact effectively with others.
- *Personal Empowerment* - This workshop seeks to change the mind-set that empowerment is something that is given. It helps employees see that they can and should look for improvement opportunities
- *Handling Conflict* - This workshop discusses how to manage conflict by dealing with differing ideas, interests or perceptions and provides hands-on tools that you can use everyday.

Section 5

Update on the implementation of recommendations from:

Infection Control: Essential for a Healthy British Columbia

March 2007

October 2008

May 1, 2008 719290

Mr. Morris Sydor
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Mr. Sydor:

Please find enclosed the joint response of the Ministry of Health (the Ministry) and health authorities to your request for follow-up information on the implementation status of recommendations in your report, ***Infection Control: Essential for a Healthy British Columbia***.

I am pleased to report that the Ministry and health authorities have made significant progress with respect to this remarkably complex and persistent challenge faced by health care systems around the world. Infection control is a priority at the Ministry, and we remain committed to ensuring government, health providers and citizens continue to work together to improve the safety and quality of care for all British Columbians.

In closing, I would like thank you and members of the Select Standing Committee on Public Accounts for your continued interest in this issue. Should there be a need for a further appearance or presentation to the Committee on this matter, we will ensure that health authority representatives are also available as a resource.

Sincerely,

Original signed by

Gordon Macatee
Deputy Minister

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

Introduction

The Ministry of Health wishes to acknowledge and thank the Office of the Auditor General and members of the Select Standing Committee on Public Accounts for their continued interest in this important issue. The Ministry would also like to once again recognize the efforts of so many dedicated professionals within British Columbia's health care system, who work tirelessly every day to provide, support and enable best practices in infection control around the province.

Given the relatively short period of time that has passed since release of the Auditor General's final report in March 2007, and the complexity of issues with which it deals, the Ministry and health authorities are confident that significant progress has been made in addressing the report's recommendations. Overall, the Ministry has endeavoured to clarify its role as steward of the health system and create a more comprehensive, consistent and effective provincial approach to infection control. Likewise, health authorities are making extensive improvements to the way they deliver services to ensure patients receive safe and effective care throughout British Columbia.

Infection control is a highly complex and ever-evolving issue that will require the ongoing dedication and persistence of government, health care providers and patients alike. Nevertheless, we are confident that significant improvements have been made and we are committed to continue working together to sustain and advance these improvements.

What follows is a brief overview of the Ministry and health authorities' progress in implementing the Auditor General's recommendations to March 2008. Also attached are submissions from each health authority using the templates provided by your office.

Progress on Recommendations to the Ministry of Health as at March 2008

Over the past year the Ministry of Health has made substantial progress in addressing the Auditor General's recommendations that the Ministry:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**

- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

With respect to the first of these recommendations, the Ministry approaches hospital acquired-infections through the wider lens of patient safety as a potentially preventable adverse effect of the health system. Reflective of the Ministry's commitment to patient safety in general and infection control in particular, an Assistant Deputy Minister of Patient Safety portfolio was created at the Ministry in March 2007, and a program area dedicated specifically to provincial infection control initiatives is presently being created.

Based on stakeholder consultations, as well as a review of international literature, a comprehensive framework was developed to guide the Ministry's provincial approach to patient safety – including infection control. Infection control initiatives as they relate to the core elements of this framework are briefly described below.

a) System-wide leadership and coordination

Aside from the organizational changes within the Ministry, two additional external organizations are intended to provide system-wide leadership and coordination in matters of infection control. The Provincial Infection Control Network (the Network) remains a pivotal organization in this respect. The Network continues to serve as a truly province-wide community of practice, providing a collaborative framework for advancing standards in surveillance, prevention and control of hospital acquired infections throughout British Columbia.

In addition, the 2008 Speech from the Throne gave notice of the Ministry's intention to create a permanent BC Patient Safety Council to provide advice to the Ministry of Health on priority issues in patient safety and to build capacity to address these in a provincially consistent and coordinated manner. Infection control will undoubtedly be among the issues addressed by the Council.

b) Policy, legislation and regulation

With respect to the policy, legislative and regulatory environment for infection control, the Ministry has adopted a non-legislative approach which employs a variety of other instruments, including policy directives, targeted funding, external accreditation mechanisms, and the Ministry's accountability framework with health authorities. Examples here include:

- The Ministry's 2007 policy communiqué on reprocessing of medical equipment and devices (which is likely to become the benchmark for the rest of the country);
- External, high level accreditation reviews conducted by the Canadian Council on Health Services Accreditation which include mandatory performance requirements around patient safety – such as reporting of antibiotic resistant organisms and surgical site infections;
- The Ministry's accountability framework for the health authorities requires (among others):

- Adoption of the Provincial Infection Control Network's surveillance protocol for *C.Difficile* (adoption of other surveillance protocols will be required as these are developed);
- Implementation of a surveillance program for hospital acquired infections approved by the Ministry of Health;
- Continued participation in provincial patient safety initiatives such *Safer Healthcare Now!*, which includes a number of evidence-based interventions for the prevention of surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and guidelines for the prevention of antibiotic resistant organisms; and,
- Communication strategies to promote and improve patient safety, such as regular reporting on safety and quality issues to health authority Board and Executive.

It should also be noted here that the Ministry is participating in an inter-provincial working group on infection control established by the Deputy Ministers of Health from the four Western provinces and Ontario. The working group is exploring opportunities for collaboration on development of common infection control standards and guidelines, common approaches to surveillance and reporting, and mechanisms for ensuring compliance.

c) Measurement, monitoring and evaluation

As per the Auditor General's second recommendation, the Ministry has provided funding to pilot test a Surveillance of Hospital-Acquired Infections Program for British Columbia (SHAIP-BC) in two health authorities. SHAIP-BC will ensure that standardized surveillance methodologies and definitions for hospital acquired infections are used in every health authority. The program will initially begin with surveillance of surgical site infections, and will later be applied more broadly to other types of infections as standardized surveillance methodologies and definitions are developed for these (PICNet presently has a number of working groups established for this purpose). Pending success of the pilot tests, provincial rollout of SHAIP-BC may begin in late 2008 or early 2009.

Additionally, the Ministry provided additional funding to health authorities to support province-wide rollout the BC Patient Safety Learning System (BC PSLS). BC PSLS is a web-based reporting system which will vastly improve the way we monitor adverse events, hazards and near misses of all kinds throughout the health care system, and will allow for dissemination of information about safety concerns on a province-wide basis. British Columbia will be the first jurisdiction in Canada to monitor adverse events in this province-wide manner.

Both of these surveillance mechanisms will allow the health care system to better understand and evaluate its shortcomings and to respond with effective and evidence-based improvement strategies.

d) Education and Professional Development

The Ministry, primarily through the Provincial Infection Control Network and sponsorship of *Safer Healthcare Now!*, continues to support opportunities to ensure that the distinct body of knowledge and skills associated with patient safety and quality improvement inform education, training, and/or professional development programs for health-care professionals. The Provincial Infection Control Network has completed a "Framework for Staffing and Core Competencies Training Designed for Infection Control Programs," and offers a variety of educational initiatives for infection control practitioners, including:

- Developing a healthcare associated infections surveillance training manual and on-line infection control modules about the prevention of surgical site infections and prevention of central venous catheter infections;
- Providing education and professional support through its educational conferences;
- Sponsoring selected working group members to attend educational conferences; and,
- Sponsoring Webber Training Courses (facilitated tele-classes relating to infection control and prevention) and other lecture series.

The *Safer Healthcare Now!* Western Node Collaborative brings together health professionals from across Western Canada to learn collaboratively about a number of interventions for patient safety and quality improvement, including prevention of surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and antibiotic resistant organisms

e) Information and communication strategies

An important component of the provincial framework for patient safety is ensuring access to accurate and understandable information, which will help the public and all other stakeholders first understand the system and then participate in improving it. A primary example of this is the "Do Bugs Need Drugs" campaign which aims at educating patients about the appropriate use of antibiotics.

Another important development in this area is the announcement of the Ministry's intention to create Patient Care Quality Review Boards in every health authority in order to deal with patient concerns about safety and quality of care in a more timely and effective manner. Where patients do not feel they have received safe, effective, high quality care, and cannot attain resolution of their concern through existing client relations mechanisms within health authorities, they will have the option of taking their concerns to a Patient Care Quality Review Board for further investigation. The Review Boards will ensure that patient feedback about the safety and quality of care provided in health facilities is incorporated in improvement strategies.

Patient safety literature also recommends that leadership at the highest levels is engaged in safety and quality improvement. As noted earlier, through its accountability framework with health authorities the Ministry has reinforced the need to ensure health authority Boards and Senior Executive are fully informed on the safety and quality of

care delivered under their leadership. This approach mirrors the Auditor General's recommendation that proper reporting is used to hold Medical Advisory Committees to account with respect to infection control.

Progress on Recommendations to Health Authorities as at March 2008
Health authorities have also made significant progress with respect to implementing the eighteen recommendations in the report directed to their performance.

Figure 1. Health Authority Implementation Status Response Summary

HA	Fully		Substantially		Partially		Alternate action		Total
FHA	6	33%	10	56%	1	6%	1	6%	18
IHA	7	39%	6	33%	5	28%			18
NHA	4	22%	9	50%	4	22%	1	6%	18
PHSA	4	22%	7	39%	6	33%	1	6%	18
VCHA	4	22%	10	56%	4	22%			18
PHC*	7	39%	11	61%					18
VIHA	3	17%	9	50%	4	22%	2	11%	18
Overall	35	28%	62	49%	24	19%	5	4%	126

* Providence Health Care

Figure 1 provides a summary of the overall implementation status of recommendations by health authority. The summary indicates:

- Seventy-seven percent of the recommendations have been either "Fully" or "Substantially" implemented;
- Nineteen percent have been "Partially" implemented;
- In four percent of cases an "Alternative Action" was taken to address a recommendation; and,
- In no instance did a health authority indicate a response of "No Action" to any of the recommendations.

With respect to the nineteen percent of recommendations "Partially" implemented, eleven of twenty-four instances are in reference to eight recommendations around the implementation of best practices; six are in reference to three recommendations for implementation of an information management system and resources for data quality support; and, seven occur with reference to the five recommendations for reporting practices within health authorities. In only one instance is the "Partially" implemented response concentrated on one recommendation ("provide information management support to the infection control program for data collection, analysis and reporting").

In general, the Ministry is satisfied that health authorities are taking appropriate actions to improve and are committed to making progress in each case identified as "Partially" implemented. Upon closer examination of the explanatory information provided the information management recommendation described above, the Ministry is confident that all health authorities have taken steps to address the recommendation appropriately and

are committed to ensuring information management requirements for infection control are adequately resourced based on jurisdictional needs. The Ministry will endeavour to monitor ongoing progress in each of these areas.

Of the responses which indicate an "Alternative Action" was taken, three instances refer to the recommendation to "work with the Ministry of Health and BC Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care." The other two instances refer to recommendations to ensure adequate resources to support information management and to ensure health authority Boards hold Medical Advisory Committees to account for their mandate. Again, similar to the "Partially" implemented responses, the Ministry is confident that the alternative actions taken either satisfy the spirit of the Auditor General's recommendations, or are appropriate in light organizational context, and further, that the health authority is committed to making progress in the area.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
A provincial framework for infection prevention, surveillance and control is limited to public health						
We recommend that the Ministry of Health: ▪ Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.			X			
• Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.			X			
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities						
We recommend that each health authority: • Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	FHA		X			
	IHA		X			
	NHA		X			
	PHSA	X				
	VCHA		X			
	PHC	X				
	VIHA	X				
• Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	FHA		X			
	IHA	X				
	NHA		X			
	PHSA	X				
	VCHA		X			
	PHC	X				
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Subs-stantially	Partially	Altern. Action	No Action
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened						
We recommend that each Health Authority: • Work with the Ministry of Health and the BC Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	FHA				X	
	IHA			X		
	NHA	X				
	PHSA				X	
	VCHA		X			
	PHC		X			
	VIHA				X	
• Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program	FHA		X			
	IHA	X				
	NHA		X			
	PHSA			X		
	VCHA			X		
	PHC		X			
	VIHA		X			
• Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	FHA		X			
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA		X			
	PHC	X				
	VIHA		X			
• Ensure that renovations and new construction designs mitigate the risks of spreading infections.	FHA	X				
	IHA	X				
	NHA			X		
	PHSA		X			
	VCHA	X				
	PHC	X				
	VIHA		X			
• Ensure that all staff receives regular ongoing education in the area of infection control and that medical staff also have access.	FHA		X			
	IHA	X				
	NHA			X		
	PHSA			X		
	VCHA		X			
	PHC	X				
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
• Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education	FHA		X			
	IHA	X				
	NHA	X				
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA	X				
• Establish a formal surveillance program appropriate to the programs and services offered.	FHA		X			
	IHA		X			
	NHA		X			
	PHSA		X			
	VCHA		X			
	PHC		X			
	VIHA			X		
• Establish a process for regular formal and informal monitoring of practice.	FHA	X				
	IHA		X			
	NHA		X			
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA			X		
An integrated information system for infection prevention, surveillance and control is in place only for Public Health						
We recommend that the Health Authorities:	FHA			X		
	IHA	X				
• Provide information management support to the infection control program for data collection, analysis and reporting.	NHA				X	
	PHSA			X		
	VCHA			X		
	PHC		X			
	VIHA			X		
• Ensure there is staff with appropriate training to support data quality.	FHA		X			
	IHA	X				
	NHA		X			
	PHSA	X				
	VCHA			X		
	PHC		X			
	VIHA		X			
• Work with the Ministry of Health and other stakeholders to ensure data quality.	FHA		X			
	IHA		X			
	NHA	X				
	PHSA	X				
	VCHA			X		
	PHC		X			
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done.						
We recommend that each Board of Directors: • Work with their senior management to determine what infection control indicators they need measured and reported on.	FHA	X				
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA	X				
	PHC					
	VIHA		X			
• Hold the Medical Advisory Committees accountable for fulfilling their mandates.	FHA	X				
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA	X				
	PHC					
	VIHA				X	
We recommend that the Health Authorities: • Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	FHA	X				
	IHA			X		
	NHA			X		
	PHSA		X			
	VCHA		X			
	PHC		X			
	VIHA			X		
• Have their senior management teams identify infection control reports and information that they need to receive on a regular basis	FHA	X				
	IHA		X			
	NHA	X				
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA		X			
• Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	FHA		X			
	IHA		X			
	NHA			X		
	PHSA		X			
	VCHA	X				
	PHC		X			
	VIHA	X				

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SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully (5)	Substantially (4)	Partially (3)	Alternative Action (2)	No Action (1)
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		√			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		√			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.				√ *	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving		√			

consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.					
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		√			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	√				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.		√			
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		√			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		√			
▪ Establish a process for regular formal and informal monitoring of practice.	√				
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			√		
▪ Ensure there is staff with appropriate training to support data quality.		√			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		√			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	√				

▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	√				
We recommend that the health authorities:					
▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	√				
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	√				
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.			√		

- Acute Care and Residential Care manuals completed and implemented across Fraser Health.

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**
- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

See IC Initiatives 15 and 16.

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

FH comment: Please note as reference for the following tables:

Fully Implemented (5)	Substantially Implemented (4)	Partially Implemented (3)	Alternative Action (2)	No Action (1)

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
Set specific goals and objectives for Infection Control as a patient safety priority for FH in both Operating Plan and Strategic Plan; include key performance measures for surveillance to be reported to Board through the Infection Control Coordinating Committee.	Spring 2007	1	5	Summer 2006 - present: Recruitment for Director positions; expect start date of May 1, 2007. Hired May 01, 2007. Completed.
	Spring 2007	2	5	May 2007: Fraser Health Board of Directors approved a Policy on patients, Clients and Resident Safety which outline FH commitment to ensuring quality care and safety in all Fraser Health programs, services and initiatives.
	ongoing	3	4	Nov 2007: CDAD, MRSA and VRE rates are being monitored on the Patient Safety Scorecard: Key Performance Indicator Report and the Board Balanced Scorecard. These reporting indicators will be tracked, trended and standardized across FH. Mar 2008: CDAD, MRSA and VRE rates continue to be monitored across Fraser Health; they are reported at local Infection Control Committees, at the Acute Care Committee and the regional Fraser Health Infection Prevention and Control Committee. They are also reported on the Board Balanced Scorecard.
	30 April 2008	4	4	Nov 2007: A FH Infection Control Strategic Plan is being developed to outline the service delivery modules for Infection Control across FH. This will include work to clarify organizational mandate, identify and understand stakeholders and their needs; develop mission and values; assess the environment to identify strengths and weaknesses, opportunities and threats. Feeding into the strategic plan will be service delivery modules for key areas of the Infection Control Program such as surveillance, outbreak management, education, accreditation, ARO management, and construction that address quality improvement and patient safety initiatives for Fraser Health. The strategic plan will identify goals, priorities, key performance indicators, barriers, timelines and resource implications to achieve the goals for Infection Control. Mar 2008: CDAD, MRSA and VRE rates continue to be monitored across Fraser Health; they are reported at local Infection Control Committees, at the Acute Care Committee and the regional Fraser Health Infection Prevention and Control Committee. They are also reported on the Board Balanced Scorecard. Infection Control is currently in the midst of developing a comprehensive, regional strategic plan that will define 5 – 6 major goals for 2008/2009. This plan is being developed collaboratively with customers, stakeholders, Medical Microbiologists, Infection Control Practitioners and the Infection Control leadership team (Administrative Director, Medical Director, and two managers). Included in the plan are the major goals and objectives for the year along with action plans and key performance indicators or measurable. The critical issues being addressed in the

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
				plan pertain to goals for education, surveillance, staff recruitment and retention, Infection Control regional service modules and increase of Infection Control profile across Fraser Health.
Align Infection Control and Public Health goals and objectives to ensure integrated approach to infection prevention, surveillance and control across service delivery areas (i.e. Acute Care, Home and Community Programs, Public Health, GPs' offices, Residential Services)	ongoing	5	4	Relationships between committees strengthened (i.e. between Fraser Health Infection Control Coordinating Committee, its regional sub-committees, local Infection Control Committees, and with HAMAC, Board, and local Medical Advisory Committees). Mar 2008: Infection Control currently sits on numerous committees and participates in many activities and aspects within Fraser Health. IC sits as a Steering Committee member on the Safer Healthcare Now Committee and the Fraser Health Reprocessing Patient Safety Project, and is an active member of the Quality Improvement and Patient Safety Committee, Pandemic Influenza Management Committee to name a few. The members of these committees are representative of the continuum of care across FH which includes Acute Care, Home Health, Health Promotion and Prevention and Community Residential programs. Infection Control, Public Health and Workplace Health (OH PH IC committee) participate collaboratively through a special committee (OH PH IC committee) to ensure these groups are meeting the safety needs of patients, clients, the public and staff. Specific alignment with Public Health occurs through the Regional Infection Prevention and Control Committee as well as on the Acute Care Committee, Residential Infection Control Committee and individual site infection control committees either as standing members or ad hoc members. Liaison and active communication between Public Health and Infection Control occurs regarding specific cases and issues as they arise in the organization such outbreak management of reportable infections including TB, mumps, GI and respiratory outbreaks as well as other unusual occurrences that may affect public safety.
	ongoing	6	4	Nov 2007: The structure of the FH Infection Control Coordinating Committee has been reviewed and renewed; now called the Fraser Health Infection Prevention and Control Committee (FHIPCC). The committee is in the process of reviewing its membership and terms of reference. This membership will include the Community portfolios across FH such as Residential care, Public Health, Quality Improvement and Patient Safety, ensuring an integrated approach to infection prevention and surveillance across all service delivery areas in Fraser Health. A FH Acute Care Committee is being formed and will report to the FHIPCC. Terms of reference and membership are being developed. All acute care sites will be represented by the Infection Control Practitioners and medical microbiologists (excluding BH – no medical microbiologist at this site). Regional programs will report to the Acute Care committees such as Medical Imaging, SPD, Laboratory and Pharmacy.

Fraser Health Authority

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
				Each of the local hospitals will also have their own Infection Prevention and Control Committees. Most committees are currently active; those not in place are currently being developed. At this level of committee structure, the sites will discuss local specific issues, discuss surveillance trends and implement regional initiatives as appropriate that have been approved at the Acute Care or regional FHIPCC committees. Mar 2008: The FH Infection Prevention and Control Committee, the Acute Care Committee and specific site Infection Control committees are now up and running and will continue to grow and develop as the needs for the organization and the committee structure evolve. The Terms of Reference for the committees have been developed and presented to the committees and will be approved at the next meeting.
	ongoing	7	4	All Infection Control stakeholders work together on initiatives to prevent and manage infections; i.e. outbreak management across the continuum (Norovirus, pandemic flu planning, emergency preparedness) – done via existing subcommittees of the Infection Control Coordinating Committee, and task groups comprised of Infection Control, Public Health, Workplace Health, Medical Microbiology, and Infectious Diseases. Nov 2007: Infection Control Practitioners are currently members on a number of committees at the local sites, across Fraser Health and provincially. These committees include Pandemic Influenza Planning, PICNet, CHICA-BC, Construction groups and numerous others groups to manage and prevent infections. Mar 2008: Key stakeholders from programs are invited to be ad hoc members of the Infection Control working groups. This includes staff from Public Health, Residential Care, Housekeeping (Sodexho), etc., ensuring alignment and engagement of stakeholders in Infection Control practices and standards.

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
Complete Regional Acute Care Manual and standardize as per PICNet approach to a provincial, evidence-based manual; link with the new Residential Services Manual (completed Dec/06) to promote continuity of evidence-based practice across various care delivery settings for similar patient and resident populations	May 31, 2008	8	4	FH-wide Residential Services IC Manual completed and distributed across the organization in December, 2006; Fraser Health Acute Care Infection Control Manual developed for all Acute Care areas, to replace pre-existing manuals in Fraser South, East and North –for completion by April/07 and is consistent with the new Residential Manual to ensure continuity of standards and approach wherever applicable. Nov. 2007: The Acute Care Infection Control manual is in the final stages of revisions after receiving initial feedback from key users. This will be distributed to Executive Directors and Medical Directors for their feedback in preparation for presentation to the FHIPCC in January for official approval. March 2008: The Acute Care Manual is being assembled this month and will be distributed in April. A document regarding information on new or updated aspects of the new manual was also included in the distribution. An electronic copy of the new manual was available for on-line for all staff April 1, 2008. The manual went out to Executive Directors and department directors for review and feedback. Edits were completed and the manual was approved at the regional Fraser Health Infection Prevention and Control Committee prior to distribution. A document outlining the changes of the new manual from the previous version has been developed. There will be collaborative work with nursing educators to provide training and education for staff and physicians for those new changes. The Education Service Delivery module for Infection Control will assist in planning the roll-out.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Complete recruitment process for key positions and implement new integrated service delivery model with Regional clinical and administrative direction and local delivery.	May 31, 2007	9	4	Integrated IC service delivery model developed Nov. 2005. Budget enhancement proposal resulted in funding for Administrative and Medical Director, 1 additional manager, 2 ICPs and 1 administrative support position. 2 – 1.0 FTE IC managers are in place and continue to define and refine work areas and reporting structures with ICPs.	Increase in ICP FTEs will require additional financial resources which are yet to be identified and need to be prioritized against other equally worthy activities. • 13.5 additional ICPs to provide national standard of service across

Establish clear accountabilities for both IC service delivery and FH committees.				Nov 2007: 0.5 FTE Medical Director and 1.0 FTE Administrative Director for Infection Control hired; start date May 1, 2007. 1.0 FTE IC Program Assistant hired June 2007. Mar 2008: Increased Medical Director FTE to 0.7FTE. 3.0 FTE Medical Microbiologists are allocated to support Infection Control work across acute care sites in FH. Medical Health Officers support Infection Control across Public Health and Residential Care.	the continuum FH-wide • Epidemiology and Decision Support resources required Medical Microbiologist services required for Burnaby Hospital. Additional Med Micro support being sought for acute care.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish, in addition to enhanced management oversight, a programmatic focus across FH for key priority areas, including environmental planning and consultation for renovations or new construction projects and clinical products/supplies analysis.	Apr 30, 2008	10	4	Mar 2008: Infection Control is developing work plan modules that identify key regional services across Fraser and outline a standardized framework for each module. Modules include: o Surveillance/Outbreak Management o ARO o Hand hygiene o Education o Accreditation o Environment o Construction & Design o Product evaluation o Respiratory infections The structure for each module will be similar to each other; they will also align with the strategic plan. The service modules are being led by an Infection Control Practitioner (ICP) in consultation with the Medical or Administrative Director for Infection Control, with other ICPs on the team, as well as appropriate business partners who are invited to participate and provide input as necessary (e.g. Sodexho Housekeeping services).	

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Develop FH staff and physician education program under the direction of the Medical and Administrative Directors of Infection Control.	ongoing	11	4	Mar 2008: The Infection Control education working group had been tasked with the responsibility for developing standardized education programs for staff and physicians. They are responsible to ensure program content and delivery are consistent yet flexible enough to allow variability for modification based on the targeted audience. There are key Infection Control topics that have education programs already developed such as hand hygiene, GI outbreaks, etc. The hand hygiene project presented a 30 minute education session to full and part time staff in acute care sites across Fraser Health. This included open sessions in a classroom setting as well as in-service education delivered in work areas. Hand Hygiene education sessions were also presented to physicians at site medical meetings. Respiratory Flu School was also presented as well as new respiratory outbreak protocol in certain sites. Other infection control topics will be targeted as necessary. This year will see a significant education program developed around reprocessing standards that has surfaced from the MOH Reprocessing audit. This education will be done in collaboration with site and program educators.	
Work with People Development to: • ensure all new staff and physicians are provided with Infection Control orientation • standardize local orientation programs to include the same Infection Control content in all areas across FH.	Dec 31, 2008	12	4	Mar 2008: Infection Control orientation is a key component of the orientation process for all new hires at Fraser Health. This module is standardized for regional orientation for all new staff and is delivered as part of the Fraser Health orientation package. In conjunction with the regional orientation, there is an Infection Control orientation for each of the individual acute care facilities but this has not yet been standardized across Fraser Health, each site has developed their own site specific infection control orientation education. Standardization of the site specific orientation and general orientation for residents and physicians is a goal for 2008. Resident Infection Control orientation for residents is currently only being done at Royal Columbian Hospital.	

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Revise IC orientation and education resource manual for staff and physicians with infection prevention and control roles, designed to complement work of PICNet, and based on standardization of certification qualifications.	Mar 31, 2009	13	3	Nov 2007: Additional funding requests proposed for Education Consultant, Epidemiologist, Epidemiologist assistant and additional ICPs. Mar 2008: Education is one of the core service delivery modules that make up the strategic plan for Infection Control. Resources have been allocated for a Project Coordinator/Educator to develop an Infection Control training program for new ICPs that will outline core competencies and educational material for their development. This person will also lead the ICPs in developing standardized orientation for new staff and physicians at the site level as well as work with nursing educators in developing education material for new Infection Control initiatives across FH. An official IC orientation program for FH has not yet been established. IC staff are asked to participate in the UBC certification course for Infection Control Practitioners. The Education working group is also tasked with exploring other options for certification for Infection Control practitioners and resourcing what other Heath Authorities have developed for orientation and certification, both provincially and nationally.	Additional funding requested for Education Consultant and/or Educational programs, Epidemiologist and Epidemiologist data analyst.

- **Establish a formal surveillance program appropriate to the programs and service offered.**
- **Establish a process for regular formal and informal monitoring of practice.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish a formal surveillance program enabling Infection Control KPIs to be regularly reported at organizational and provincial levels using data collection and analysis methods consistent with BC PICNet activities.	ongoing	14	4	FH Infection Control Practitioner participated as co-lead of PICNet SSI Working Group to develop recommendations for province-wide surveillance plan. Mar 2008: Fraser Health continues to work on a formal surveillance plan and the development of IC KPIs consistent with PICNet. MRSA, VRE and CDAD are regularly reported at local Infection Control Committees, the Acute Care Committee and the regional FH Infection Control and Prevention Committee. Surveillance results are also reported on the Board Balanced Scorecard and on the Patient Safety Scorecard of the Quality Improvement and Patient Safety Committee. Development continues on the FH CDAD, MRSA and VRE rate reduction strategies. FH aligning surveillance components with PICNet criteria in preparation for the provincial launch of the CDAD surveillance.	

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**
- **Ensure there is staff with appropriate training to support data quality.**
- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

Fraser Health Authority

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Coordinate development and implementation with timing of PICNet activities which will occur through 07/08 and 08/09	ongoing	15	4	Mar 2008: Infection Control at Fraser Health is actively engaged with the PICNet group and activities, both at a participant level and on the Executive Steering committees as well as Safer Health Care Now Initiatives. Data Analysts within Decision Support at FH and one of the Infection Control managers support Infection Control surveillance with data analysis and reporting. FH Infection Control Practitioners to provide consistent definitions, education and training to support accurate data collection.	Resources urgently required for a Infection Control Epidemiologist and data entry and analysis support. This is role is currently being filled by a casual employee on part-time basis with funds from another ICP position.
Determine most cost-effective means to collect, analyze and report on infection control and implement same. Work with PICNet to align Health Authority efforts with possible province-wide solution using standardized data definitions and ensuring data quality	ongoing	16	4	The Fraser Health Surgical Clinical Services Planning and Delivery Team implementing key performance indicators as part of the NSQIP Initiative. Surveillance reporting on SSI, BSI, CDAD, MRSA and VRE, and Noro-virus across Fraser Health underway over the past year with a focus on establishing consistent use of case definitions. Sub-group of the Fraser Health Infection Control Coordinating Committee struck to provide KPI reporting to the Committee and Quality Council and onwards to HAMAC and the Board. Establishing set of Infection Control KPIs to be regularly reported at organizational level, using consistent data collection and analysis methods. Nov 2007: FH surveillance for *Clostridium difficile* includes components that will also be in the PICNet surveillance program. Surgical site infection and antibiotic resistant organism surveillance programs are comprehensive and can easily be adapted for participation in PICNet's future programs. Mar 2008: An Infection Control Manager continues to collaborate with PICNet group on CDAD surveillance. FH is developing an MRSA strategy aimed at reducing the incidence of nosocomial infections across FH.	The ability to provide standardized comprehensive surveillance data is dependent on IM/IT resources and capabilities to interface with current information systems.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish a formal surveillance program enabling Infection Control KPIs to be regularly reported at organizational and provincial levels using data collection and analysis methods consistent with BC PICNet activities.	ongoing	17	4	FH Infection Control Practitioner participated as co-lead of PICNet SSI Working Group to develop recommendations for province-wide surveillance plan. Mar 2008: Fraser Health continues to work on a formal surveillance plan and the development of IC KPIs consistent with PICNet. MRSA, VRE and CDAD are regularly reported at local Infection Control Committees, the Acute Care Committee and the regional FH Infection Control and Prevention Committee. Surveillance results are also reported on the Board Balanced Scorecard and on the Patient Safety Scorecard of the Quality Improvement and Patient Safety Committee. Development continues on the FH CDAD, MRSA and VRE rate reduction strategies.	
Put systems in place to enable Infection Control KPIs to be regularly reported at organizational and provincial levels, using consistent data collection and analysis methods. Identify data collection methods that enable capture of data across continuum and outside FH (i.e. GP offices) and develop a feasible approach to same (Align with PICNet data definitions and standardized collection procedures.	ongoing	18	4	Mar 2008: Infection Control KPIs regularly reported at ICCC and Quality Council including consistent data collection and analysis methods - underway for 3 months; IC surveillance incorporated into improvement efforts within the FH SSI Collaborative for Safer Healthcare Now. Improvement practices from the VAP bundle are being rolled out by ICU collaborative teams. FH teams and Infection Control are initiating efforts to implement the bundle to reduce CLIs.	A review of the IM/IT infrastructure will be part of the analysis and delivery of the key performance indicators.

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish regular reporting from ICCC to HAMAC and promotion by HAMAC of Infection Control principles and practices with physicians	ongoing	19	5	Mar 2008: Minutes from the Regional Fraser Health Infection Prevention and Control Committee are presented to HAMAC and reviewed at their meetings. The Medical Director and Infection Control practitioners liaise with physicians through the local Infection Control committees, the Medical Microbiologist network and through direct communication as issues and questions about Infection Control practices and standards arise.	

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Develop and implement FH-wide surveillance and reporting plan for regular submission to Board. Establish information systems to enable data collection and reporting.	ongoing	20	5	Mar 2008: Over the past year a formal and consistent surveillance reporting mechanism has been established for SSI, CDAD, MRSA, VRE, and GI outbreak across Fraser Health. Reports are presented to Board using Balanced Scorecard, to Quality Improvement and Patient Safety Committee through the Patient Safety Scorecard, at the local Infection Control Committees and the Acute Care Committee. A comprehensive Fraser Health surveillance report is being discussed which will identify all surveillance activities being done in the organization, including the surveillance independent of Infection Control.	The ability to provide standardized comprehensive surveillance data is dependent on IM/IT resources and capabilities to interface with current information systems.

Build into Executive Committee Annual Organizational Objectives as a key component of the FH Patient Safety Strategy, including regular reports on KPIs to support decision-making, evaluation, and priority-setting. Specific objectives will include, in addition to the Hand Hygiene Campaign, a strategy for CDAD prevention and ARO.	ongoing	21	5	Nov 2007: This is one of the key initiatives for Service delivery module on Surveillance. Five (5) Key Performance indicators will be reported on a monthly basis. Mar 2008: Quarterly Infection Control surveillance reports pertaining to MRSA, VRE, CDAD, Hand Hygiene compliance and GI outbreak rates will be provided on the Patient Safety Scorecard that is part of the Quality Improvement and Patient Safety Committee and is also reported to the Quality Performance Committee of the Board. Serious respiratory infections (SRI) will also be included in the reporting.	

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Prepare annual report with infection rates and types of infections, in alignment with PICNet public reporting framework	Dec 31, 2008	22		Mar 2008: FH IC Annual Report planned for end of 2008. Currently in place are regular reports on the Balanced Scorecard, Patient Safety Scorecard and surveillance information reported at the local site Infection Control Committees, Acute Care Committee, and Fraser Health Infection Prevention and Control Committee.	Resources are required to produce a published Fraser Health Infection Control report for 2008.

Interior Health

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		✓			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	✓				

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.			✓		
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.	✓				
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.			✓		
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	✓				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	✓				
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	✓				
▪ Establish a formal surveillance program appropriate to the programs and services offered.		✓			
▪ Establish a process for regular formal and informal monitoring of practice.		✓			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.	✓				
▪ Ensure there is staff with appropriate training to support data quality.	✓				
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		✓			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					

We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.			✓		
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.			✓		
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			✓		
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		✓			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		✓			

Interior Health

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

In the period since the audit was done, Interior Health has been successful in implementing many of the recommendations. The Interior Health Infection Prevention and Control manual has been distributed throughout Interior Health and is in use in all IH facilities as well as the contracted facilities. The manual is available in hard copy as well as on the Interior Health website and the Intranet.

The 1st Infection Prevention and Control annual report is available on the Intranet.

The IH wide surveillance program is approximately 75% implemented in all acute care sites throughout the health authority. The residential component will be implemented and completed by the end of March, 2009

At the present time Interior Health is working with Vancouver Coastal Health on a pilot surgical site infection project. If successful this program will be the basis for a provincial surgical site infection surveillance program.

An Interior Health hand washing initiative has been implemented in most sites throughout the region with education to all staff.

Infection Prevention and Control has been included on the Public Health CD committee.

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**

  Status – Unable to respond to this recommendation as it is a Ministry recommendation.

- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

  Status – Unable to respond to this recommendation as it is a Ministry recommendation.

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**

  Status – Substantially completed.

  The Surveillance system (Picis) is approximately 75% implemented in the acute care sites. This implementation will be completed in all acute care sites by June 30, 2008.

  Interior Health will be doing surveillance on Surgical Site infections, Central Lines (ICU patients only at this time), Ventilator Associated Pneumonias, Health Care Associated Pneumonias, Antibiotic Resistant Organisms, C Difficile and Outbreaks (in conjunction with Public Health).

  The Residential care component of the program will be implemented by March 31, 2009. The surveillance program will be in place in all Interior Health facilities.

  At the present time, the program has a Practice Leader who is responsible for the implementation of standardized policies and procedures, surveillance program using standard definitions etc. The Infection Control Practitioners report to a manager in the respective HSAs. The Practice Leader works in collaboration with the managers to ensure consistency in the program. A practice committee is in place and reports up through the Health Authority Infection Prevention and Control Committee.

  The program has had an external review performed in December, 2007 and the results will be presented to the Senior Executive Team in April, 2008 with recommendations on the structure and revised plan.

- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

Status – Fully completed

The Practice Leader sits on the CD Committee and works in collaboration with the MHO as well as the manager of the CD team to ensure all aspects are included in the planning of the programs. Public Health is represented on the Practice Committee as well as the Health Authority Infection Prevention and Control Committee.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

  Status – Partially completed

  The Interior Health Infection Prevention and Control Manual is in use in all IH facilities as well as the contracted facilities. This manual is available in hard copy as well as on the Inside Net and the IH website.

  Infection Control Practitioners from Interior Health sit on the PICNet guideline groups as they are formed and give input to the process.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

  Status – Fully Completed

  A review of the Interior Health Infection Prevention and Control Program was conducted in December, 2007. All stakeholders including Public Health were included in the process. Recommendations were received and the report will be taken to the Senior Executive Team in April, 2008.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

  Status – Partially Completed

  The review was completed, but the physician support remains lacking throughout Interior Health.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

  Status – Fully completed

  The ICPs are included in all renovations and construction projects. The policy is in place in the IC manual as well as the manual in Facilities Management. The IH document is given out to all contractors doing work for IH. This document is included in the documents given out for tendering.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

  Status – Fully completed

  The ICPs are doing inservicing as required on the units. They are included in all new staff orientation. The ICPs in facilities attend unit meetings and present education to the staff

on a regular basis. One on one education is also provided as required. Physicians are included in all education sessions if they wish to attend.

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

  Status – Fully completed

  The Health Service Areas have an education budget specifically for Infection Control. There is also some budget at the corporate level to ensure ICPs have access to education sessions and current resources

- **Establish a formal surveillance program appropriate to the programs and service offered.**

  Status – Substantially completed

  As stated above.

- **Establish a process for regular formal and informal monitoring of practice.**

  Status – Substantially completed

  At this time, the Practice Leader works in conjunction with the Health Service Area ICP Manager to ensure practices are current. The Practice Leader gives input to the performance appraisals as requested.

  An audit tool pertaining to the implementation of the Interior Health Infection Control Manual is in place. There is an audit component within the Picis surveillance system and within our process. The Practice Leader will be able to ensure compliance with best practices using this tool. This will be implemented by June 30, 2008.

  All sites have had Infection Prevention and Control audits done on a 3 year cycle to ensure compliance with standards and best practices. Feedback is given to sites following the audit and this is used to improve practice as needed. All repeat audits have been completed in the acute care sites and the residential sites will be completed by June 30, 2008.

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

  Status – Fully completed

  As part of the Picis implementation Infection Prevention and Control has a Systems Analyst on an ongoing basis. A 0.5 FTE Report Writer is also part of the surveillance program that is being implemented throughout the Interior Health.

- **Ensure there is staff with appropriate training to support data quality.**

  Status – Fully completed

  The IMIT staff are fully trained in data quality and on the Picis system and can provide excellent support to the Infection Prevention and Control Program.

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

  Status – Substantially completed

  Infection Prevention and Control has not been asked to provide any data from the Ministry at this time. Public Health works in collaboration with the Ministry of Health and reports data to the Ministry and other stakeholders as required.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

  Status – Partially Completed

  Interior Health will be capturing surveillance data on Surgical Site infections, Ventilator Associated Pneumonias, Health Care Associated Pneumonias, Antibiotic Resistant Organisms, CDAD, Outbreaks in conjunction with Public Health and Central lines in ICUs only at the present time. This will be gradually implemented and is slated for completion by June 30, 2008. Reports will be taken to the Senior Executive Team by the Chief, Planning and Improvement Officer, on a regular basis.

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

  Status – Partially Completed

  We have taken a dashboard of key performance indicators to the Board which includes targets and indicators for specific procedures. These indicators will be reported to the board on bi-monthly basis as well as going to HAMAC.

  The physician leader for IPC is an attending member of HAMAC and IPC is a standing report on the month agenda.

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

  Status – Partially completed

  We completed an audit of hand washing practices and have shared these with the sites and are working on various improvement strategies to improve the overall hand washing rates.

The surveillance data will be made available to all programs once the implementation is complete and the data quality has been tested. Complete implementation will be done by March 31, 2009 and reports will be available at that time.

Audit reports are made available to all programs i.e. the Sterile Processing audit has been used to provide sites with education and to improve practice.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Status – Substantially Completed

Senior Executive and the Board will be receiving a bi-monthly update on infection rates across the health authority for specific areas and specific procedures. Work continues on the implementation of an IMIT platform and data base for infection. Anticipated that implementation will be complete in late spring with data available in early summer. This system will offer standardised and automated reporting on specific infection issues across IH

The Chief, Planning and Improvement Officer reports on the infection control issues and their status on a regular basis.

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

Status – Substantially Completed

The 1st Annual Report is posted on the IH intranet. All IH staff have access to the intranet. The 2nd Annual Report will be completed and posted in May 2008.

northern health

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	**Substantially**	**Partially**	**Alternative Action**	**No Action**
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		Substantially: Plan developed by Regional Manager IPC in 2007. Approved, in principle by NH Executive. Plan does not formally extend into Home and Community care beyond provision of manual. Pre hospital care requires more collaboration and development. Work collaboratively with Public Health on appropriate communicable disease cases			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		Substantially: Progress has been made with integrated planning Examples include TB algorithm, outbreak management			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	Fully: Not a provincial template but the manuals in NH are consistent with recommendations from the BCCDC.				
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of		Substantially: Formal review undertaken and included in plan with estimates for human resources in IC based on complexity of care. Reviewed residential care. Mental health not included currently			

staff. They should also ensure adequate medical and clerical support for the program.			
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		Substantially: The structure for IPC program includes involvement of physicians on IC committees. IP&C reports to the MACs and the VP Medicine Medical Health Officers are part of the IP&C committees	
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.			Partially: The policies developed and endorsed by IP&C committee and MAC. In practice there are still gaps in involving ICPs in planning, especially during initial stages.
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.			Partially: ICPs have used several strategies to bring education especially to the smaller rural facilities. Access to staff has been variable. Online resources are not accessed by staff as one would expect. Orientation programs with ICP participation varies across NH and related to individual site process and capacity i.e. number of ICP to do education in each facility.
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	Fully: All new ICPs receive a formal IC course through a college/university. All ICP have access to ongoing tele-classes given by experts. All ICPs are supported for one conference per year and provided reference textbooks and other literature as needed. All ICPs encouraged to become involved in a working group under PICNet		
▪ Establish a formal surveillance program appropriate to the programs and services offered.		Substantially: In areas with ICPs – targeted surveillance programs have been developed appropriate to programs and services	
▪ Establish a process for regular formal and informal monitoring of practice.		Substantially: Some formal audits done. ICPs are visible presence on the acute care units daily for formal and continuous informal monitoring of practice. ICPs involvement in the 2007 reprocessing audit provided other opportunities to identify gaps in practice. Formal progress of audit development limited by the number of ICPs available.	
An integrated information system for infection prevention, surveillance and control is in place only for Public Health			
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			Alternative Action: Currently IT resources have not been identified to support IC. Basic databases have been created by the Regional Manager for data tracking.

▪ Ensure there is staff with appropriate training to support data quality.		Substantially: Basic surveillance training is included in formal IC courses. Further training has been provided during educational conferences. Quality of data is monitored by Regional Manager and epi tech	
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Fully: NH has availed itself of all opportunities to work with provincial stakeholders to develop standardized methodology in surveillance		
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done			
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		Substantially: Information supplied to the Board Performance, Aboriginal and Quality committee by the Regional Manager of IPC on infection control and discussion commenced on indicators to be reported	
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.		Substantially: Work has started on a MAC performance scorecard that includes infection control indicators	
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			Partially: Targeted surveillance reports are available to programs. Formal structure of specific services continue to evolve
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	Fully: Specific criteria is reported to NH executive and the Board on a regular basis		
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.			Partially: Annual report for 2007-2008 currently being developed for NH Executive. Public access will be determined.

northern health

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

A three year strategic plan was developed by Regional Manager IPC in 2007. Approved, in principle by NH Executive. Plan does not formally extend into Home and Community care beyond provision of manual.

Pre hospital care requires more collaboration and development.

IPCP works collaboratively with Public Health on appropriate communicable disease cases

Progress has been made with integrated planning

Examples include TB communication algorithm, outbreak management

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

A provincial template has not been realized yet; however the manuals in NH are consistent with recommendations from the BCCDC and Health Canada. Manuals are completed for Acute Care, Complex Care (LTC) and the manual for Home and Community Care is in the final editing process.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of**

staff. They should also ensure adequate medical and clerical support for the program.

Formal review undertaken and included in plan with estimates for human resources in IC based on complexity of care, including complex (residential care). Mental Health and Home and Community Care not included. Increases will be incremental over a three year period.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

The structure for IPC program includes involvement of physicians on IC committees. IP&C reports to the MACs and the VP Medicine
Medical Health Officers are part of the IP&C committees

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

There are policies developed and endorsed by IP&C committee and MAC. In practice there are still gaps in involving ICPs in planning, especially during initial stages.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

All new ICPs receive a formal IC course through a college/university. All ICP have access to ongoing tele-classes given by experts. All ICPs are supported for one conference per year and provided reference textbooks and other literature as needed. All ICPs encouraged to become involved in a working group under PICNet

- **Establish a formal surveillance program appropriate to the programs and service offered.**

In areas with ICPs – targeted surveillance programs have been developed appropriate to programs and services and these will be phased in to other sites as ICP presence increases.

- **Establish a process for regular formal and informal monitoring of practice.**

Some formal audits done. ICPs are visible presence on the acute care units daily for formal and continuous informal monitoring of practice.
An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

Alternative Action: Currently IT resources have not been identified to support IC. Basic databases have been created by the Regional Manager for data tracking.

- **Ensure there is staff with appropriate training to support data quality.**

Basic surveillance training is included in formal IC courses. Further training has been provided during educational conferences. Quality of data is monitored by Regional Manager and epi tech

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

NH has availed itself of all opportunities to work with provincial stakeholders to develop standardized methodology in surveillance

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

Information supplied to the Board Performance, Aboriginal and Quality committee by the Regional Manager of IPC on infection control and discussion commenced on indicators to be reported

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

Work has started on a MAC performance scorecard that includes infection control indicators

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

Targeted surveillance reports are available to programs. Formal structure of specific services continue to evolve

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Specific criteria is reported to NH executive and the Board on a regular basis

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

Annual report for 2007-2008 currently being developed for NH Executive. Public access will be determined.

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PHSA: SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
as of March 2008

March 25, 2008; compiled by Dr. Eva Thomas, Corporate Director for Infection Prevention and Control

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
A provincial framework for infection prevention, surveillance and control is limited to public health					
We recommend that the Ministry of Health: ▪ Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.					Not applicable at HA level
▪ Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.					Not applicable at HA level
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	Fully				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	Fully				

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.					Other Action
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.			Partially		
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		Substantially			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.		Substantially			
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.			Partially		
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.			Partially		
▪ Establish a formal surveillance program appropriate to the programs and services offered.		Substantially			
▪ Establish a process for regular formal and informal monitoring of practice.			Partially		
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			Partially		
▪ Ensure there is staff with appropriate training to support data quality.	Fully				
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Fully				

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		Substantially			
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.		Substantially			
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		Substantially			
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.			Partially		
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		Substantially (not yet publicly available			

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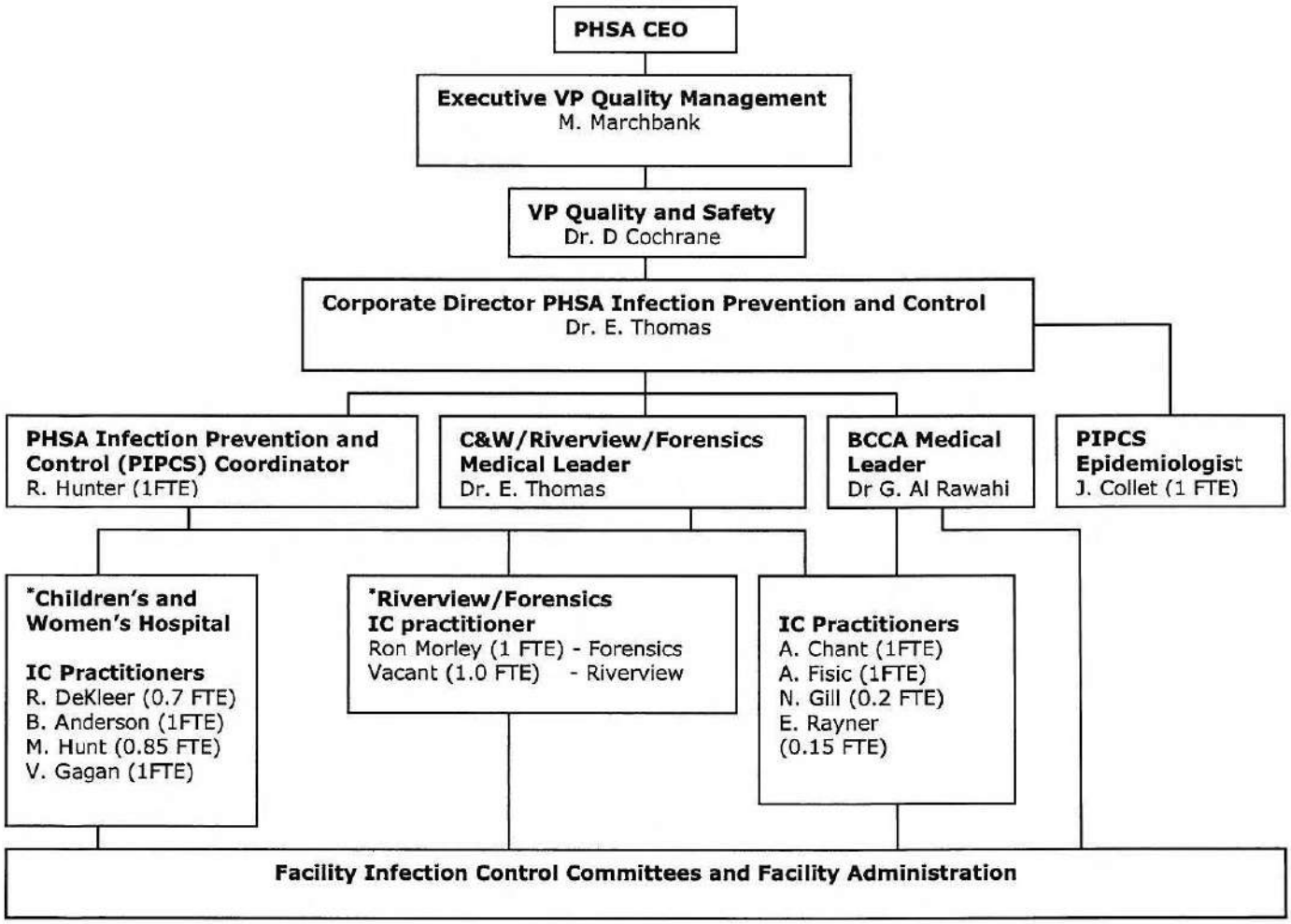
PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

PHSA Response to request for Follow up review on the Auditor General's Report on Infection Control.

Introduction:

- Until May of 2005, the PHSA Infection Control Services were left within their respective Agency and were organizationally separate. The Agency control for Infection Control lay with Administration in the case of the BCCA and Riverview or with the Department of Pathology as in C&W. In response to a CCHSA review of infection control services at BCCA it was decided that the needs of the various populations would be best served by a coordinated corporate infection control service. In 2006 organizational structure was modified to bring the PHSA Infection Prevention and Control service under the portfolio of the VP Quality and Safety.
- In 2007, funding increases were approved for PHSA infection prevention and control, and the institution specific budgets were rolled into a single corporate cost centre. This has enabled PHSA to reorganize and strengthen institution specific and PHSA wide infection prevention and control services. In 2007, 1.4 additional infection control practitioner FTE and 1 FTE infection control hospital epidemiologist were approved. A Corporate Director position was created to provide medical and administrative coordination of the service.
- The Corporate Director meets every three weeks with the VP of Safety and Quality and has excellent relationships with administration in all PHSA institutions.
- The job descriptions of all PHSA IC practitioners have been revised and are now uniform across PHSA.
- A new organizational reporting structure was created for PHSA Infection Prevention and Control Service (PIPCS) – please see chart below.
- PIPCS have monthly meetings to discuss infection control issues
- MAC receives bimonthly reports from the Infection Control Committee and additional updates as necessary



PHSA Infection
Prevention and Control after hours Medical Call Group
Coverage through 604-875-2161 Children's Hospital paging

Dr. E. Thomas. Medical Microbiologist
Dr. R. Tan, Medical Microbiologist
Dr. E Blondel-Hill, Medical Microbiologist
Dr. S. Dobson, Infectious Disease
Dr. G. Al-Rawahi, Medical Microbiologist

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**

- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

Not applicable at the HA level.

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**

- **Implementation Status (Fully):** The Corporate Director and the PHSA Infection Prevention and Control Service (PIPCS) developed a strategic plan in 2006 for the reorganization of IC services PHSA wide. We are well on our way to address infection prevention, surveillance and control across the continuum of care.

- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

- **Implementation Status (Fully):** The Infection Control structure outlined in the organizational chart above was established to ensure integrated planning and service delivery across the HA. Communicable Diseases are instantly reported to Public Health from all PHSA IC teams. There are Public Health representatives on the C&W and the BCCA Infection Control Committees. The presence of Public Health representatives on the Riverview and Forensics IC Committees has been suggested.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

- **Implementation Status (Alternative Action):** While it is not a practical solution for the highly specialized, tertiary care PHSA institutions, it may be helpful for acute care and residential care with limited IC support on site and should be developed through PICNet. We deem it more realistic to focus on reviewing and improving the existing PIPCS

institution specific infection control manuals. For BCCA, we are working on a new, comprehensive manual that will cover all Cancer Clinics in B.C

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

- **Implementation status (Partially):** A review of the PIPCS staffing needs was performed in the summer of 2006 by the newly appointed PHSA Corporate Director, a medical microbiologist and infection control expert, through site visits and consultation with facility administrations and infection control practitioners. Recommendations were discussed with the VP of quality prior to submitting budget requests and budget requests were submitted for 2007-2008. Status indicated in table below.

Institution	Existing in 2006	Recommended total FTE in 2008	Approved in 2007	Current 2008	FTE Shortfall 2008
Infection Control Practitioner FTE:s					
C&W	3.5	3.5	n/a	3.5	0
BCCA-Vancouver	0.8	1.5	0.7	1.5	0
BCCA - Fraser	0.2	0.5	0.3	0.5	0
BCCA - Abbotsford	0	0.5	0.4	0.4	0.1
BCCA - Victoria	0.2	0.5	0	0.2	0.3
BCCA - Kelowna	0.2	0.5	0	0.2	0.3
Riverview	1.0	1.0	n/a	1.0	0
Forensics	0	1.0	1.0	1.0	0

Infection Control Epidemiologist					
PHSA	0	1.0	1.0	1.0	0
Infection Control Coordinator					
PHSA	0	1.0 (in 2007-2008 budget request)	0	0	1.0
Clerical Support					
PHSA	0	1.0	0	0	1.0

- **Communicable disease nurses:** PIPCS does not need communicable disease nurses, as we report and interact with Public Health in all cases of communicable disease that have ramifications for the public and community care.

- The corporate director has now identified that PIPCS, resulting from its expansion, is in urgent need of an experienced IC coordinator. This request has been submitted in 2008-2009 Budget. We have recently identified a highly qualified person for this position, who will be starting mid April. This was deemed unique opportunity, as recruitment of experienced ICP:s is recognized to be challenging. This recruitment also allows for appropriate succession planning.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program**

- **Implementation status (substantially):** A single PHSA Infection Prevention and Control Service (PIPCS) are now in place to provide infection prevention and control arrangements for PHSA. The service comprises of infection control practitioners, a corporate director (Medical), Medical Microbiologists and a part time designated IC physician at BCCA

    - **Current PIPCS Medical Staff:**

    - **PHSA:** Dr. Eva Thomas, Corporate Director, PIPCS

    - **BCCA:** Dr. Ghada Al – Rawahi (0.5 FTE), Medical staff BCCA

    - **On call service:** Medical Microbiologists: Dr. Rusung Tan, Dr. Edith Blondel Hill, Dr. Eva Thomas. Infectious Disease: Dr. Simon Dobson

- **New request:** 0.5 additional Medical FTE needed to ensure support for BCCA, Riverview, Forensics, transplant services and STD/TB Clinic at BCCDC.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

- **Implementation status (substantially):** PIPCS is very cognizant of IC risks associated with renovation and construction, particularly in our large immune compromised patient population at BCCA and also at Children's hospital. PIPCS works closely with the planning department, plant services and is notified and involved when new projects are planned. In fact, we are commonly involved already during the design phases.
- Several of our IC practitioners have attended construction workshops (organized by CSA – Canadian Standard Association).
- C&W has a construction /renovation policy that is based on CSA guidelines. We do regular assessments of construction areas during all phases and follow best practices as outlined by CSA, APIC and 2006 Guidelines for Design and Construction of health Care Facilities, American Institute of Architects Academy of Architecture for Health, Construction and Renovation - 2005 Association for Professionals in Infection Control and Epidemiology text of Infection Control and Epidemiology. June 2007 Infection Control during Construction, Renovation, and Maintenance of Health Care Facilities - Canadian Standards Association.
- BCCA has 2 containment units with HEPA filter at VCC, (one that has been in use for a few months, another very recently purchased). There are no BCCA owned containment units at the other BCCA sites, however because of the differing relationships with host hospital facilities & departments at each BCCA site there may be access to containment units.
- C&W has had 3 such units in place since 2005.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

- **Implementation status (partially):** All new PHSA medical and non medical employees receive introductory infection control education as part of the hiring process, organized by Employee Health, but provided by PIPCS. We also provide regular Hand Hygiene (HH) lectures and other education as needed. We are working on a web based HH module for physicians in conjunction with St Paul's Hospital. We do not yet have a system in place for other ongoing education, but provide IC education on an ad hoc basis. At C&W, new medical students and nurses receive regular IC orientation every 6 weeks at C&W. Plant services have regular IC updates as per request. Other "in service" IC education is offered as needed and upon request both at C&W, BCCA, Riverview and Forensics. At BCCA we do monthly VCC new employee orientations, monthly VCC and FVCC nursing orientations, and FVCC new employee orientations as they are offered - usually every few months. We intend to develop other staff education sessions, some of which would be offered on a regular basis (perhaps ARO updates, isolation precaution reviews etc.).

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

- **Implementation status (partially):** Our current budget allows for 2 education opportunities/year for the entire IC practitioner team + 1 opportunity for medical staff. We have requested an increase to include 1 opportunity/year for all IC practitioner staff/year.

- **Establish a formal surveillance program appropriate to the programs and service offered.**

- **Implementation stage (substantially):**

    - **C&W:** Since the opening of the hospital in 1984, C&W has had a formal paper based surveillance program of hospital acquired infections in place which included daily, comprehensive ward rounds. In 2003, a handheld data entry tool was developed in-house. This tool is well liked by the IC practitioners and used routinely. The data is down-loaded to an Access data base, which allows the generation of regular IC reports of hospital acquired infections. Blood stream and surgical site infections are reported through decision support services, which provide appropriate denominators for the IC data. Additionally, our newly hired IC epidemiologist has been successful in downloading MRSA epidemiology data form the laboratory information system (MISYS), and has produced epidemiological MRSA reports for the first time in 2008. Our VRE rates are very small (1-2 new cases/ year) and are therefore reported manually. We have also produced data for *C difficile* infections this year – but the definitions of hospital acquired *C difficile* infections must be reviewed in the context of paediatrics, as children < 1 year of age can carry the organism asymptomatically.

    - **BCCA:** Very limited surveillance was in existence prior to the formation of PIPCS. Currently, daily rounds on inpatient wards at the Vancouver Centre are performed where hospital acquired MRSA, VRE and *C difficile* infections are monitored, as well as any other infection of concern, such as for example respiratory infections. An MRSA, VRE "verbal" screening tool is being developed, as most BCCA patients are tertiary care outpatients. This verbal screening tool as well as a new MRSA protocol is being developed to suit not only the Vancouver Clinic, but also Surrey, Victoria, Kelowna and Abbotsford. Very limited surveillance in place at these clinics – primarily due to IC staff limitations who are focused on outbreak management, consultation and education. We plan to address the surveillance concerns in a focused fashion when staffing is available.

    - **Riverview and Forensics:** A database exists for infections in Riverview patients, but no formal reporting from this has occurred to date. The Riverview ICP position is currently vacant and surveillance capability has to be reassessed when this position is filled. Currently the Forensics ICP provides "Outbreak" coverage for Riverview.

- **Establish a process for regular formal and informal monitoring of practice.**

- **Implementation stage (partially):** IC practitioner performance reviews now occur yearly and will be a task for the new IC coordinator

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

- **Implementation stage (Partially):** We work with decision support service and IMIT. PIPCS is evaluating two tools at the moment; one is a web enabled data collection tool (based on the Patient Safety Learning System), the other is a data-mining and reporting tool.

    - **Web enabled data collection tool:** requires further modification with the support of PIPCS IC practitioners and IMIT. We plan to develop, test and use this tool, beginning with C&W as a pilot, then roll out to BCCA, Riverview and Forensics..

    - **Data-mining tool:** We have reviewed several data-mining/IC soft ware products for the purpose or surveillance, monitoring and reporting. (ACE, ICNet, Riverview's in-house program and Medmined). At this point in time we favour Medmined, but further integration testing is required. The issue of privacy protection is being explored by Cardinal Health, the vendor of Medmined. This project is likely 1-2 years away from implementation.

- **Ensure there is staff with appropriate training to support data quality.**

- **Implementation stage (Fully):** We hired a full time infection control epidemiologist, Jun-Chen Collet, in October of 2007. She has already greatly enhanced the quality of our data. For example, C&W participates in CNIPS (Canadian Nosocomial Infection Surveillance network) and our epidemiologist has reviewed this data and made significant improvements of the quality. The same is true for our MRSA, VRE and *C difficile* data.

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

- **Implementation stage (fully):** The PIPCS epidemiologist participates in the PICNet working group for *C difficile* infections. The Corporate Director is a member of the PICNet Steering Committee.

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

- **Implementation stage (Substantially):** The new CCHSA (Canadian Council on Health Services Accreditation) regular reporting requirements include: Hospital acquired

MRSA, VRE, *C difficile*, post surgical infections and the rate of timely administration of prophylactic antibiotic. C&W can currently report on MRSA, VRE, *C difficile* and surgical wound infections, with the caveat that wound infections are only monitored in inpatients and readmissions).We also report on blood stream infection surveillance and catheter related bloodstream infections using line days as a denominator (please see below). BCCA Vancouver Clinic can report these parameters on inpatients only. We will continue take direction from senior management to improve the reporting system.

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

- MAC receives bimonthly reports from the Infection Control Committee and additional updates as necessary. Occurrence rates for nosocomial infections, post surgical infections and timely administration of prophylactic antibiotics are reported and discussed.
- Agency based nosocomial infection rates are also reported to the Executive Leadership Council and the Board

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

- **Implementation stage (substantial)**: The IC teams in the respective PHSA institutions provide monthly reports both to the corporate director as well as their institutional infection control committees. These reports are then forwarded to the VP of Quality, institutional MAC's, site nursing and administrative managers. They are also summarized in the monthly PIPCS meetings and the minutes from this meeting are distributed to the PIPCS members, site management and the VP of Quality and Safety.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Implementation stage (Partial):

- At C&W PICU participates in the Intensive Care Unit Collaborative using Institute of Healthcare Improvement initiatives.
- NICU (Safer HealthCare now for Catheter related blood stream infection) – these initiatives have improved the dialogue between infection control and clinical services, and we all now have a better understanding of what kind of data we are able to provide and what is required. At BCCA we are working on an expansion of data reporting as well.

- **C&W regularly reports after consultation with medical management teams:**

    - **PICU** – all hospital acquired infections, surgical site infections, UTI:s, respiratory infections including ventilator associated pneumonia (VAT) and any other wounds etc. Reports go to Medical Head, PICU.

- **Paediatric Oncology**: Catheter related blood stream infection are reported to –, Medical Oncology Head, Oncology Nursing Manager
- **NICU**- Hospital acquired bloodstream and surgical site infections only – Reports go to Medical Heads of NICU.
- **C&W:** Hospital acquired blood stream and surgical site infections are reported to the Hospital Presidents, and Chair, Quality and Safety at Children's Hospital.

- **BCCA** – the Safer Health Care Now program for line insertions is now being piloted at the Vancouver Clinic.

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

- **Implementation stage (Substantially)** The First Annual PIPCS report will be ready on March 31, 2008 – not yet publicly available.

Vancouver CoastalHealth
Promoting wellness. Ensuring care

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008
FINAL RESPONSE;
Vancouver Coastal Health Authority

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		X			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		X			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.		X			
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.			X		
▪ Review their infection control structures to ensure there is appropriate		X			

and designated medical support in place for the program.					
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	X				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.		X			
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		X			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		X			
▪ Establish a process for regular formal and informal monitoring of practice.		X			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			X		
▪ Ensure there is staff with appropriate training to support data quality.			X		
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.			X		
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	X				
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	X				
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		X			
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		X			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	X				

Vancouver CoastalHealth
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PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

VANCOUVER COASTAL HEALTH AUTHORITY

FINAL RESPONSE

MARCH 2008

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**
  - The Provincial Infection Control Network (PICNet) has established a collaborative framework for the sharing of best practices as well as consensus standards for surveillance.
  - VCH is actively participating on many working groups:
    - Respiratory Outbreak Prevention and Control Guidelines Working Group. This working group established guidelines (June 2007) for the prevention and control of respiratory infections in all health settings.
    - Antibiotic Resistant Organisms Working Group. This working group is currently working on revising the current BCCDC antibiotic resistant organism guidelines. In addition to updating the existing guidelines, the working group will enhance them to include section on hemodialysis and occupational health.
    - Clostridium difficile associated disease (CDAD) Surveillance Working Group. The CDAD surveillance working group is coordinating the implementation of a standardized surveillance protocol throughout the province. Supporting the implementation, the working group has also developed a Participation Agreement outlining roles and responsibilities of the collaborators for information sharing, as well as standards for provincial reporting of CDAD rates and outcomes.
- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

- VCH is actively involved in PICNet's CDAD Surveillance Working Group. The CDAD Surveillance working group has developed a surveillance protocol with standardized definitions and minimal data set, as well as consensus standards for provincial-level reporting. The goal is to build upon the work of this group to expand provincial surveillance to other healthcare associated infections.

- VCH and the Interior Health Authority are currently collaborating on a pilot project for the development of a standardized surveillance protocol for surgical site infections. Standard definitions and a minimal data set have been developed. Consensus case finding methods have been developed and implemented in the two pilot facilities (Vancouver General Hospital and Kelowna General Hospital).

- VCH has established standardized surveillance and reporting for MRSA, VRE and CDAD. VCH participates in national surveillance for these organisms through the Canadian Nosocomial Infection Surveillance Program (CNISP). Standardized annual reporting has been in place since 2005/2006. Working with key stakeholders, reporting of nosocomial rates by administrative period is currently underway for the seven acute care facilities.

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**

  - VCH has a regional infection control team with local responsibility. The Medical Health Officer attends infection control meetings regularly. There are integrated mechanisms in place that coordinate infection prevention and surveillance across the continuum. In addition, because infection prevention involves employee infection prevention as well there are structures and procedures in place to support the coordination of these efforts with Occupational Health and Safety.

  - VCH has established a long term/residential care working group aimed at identifying priority areas for infection control surveillance for benchmarking and ongoing monitoring in the region's directly funded long term/residential care facilities. Surveillance definitions and protocols applied in acute care are not directly transferable to the long term/residential care setting. As a result, new definitions and protocols will need to be developed.

  - PICNet recently accepted a proposal submitted by VCH to examine infection control in long term and residential care across the province. Building on the previous PICNet needs assessment, the primary objectives of the proposal are to: (1) establish the current status of infection surveillance in long term care and rehabilitative care (LTRC) province wide; (2) identify resources and needs in infection control in LTRC; and (3) identify priorities for infection control in LTRC. The working group will get underway in April 2008.

- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

- Current structures within VCH support the integration of infection control with public health in residential care practices however, further opportunities to better align and integrate services across VCH still exist.

- In collaboration with Occupational Health and Safety we have further established committees, policies and procedures, outbreak management protocols, algorithms, and communication tools to better align these structures.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

  - VCH has completed a regional manual that is available to all practitioners within residential and acute care facilities across VCH via hard copy as well as intranet. This addresses common procedures as well as signage across VCH. There are numerous resources available for our contracted facilities, primary care clinics and public health staff.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

  - VCH Infection Control participated in the Provincial Needs Assessment. It was determined that VCH resources fell below the national standards for the number of Infection Control Practitioners per bed ratio.

  - VCH Infection Control has submitted a business case to address these needs.

  - Communicable disease control has received MOH funding the last 2 years to enhance their capabilities for surveillance, reportable disease management, and education.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

  - The VCH Infection Control business case addresses the need for a dedicated Infection Control Officer (0.2 FTE) at Lion's Gate Hospital. Other HSDAs have medical support for infection control in place as well as a Regional Medical Director for Infection Control. Infection Control Officers responsible for the Acute and Residential Care facilities work collaboratively with Medical Health Officers to ensure continuity of care for patients, clients, residents and staff as well as the public.

  - VCH has a regional community infection and prevention educator who supports the contracted facilities, primary care clinics and the public health staff.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

  - The Infection Control Team across VCH is involved in all construction activities within the acute and residential care sites to ensure awareness and understanding of CSA construction guidelines for construction and renovations. Infection Control Practitioners from across VCH recently participated in a regional construction standards workshop hosted by the Facilities Department of VCH. There is a lot of internal collaboration with construction and renovation activities.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

  - VCH has a comprehensive Hand Hygiene program in place. The on-line resources are made available to all staff including physicians. All physicians will be completing these on-line modules as a condition of their ongoing renewal of privileges at VCH. This on-line learning module has been made available to other health authorities as well as schools of medicine and nursing.

  - All new staff to VCH receives infection control education during orientation as well as more detailed information on aseptic techniques in clinical orientation. In addition, regular educational sessions are given at each site.

  - Numerous on-line resources are also available on the Infection Control, Learning and Development, Centre for Surgical Excellence and Innovation intranet sites.

  - The Innovation Fund recently supported the development of an eLearning module for physicians and nurses that addresses the best practices techniques for the insertion, care and maintenance of central lines. This will also be made widely available.

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

  - VCH Infection Control Practitioners not only participate in a variety of conferences and activities to maintain best practice standards they are also involved in providing educational sessions to other agencies.

  - VCH Infection Control Team is involved in numerous provincial, national and international activities. We participate in a variety of ways with Health Canada, CSA, Public Health Agency of Canada, CNISP (Canadian Nosocomial Infection Surveillance Program), Safer Health Care Now! (Canadian Patient Safety Institute), PICNet, and ISO.

  - The VCH Regional Infection Control Coordinator participated as a working group member on the Canadian Committee on Antibiotic Resistance (CCAR) 2007 publication, *Infection Prevention and Control Best Practices for Long Term Care, Home and Community Care including Health Care Offices and Ambulatory Clinics.*

  - In the past year two members of the team were invited to assist in the establishment of an infection control program in hospitals in Guatemala and

South Africa. One member is currently in South Africa assessing the success of the program.

- Through PICNet, the VCH Infection Control team as well as that of the other Health Authorities receive access to WEBBER teleclass lectures in infection control. Lectures are scheduled weekly and involve speakers from around the world.

- In the last year, members of the VCH Infection Control team have presented at multiple conferences and meetings, including CHICA, APIC

    - June 01, 2007 – "*Clean Hands for Life*™: Innovation in Poster Presentation" poster presentation at Innovations in Health Care Best Practices Forum, BC Ministry of Health, Vancouver, BC.
    - June, 2007 – "Ventilator Associated Pneumonia in Residents Chronically Ventilator Dependent". Poster presentation at CHICA, 2007. Edmonton, AB.
    - October 26, 2007 – Hand Hygiene. Oral presentation at CHICA-BC Education Day. Vancouver, BC.
    - June 2, 2008 – Invited panellist for Surveillance Programs across Canada at CHICA, 2008. Montreal, QC
    - June 15, 2008 – *Clean Hands for Life*™: Results of a Regional Hand Hygiene Campaign Abstract accepted for poster presentation at APIC. Denver, Colorado.

- The Infection Control Team currently has grants with CIHR to assess the effectiveness of on-line learning and another with the CIHR/MSFHR Strategic Training Program Grant to assess the needs for occupational health and safety and infection control and to establish a sustainable occupational health and infection control program in a public/private/academic ambulatory care setting. Another is in partnership with Bayer Healthcare Canada for the Clean Hands for Life hand hygiene campaign.

- Numerous members of Infection Control and Medical Microbiology have published research articles and continue to participate internationally in research programs.

- **Establish a formal surveillance program appropriate to the programs and service offered.**

    - VCH Infection Control publishes an Annual Report which formally assesses all activities of the Infection Control Department. This report is published to the internet site of VCH. We are in the process of evaluating all of our services via an internal customer satisfaction survey.

    - VCH has a standard surveillance program for MRSA, VRE and CDAD in its acute care facilities. Surveillance results are continuously updated on the shared drive. Standard reports include nosocomial rates by administrative period for

MRSA, VRE and CDAD for each facility. Reports of the number of cases acquired on a given service/ward are also prepared regularly.

- **Establish a process for regular formal and informal monitoring of practice**

  - Within the Infection Control Team there is a well established process for review of our own practices. Clear roles and responsibilities for each team member have been defined and practices are monitored against these standards. We have regular team meetings and routinely share issues and concerns across the health authority.

  - In addition to the surveillance programs in place the Infection Control department participates in audits, quality assurance and quality initiative activities. For eg. Operating Room Audit, Surgical antibiotic review, C. Difficile procedures, review of CJD practices, outbreak management and debriefing, involvement in critical incident reviews that have an infection control component. Infection Control participates with the review of audit results for certain contracted services as well.

  - VCH has a standard surveillance program for MRSA, VRE and CDAD in its acute care facilities. Surveillance results are continuously updated on the shared drive. Standard reports include nosocomial rates by administrative period for MRSA, VRE and CDAD for each facility. Reports of the number of cases acquired on a given service/ward are also prepared regularly.

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

  - Numerous data and information sources are available to Infection Control. VCH recognizes the challenge of multiple information databanks and is working on a plan to coordinate all of these data sources into one comprehensive system. In addition, VCH is actively participating with PICNet in establishing a provincial database for surveillance data.

- **Ensure there is staff with appropriate training to support data quality.**

  - The infection control team has participated in the establishment of common definitions for data quality and routine auditing of data quality processes are in place. However, there remains the challenge of meeting the demands for staff to input data and to maintain those processes once established.

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

  - VCH is involved in a data quality working group with the Canadian Nosocomial Surveillance Program (CNISP). Random samples of data submitted from participants of the national surveillance program are resubmitted and evaluated for quality and accuracy. The results of the analysis will be presented at the next CNISP annual meeting.

  - VCH routinely examines its surveillance data for completeness and accuracy. We are currently working with QUIST and ORMIS to examine data quality issues in denominator data required to support surgical site infection surveillance.

- The PICNet CDAD surveillance project will involve routine evaluation of the surveillance program and the data collected.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**
  - In collaboration with the Senior Executive Team for VCH as well as the Health Authority Medical Advisory Council infection control indicators have been developed. These rates are regularly reported to the local infection control committees, medical advisory committees, and senior management teams as well as to the Board of VCH.
  - As noted previously the VCH Infection Control Annual Report is available to all staff as well as the public via the internet.
- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**
  - Guidelines and reporting structures ensure compliance by the Medical Advisory Committees across VCH.
  - The Health Authority local Medical Advisory Committees receive reports from their local infection control committees.
  - The Health Authority Medical Advisory Committee (HAMAC) receives reports on infection control matters through its Quality of Care Committee.
  - The HAMAC has mandated that all medical staff must take and pass the on-line hand washing module and the infection control module before their 2009 re-credentialling.

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
  - Each HSDA has mechanisms and structures in place to disseminate surveillance and audit information for infection control. For eg. Each HSDA has an Infection Control Committee that is multidisciplinary. These committees report to the local medical advisory committees and then to the Health Authority Medical Advisory.
  - As well, numerous program areas receive regular 'report cards' from infection control. This includes information and trending on infection control indicators for that department or functional program– We are in the process of spreading this activity to multiple program areas across VCH.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**
    - See above. In addition regular reports are reviewed by each of the HSDA senior leadership teams via the infection control committees.
- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**
    - VCH has published their annual report to the public for the past 3 years.

Providence HEALTH CARE

How you want to be treated.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

RESPONSE FROM PROVIDENCE HEALTH CARE

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	√				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	√				
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.		√			
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of		√			

staff. They should also ensure adequate medical and clerical support for the program.					
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	√				
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	√				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	√				
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		√			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		√			
▪ Establish a process for regular formal and informal monitoring of practice.		√			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.		√			
▪ Ensure there is staff with appropriate training to support data quality.		√			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		√			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.					
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.					
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		√			

▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		√			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		√			

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: ***The Provincial Overview***
As at March 2008

(Please provide the information noted below)

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
  - ***PHC has a strategic plan, which guides prevention, surveillance and control across the continuum of care (see attached strategic plan).***
  - ***The strategic plan was finalized in 2005 and will be reviewed in 2008.***
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**
  - ***The structure of infection control at PHC was formally reviewed by an independent consultant in 2005 and a report with recommendations was produced.***
  - ***The Vision of the PHC Infection Prevention and Control Team (IPAC) is to create and sustain a culture in which infection control is integrated into all aspects of care.***

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**
  - ***PHC has an IPAC website which includes an on online manual.***
  - ***This manual is accessible by all acute care sites, and residential care sites (with the exception of Marion Hospice which has a CD of the IPAC manual), and is also available through the VCH website.***

- *VCH Communicable Disease Control has suggested that this manual used as a potential template for the Region and is available as a possible template at the provincial level.*

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

  - *In 2005, a business case detailing the requirements for a functional infection control program at PHC was performed.*

  - *Since then, the PHC IPAC Team has been expanded to include: one IPAC Physician Leader/Medical Microbiologist, two part-time Physicians (acute and residential care), one full-time Epidemiologist, one full-time clerical position, 5 full-time Infection Control Practitioners, as well as access to a Molecular Biologist.*

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

  - *The PHC IPAC Team has been expanded to include: one IPAC Physician Leader/Medical Microbiologist, and two part-time Physicians (acute and residential care).*

  - *Two additional Medical Microbiologists participate in IPAC at PHC and allow for 24 hour / 7 days per week coverage.*

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

  - *The IPAC Team is involved in all new construction and renovation projects, e.g., renovation of the St. Paul's Hospital Emergency Department, PHC Renewal project.*

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

  - *The IPAC Team provides education to all areas, including medical staff.*

  - *Detailed information on educational activities can be found in the annual report.*

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

  - *The IPAC Team participates in teleconferences, seminars, workshops and other educational opportunities, which are available locally.*

  - *In addition, ICPs attend workshops in other geographical locations as funding permits.*

- *IPAC medical staff attends and present at national and international medical conferences.*

- **Establish a formal surveillance program appropriate to the programs and service offered.**
  - *A full-time Epidemiologist oversees the design and implementation of a formal surveillance program and multiple surveillance systems, including:*
    - *Acute Care: comprehensive surveillance for MRSA, VRE, TB, and C. difficile; surveillance for surgical site infections, ventilator-acquired pneumonia, and catheter-related bloodstream infections is partially implemented.*
    - *Residential Care: surveillance for C. difficile, TB, influenza-like illness, and viral gastroenteritis is currently performed.*

- **Establish a process for regular formal and informal monitoring of practice.**
  - *Hand hygiene audits are performed periodically using a standardized format; data are presented to all PHC staff.*
  - *Weekly IPA0C ward rounds are performed on the wards in acute care facilities.*

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**
  - *The IPAC Team includes a full-time Epidemiologist to support data collection, analysis and reporting.*
  - *Members of IPAC have access to multiple computerized databases and statistical computer programs, including: ADT, LIS, SCM, SPSS, MS Access, ORMIS, Sunset, and others.*

- **Ensure there is staff with appropriate training to support data quality.**
  - *The IPAC Team includes a full-time Epidemiologist to support data quality.*
  - *Data quality systems are incorporated in to all aspects of laboratory testing.*
  - *IPAC staff attends education sessions on computer programs and applications.*

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**
  - *IPAC staff collaborate with provincial and regional partners (including VCH Communicable Disease Control) to ensure data quality.*
  - *Members of IPAC participate in various provincial projects coordinated through PICNet BC, including the Steering Committee.*

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**
  - ***The IPAC Medical Director meets with senior management and the PHC Board of Directors to report on indicators.***
  - ***The senior management "Balanced Scorecard" includes the following infection control indicators: hand hygiene compliance, and the prevalence of antibiotic-resistant organisms (VRE and MRSA).***
- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**
  - ***All Infection Control Standard Committee minutes are provided to MAC.***
  - ***The IPAC Medical Director presents at MAC meetings and supports MAC on all issues relating to the prevention and control of nosocomial infections.***

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
  - ***Members of IPAC have presented results on hand hygiene audits to front-line health care workers and senior management teams.***
  - ***In addition, data and rates are available to all staff via the intranet site, and will be available to the public in the coming fiscal year.***
  - ***The annual report for 2006/7 has been reported; the report for 2007/8 will be available in April 2008, and available on the IPAC website.***
- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**
  - ***The 2006/07 IPAC Annual Report has been presented to senior management teams and is available on the intranet site.***
  - ***For the coming fiscal year, IPAC will be working to produce quarterly infection prevention and control reports.***
- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**
  - ***The first annual report was produced for the 2006/07 fiscal year and has been presented internally to senior management teams for approval and posted on the IPAC intranet site.***

- ***The 2007/08 report will be completed in April 2008; in order to make these reports available to the public, they will be posted on the Providence Health Care internet site.***

Completed March 27, 2008.

VANCOUVER ISLAND health authority

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008
(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
THERE IS LITTLE OR NO INTEGRATED PLANNING FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL ACROSS THE CONTINUUM OF CARE IN THE HEALTH AUTHORITIES					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	X				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		X			
DEMONSTRATING BEST PRACTICES IN INFECTION PREVENTION, SURVEILLANCE AND CONTROL NEEDS TO BE STRENGTHENED					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.				X	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.		X			
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		X			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.		X			
▪ Ensure that all staff receive regular ongoing education in the area of infection		X			

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
control and that medical staff also have access.					
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	X				
▪ Establish a formal surveillance program appropriate to the programs and services offered.			X		
▪ Establish a process for regular formal and informal monitoring of practice.			X		
AN INTEGRATED INFORMATION SYSTEM FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL IS IN PLACE ONLY FOR PUBLIC HEALTH					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			X		
▪ Ensure there is staff with appropriate training to support data quality.		X			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		X			
REPORTING ON PREVENTION, SURVEILLANCE AND CONTROL OF INFECTIONS VARIES BY THE HEALTH AUTHORITY AND, OVERALL, IS NOT WELL DONE					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		X			
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.				X	
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			X		
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		X			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	X				

VANCOUVER ISLAND health authority

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

Vancouver Island Health Authority Response:

The Vancouver Island Health Authority has in the last two years made substantial progress towards meeting the Recommendations outlined in the Office of the Attorney General's Report. These have included the establishment of an infrastructure through the provision of additional funding that supports a regional infection prevention and control (IPC) Program that covers the spectrum of health services (acute, long term care, and community) as well as creating linkages between the programs that promote IPC practices (Public Health, Wellness & Safety, Laboratory, Infection Prevention and Control). A number of initiatives and projects have occurred, such as the Hand Hygiene Initiative, amalgamation of existing IPC manuals into one regional manual that is available through the Intranet, development of Outbreak management toolkits for Residential and Assisted Living Sites. The IPC Program positions have all been filled with the most recent practitioner arriving in September 2007.

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
THERE IS LITTLE OR NO INTEGRATED PLANNING FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL ACROSS THE CONTINUUM OF CARE IN THE HEALTH AUTHORITIES			
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	VIHA Infection Prevention and Control Program Plan 2006-2010 approved by the Board. Includes coverage for services across acute, long term care and community through collaborative and consistent practices with Public Health and Wellness and Safety.		Fully

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	CD Program and IPC have established cross-representation on committees to support integrated planning and service delivery; especially around influenza immunization program and outbreak management. Work developed jointly includes: Roles and Responsibilities in Outbreaks (delineation between amalgamated/ affiliated facilities), Outbreak Management Toolkit for Residential Facilities, Management of Gastrointestinal or Respiratory Illnesses in Assisted Living Residences, Guidelines during Outbreaks (staff restrictions, return of residents to LTC facilities during outbreaks), Health Space (broad reporting to Acute and LTC facilities of LTC facilities experiencing outbreaks). Public Health has established CD Program Hubs (PHNs and EHOs) to respond to outbreak situations in affiliated LTC facilities. IPC covers outbreaks in amalgamated acute/LTC facilities. VIHA participated in review of Public Health Core Services documents. CD Program and IPC are involved in pandemic planning. The lab supports outbreak management throughout VIHA with results provided to public health and IPC.	- Build upon work already underway to continue developing consistent guidelines implemented across the sectors, and maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	**Substantially**
DEMONSTRATING BEST PRACTICES IN INFECTION PREVENTION, SURVEILLANCE AND CONTROL NEEDS TO BE STRENGTHENED			
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	MOH/BCCDC/Health Authorities through PICNet develop provincial guidelines. VIHA has revised its IC Manual, which has been adopted island wide. It will be web-based and will have ongoing realtime review and revision. This manual is consistent with provincial guidelines and is applicable to the services VIHA provides.	- Phase 1 is complete. - Phase 2, which includes outbreak management, housekeeping and other specific service sections, is anticipated for Fall 2008. - Phase 3, which incorporates any additional areas that have been identified for inclusion,	**Alternative Action**

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
		will be completed for Winter 2008.	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.	All current IPC positions are filled. IPC staff requirements have been reviewed and additional resources identified through the VIHA budget approval process. A formal review of the public health communicable disease requirements was completed in 2006 and recommendations were made to establish a specialized CD control program for the HA with CD offices in South, Central and North. These recommendations were implemented in fiscal 2007/08 and the three CD offices have been established and staffed. A post-implementation evaluation of the CD service is occurring.	Building upon work already underway to continue developing consistent guidelines implemented across the sectors, and to maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	Substantially
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	Currently have 2 physicians allocated to the IPC Program (Medical Microbiologist and Infectious Diseases Physician). Have identified need for 1 additional IPC physician position, which is being considered through the physician approval process. Work closely with the VIHA Medical Health Officers and BCCDC.		Substantially
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	IPC representation on Capital Projects Committees (SI, CI/NI), involved in all new construction and major renovation projects, working relationship with Facilities Maintenance Operations at all sites.	Building upon work already underway to continue developing consistent guidelines implemented across the sectors, and to maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	Substantially
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	Provide IPC principles to Acute/LTC nursing staff as part of their orientation to VIHA. Developing presentation for inclusion in New Employee Orientation. Ongoing education is provided to staff in a number of venues: staff inservices, formal presentations, point-in-time education, initiatives such as Hand Hygiene update. Currently determining the educational needs in community. IPC physicians will be developing a resource for physicians. Limited in what can be accomplished by the availability of resources (IPC practitioners/ physicians and clinical staff relief).		Substantially

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	VIHA has funded Webber teleconference education sessions, attendance at IPC conferences locally, provincially and nationally (Infectious Diseases, PICNet, CHICA), as well as supporting IPC practitioners in acquiring an approved Infection Control course through nationally recognised universities (McMaster, University of Calgary, University of BC).		Fully
▪ Establish a formal surveillance program appropriate to the programs and services offered.	Data definitions consistent with provincial/national criteria, have been established for surveillance of AROs, CDAD, surgical site infections, and outbreaks. IPC is currently doing only targeted surveillance as our contribution to Safer Health Care Now. It works collaboratively with the department of surgery to collect targeted surveillance. VIHA has IPC representation on the PICNet Community IPC Working Group to participate in the development of surveillance guidelines for community.		Partially
▪ Establish a process for regular formal and informal monitoring of practice.	There are a number of audits/inspections that occur within VIHA facilities: inspections completed by the Community Care Licensing staff and Environmental Health Officers, IPC practitioner walk-abouts with a focus to promote IPC principles and practices through point-in-time teaching, identification of problem areas with recommendations on how they can be resolved. Recently with the assistance of two Employed Student Nurses (ESN), the Program audited the implementation of the ARO screening questionnaire and hand hygiene practices at NRGH, RJH, and VGH. Housekeeping services has an annual audit completed by external auditors. IPC has done spot environmental swabs post-cleaning during recent outbreaks, which has improved outbreak management. VIHA participates in CCHSA accreditation.	- Continue to maximize on opportunities to regularly monitor practice (employed student nurses, staff on LTD who are preparing to return to the work place). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process. - Cerner (operating system) is currently being rolled out throughout VIHA. Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	Partially
AN INTEGRATED INFORMATION SYSTEM FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL IS IN PLACE ONLY FOR PUBLIC HEALTH			
We recommend that the health authorities: ▪ Provide information management support to the infection control	Rollout of the Cerner operating system throughout VIHA, including St. Joseph's General Hospital in 2008 will provide the IPC program the capacity of working off the same client record. Working with IMIT to access reports and modules through the	- Cerner (operating system) is currently being rolled out in VIHA - Continue working with IMIT to access reports and modules	Partially

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
program for data collection, analysis and reporting.	Cerner system that will support surveillance and case management. Currently all IPC practitioners are using a "home grown" Access database for data collection and reporting.	through the Cerner system that will support surveillance and case management.	
▪ Ensure there is staff with appropriate training to support data quality.	Program has developed data definitions that are used by all staff in data collection and reporting. Access database has been developed to display many of these definitions or to provide a drop down list, to improve data quality.	- Continue developing and refining data definitions to ensure they are consistent with provincial and national agencies. - Work with IPC practitioners to enhance data consistency and quality. - Have identified the need for an epidemiologist as a resource within the IPC Program. This has been submitted through the VIHA budget request process.	Substantially
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Program uses criteria set by provincial (PICNet, BCCDC) and/or national agencies (CNISP, Safer HealthCare Now) in developing its data definitions. There is sometimes variance in data definition between these agencies, and these are raised by VIHA representatives for consideration and resolution.		Substantially
REPORTING ON PREVENTION, SURVEILLANCE AND CONTROL OF INFECTIONS VARIES BY THE HEALTH AUTHORITY AND, OVERALL, IS NOT WELL DONE			
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	The IPC Program reports its status on activities identified in the IPC Program Plan, as well as its hospital acquired infection rates, as a component of the Quality and Patient Safety quarterly and annual report to the Board.	- Continue working with senior management to determine what additional indicators and reports they require and are required by the Board. Based on this information, the IPC program will determine what data collection is required, and develop or access a system to collect, compile, and report this data. - Have identified the need for an epidemiologist as a resource within the IPC Program. This has been submitted through the VIHA	Substantially

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
		budget request process. - Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	The Board of VIHA holds the Health Authority Medical Advisory Committee accountable for ensuring that quality review mechanisms are in place in relation to IPC. When compromises to IPC principles/practices are reported quality reviews occur.		Alternative Action
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	Reports of housekeeping and environmental audits are provided to the managers. Have initiated an Outbreak Management Summary Report, which is completed in conjunction with the unit manager, and identifies successes and areas for improvement. The regional IPC team will review these reports to determine options in promoting decrease in transmission of disease and length of outbreaks. Issues requiring further review will be forwarded to IPC Quality Committee and VIHA Quality Council. Informal feedback and recommendations occur as routine IPC practice. Developing process for regular quarterly reporting to program areas. Provision of tracking and trending reports is limited by available IPC resources.	- Continue providing those reports that are currently being provided. - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process. - Cerner (operating system) is currently being rolled out throughout VIHA. - Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	Partially
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	See response above. The information requested has been identified (i.e., trends in infection rates, outbreaks – numbers/types/length). The provision of these reports is limited by available IPC resources.		Substantially
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	2006/07 Regional IPC Annual Report is posted on the VIHA website. Report includes rates and types of infections, based on the data collected. It incorporates an excerpt from the Public Health annual report to provide a broader perspective of influenza immunization rates and outbreaks in affiliated LTC facilities.		Fully

Section 6

Update on the implementation of recommendations from:

Managing Pharmacare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program

March 2006

October 2008

April 30, 2008 719851

Mr. Morris Sydor, CA
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria, BC V8V 1X4

Dear Mr. Sydor:

As requested by the Office of the Auditor General, I am pleased to enclose an update on the significant progress the Pharmaceutical Services Division has made in implementing the Auditor General's recommendations since the February 2, 2007, presentation to the Public Accounts Committee.

Since the report was tabled, the Pharmaceutical Services Division has made considerable progress in addressing both its substance and direction. The division has fully implemented eight recommendations and substantially or partially implemented the remaining seven. The new divisional structure and capacity has supported this progress.

The Ministry of Health is committed to providing British Columbians with access to the best drug therapies at the best price. PharmaCare is already one of the most comprehensive programs in Canada. We intend to safeguard this valuable program by continuing to base drug coverage decisions on a rigorous review of clinical evidence, by implementing strategies to better control costs, and by promoting better drug prescribing and optimal use of drug therapies throughout the province.

I would like to thank the Auditor General for the recommendations and for this opportunity to report on our progress to date.

Sincerely,

Original signed by

Gordon Macatee
Deputy Minister

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION

Managing PharmaCare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program

As at April 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	**Implementation Status**				
	Fully	**Sub-stantially**	**Partially**	**Alter. Action**	**No Action**
We recommend that the ministry: 1. Review PharmaCare's strategic objectives and make necessary adjustments to reflect current thinking.	X				
2. Align PharmCare strategic objectives with statements of actions that describe how the objectives are to be achieved.	X				
3. Determine the human resources needed to achieve the program's objectives and build capacity to meet those needs.		X			
4. Develop performance measures for, set targets for, and collect information to support the achievement of program objectives.	X				
5. Work with the College of Pharmacists and others to move custodianship of PharmaNet information to the ministry, and provide timely access.			X		
6. Formally evaluate the MAXIMUS BC contract on a regular basis, to determine its effectiveness.	X				
7. Review internal procedures for assessing the cost-effectiveness of new drugs to identify and implement ways to streamline the assessment process, including consideration of a fast-track process.		X			
8. Put in place a process to systematically assess the cost-effectiveness of existing drugs in the formulary.			X		
9. Explore and implement ways to ensure best prices are paid for drugs by the province.		X			

Auditor General's Recommendations (cont.)	Implementation Status				
	Fully	Sub-stantially	Partially	Altern. Action	No Action
We recommend that the ministry:					
10. Use PharmaNet information to identify trends in prescribing practices and to inform physicians about their own prescribing practices and the projected results had currently recognized clinical best practices been followed.		X			
11. Significantly increase support for PharmaCare-sponsored programs that encourage appropriate drug use through physician best practices in prescribing (such as Therapeutics Initiative Letters, physician access to PharmaNet, and the academic drug detailing program).	X				
12. Support greater involvement of physicians in developing actions to promote appropriate drug use.	X				
13. Review Plan G – No-charge Psychiatric Medication Program and the supporting policy framework, to ensure they are consistent.	X				
14. Ensure that eligibility criteria for Plan G – No-charge Psychiatric Medication Program are clear, and that eligibility is being assessed in accordance with the criteria.		X			
15. In its annual report, move toward reporting in a manner consistent with the British Columbia reporting principles on the performance of the PharmaCare program.	X				

(1) Although the Ministry reviews Health Insurance BC's reported performance measures, on a regular basis, related to the contract, and the ministry contracted with Deloitte to do Sys Trust audits–formal review has been postponed until year 5 or 6 in Maximus BC's 10-year contract—when the key legacy systems that support the Medical Services Plan and PharmaCare have been replaced.

Pharmaceutical Services Division

Progress on Implementing the Auditor General's Recommendations on *Managing PharmaCare*

April 2008
BC Ministry of Health
Victoria, British Columbia

BRITISH COLUMBIA
The Best Place on Earth

Table of Contents

1. Introduction

In March 2006, the Office of the Auditor General released a report reviewing how well the Ministry of Health manages the PharmaCare program in order to achieve its goal of operating a sustainable, evidence-based, prescription drug insurance program that improves the health of British Columbians. Overall, the report concluded that "progress toward cost-effective drug use and a sustainable PharmaCare program is being compromised by insufficient management attention."

The Pharmaceutical Services Division of the Ministry of Health appeared before the Select Standing Committee on Public Accounts on February 2, 2007, to address the points raised by the report.

On March 19, 2008, Pharmaceutical Services received a written request from the Office of the Auditor General to provide an update on the progress that has been made in implementing the Auditor General's recommendations since the February 2, 2007, presentation to the Select Standing Committee on Public Accounts.

The division is pleased to report that the past year has brought considerable progress on all of the recommendations made by the Auditor General.

During 2007/08, we took stock of our role in British Columbia's health care system to determine how we could more fully contribute to the Ministry of Health's vision of a 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. The result has been greater clarity in our goals and objectives and the development of clearly defined strategies to support accessible, sustainable, optimal drug therapy for all British Columbians.

We continued to build the capacity necessary to effectively manage the programs and services we deliver and to expand our role to encompass educational initiatives. Increased capacity also allowed us to move forward on many key projects, to undertake keen evaluations of the robustness of current programs and policies, and to examine the efficiency and effectiveness of internal processes.

Although we are pleased with the progress we have made, we recognize that careful planning and continued commitment will be necessary to maintain our momentum. In the year ahead, we will continue to implement our divisional plan and to critically evaluate our success in meeting our goals and specific performance targets.

2. Managing PharmaCare's Performance

Recommendation 1: ***Review PharmaCare's strategic objectives and make necessary adjustments to reflect current thinking.***

Status - Fully Implemented

The Pharmaceutical Services Division is responsible for developing programs to provide British Columbians with timely access to cost-effective and evidence-based drug therapy. Our vision is "pharmaceutical excellence for better health" and our mission is "to improve the health of British Columbians by advancing optimal drug therapy."

Pharmaceutical Services develops an annual Divisional Plan that aligns our strategies and objectives with the broader Ministry of Health goals. The objectives are designed to address both present and future challenges. Our 2007/08 Divisional Plan highlighted the strategic objectives which allowed us to support B.C. citizens to have the best possible health and the best pharmaceutical system in the world (see Appendices A and B for 2007/08 and 2008/09 Pharmaceutical Services Divisional Plans).

Pharmaceutical Services' first goal, *supporting citizens to have the best possible health*, is aligned with the ministry goal of *improved health and wellness for British Columbians*.

As outlined in our 2008/09 Divisional Plan, Pharmaceutical Services will achieve these goals through the following objectives:

- Patients understand the drug therapy benefits available to them
- Health professionals are able to provide appropriate professional advice to patients
- British Columbians have access to a comprehensive drug benefit program

Our second goal of *providing the best pharmaceutical system in the world* is aligned with the ministry goals of *high quality patient care* and *a sustainable, affordable, publicly funded health system*. We plan to achieve these goals through the following objectives:

- The best drug at the best price
- Improved patient care and safety
- Drug policies are fair, equitable, accountable, sustainable and meet the changing needs of British Columbians
- Effective stakeholder engagement
- Enhanced operational performance through continuous improvement
- Research and knowledge translation on health outcomes, drugs use optimization and pharmaceutical policy

Our third and last goal of *providing the best place to work, with the best people* includes the following objectives:

- Pharmaceutical Services Division has the human resources capacity to achieve its goals
- A supportive, professional working environment that promotes teamwork and celebrates success
- Effective administration and people processes

To develop the 2008/09 Divisional Plan and meet strategic objectives, Pharmaceutical Services staff and external stakeholders participated in planning and input sessions that aligned strategic objectives with current thinking. We held the following 12 meetings between September 2007 and February 2008.

Dates	Attendees	Purpose
September 26, 2007	Executive Directors & ADM (PSLT)	Review deliverables in 2007/08 Divisional Plan
October 12 & 15, 2007	All staff participated in ½ day sessions	Review 2007/08 Divisional Plan and provide feedback to be used in the development of 2008/09 Divisional Plan
October 31, 2007	PSLT, Directors and Managers	Debrief session on the Work Environment Survey
November 16, 2007	All PSD stakeholders, PSD Executive Directors and Directors	Multilateral Stakeholder meeting - input from external stakeholders included in the building of our 2008/09 Divisional Plan
November 13 & 21, 2007	All staff	Work Environment Survey Drill Down- input gathered and used in the development of 2008/09 Divisional Plan
Nov 22 & 23, 2007	PSLT, Directors and Managers	Met to develop 2008/09 Divisional Plan
December 10, 2007	PSLT	Reviewed/discussed next steps for development of 2008/09 Divisional Plan
January 18, 2008	PSLT, Directors and Managers	Further development of 2008/09 Divisional Plan
February 15, 2008	PSLT, Directors and Managers	Finalized 2008/09 Divisional Plan

Pharmaceutical Services also holds external bilateral and multilateral stakeholder engagement meetings to ensure that stakeholders' voices are heard during the strategic planning process and to ensure the Divisional Plan is communicated back to stakeholders. The multilateral engagement sessions are used to outline each year's Divisional Plan and incorporate feedback from these sessions into future strategic planning (see Appendix C for a list of stakeholders).

Pharmaceutical Services' management meets quarterly to review the division's objectives, to share progress on the supporting strategies from the branches, and to update the divisional plan.

Recommendation 2: ***Align PharmaCare strategic objectives with statements of actions that describe how the objectives are to be achieved.***

Status - Fully Implemented

The 2007/08 Pharmaceutical Services Divisional Plan linked the division's objectives to specific strategies and actions for achieving objectives. Each of the five branches (Drug Use Optimization; Drug Intelligence; Business Management, Supplier Relations and Systems; National Pharmaceuticals Strategy; and Policy Outcomes, Evaluation, and Research) has defined accountabilities and deliverables that are aligned with their strategic objectives. Further, our division has developed performance measures to evaluate effectiveness and ensure strategic objectives are being met. Each performance measure contains a description of activities/projects, accountability, deliverable/outcome measure, and target date for completion. Where appropriate, activities/projects are also incorporated into the Ministry's Corporate Calendar.

Please refer to Appendices A and B for the 2007/08 and 2008/09 Pharmaceutical Services divisional plans containing objectives and performance measures.

Recommendation 3: ***Determine the human resources needed to achieve the program's objectives and build capacity to meet those needs.***

Status - Substantially Implemented

In February of 2006, the ministry created the new Pharmaceutical Services Division and retained an Assistant Deputy Minister (ADM) whose sole responsibility is the management of pharmaceutical-related programs and initiatives including PharmaCare and the BC National Pharmaceuticals Strategy Secretariat. The division is divided into five branches: the National Pharmaceuticals Strategy; Drug Intelligence; Drug Use Optimization; Policy, Outcomes, Evaluation and Research; and Business Management, Supplier Relations and Systems.

The leadership component of the Pharmaceutical Services Division is in place, as each branch now has an Executive Director. Our division has a plan to build capacity (please refer to Appendix D for the division's Organizational Chart). Hiring is currently underway to build the capacity to accomplish our goals as outlined in our divisional plans (see Appendices A and B for our 2007/08 and 2008/09 divisional plans). To emphasize the importance of this recommendation our divisional plan contains an overarching goal "to build a foundation for sustainable growth."

As outlined in the Pharmaceutical Services 2007/08 Divisional Plan, our division's human resource objectives included the finalization of a staffing plan and development of a retention/succession plan. In our 2008/09 Divisional Plan, we commit to identify our staff and management needs for the next five years, identifying recruitment and retention plans, and determining succession options for the ADM and leadership team. Performance measures, such as a needs assessment and the production of space and succession plans, will ensure we meet our objectives.

As demonstrated by our divisional plan and organizational chart, Pharmaceutical Services has determined the human resource capacity required to achieve our program objectives and are actively building that capacity. Our division will have the human resource capacity to achieve program objectives by the end of fiscal year 2008/09.

Recommendation 4: ***Develop performance measures for, set targets for, and collect information to support the achievement of program objectives.***

Status - Fully Implemented

Pharmaceutical Services Division produced its first Annual Performance Report (the 2005 edition) in May 2007. The report outlines PharmaCare plans and utilization data, as well as divisional expenditures and branch-specific activities. As part of the strategic planning process, branch activities are part of performance measures that feed back to the overarching divisional strategic goals.

The 2006 Annual Performance Report has been completed and was released to the public on March 18, 2008.

For 2007, reporting will shift from calendar year to fiscal year and the 2007 Annual Performance Report will become the 2007/08 Annual Performance Report. The report is scheduled to be released in August 2008 and will include performance measures.

The Pharmaceutical Services 2007/08 Divisional Plan set performance measures for the first time as we moved toward formal evaluation of divisional objectives (Please see Appendix A). Performance measures met included the following:

Strategic Objectives	Performance Measures Met
Citizens are supported to have the best possible health	• Produced PharmaCare and Fair PharmaCare policy brochures. • Hired staff for Drug Use Optimization branch. • Participated in one health fair. • Implemented exclusion of Universal Child Care Benefits income when determining Fair PharmaCare assistance. • Completed PharmaCare Diabetes Policy Review. • Launched first Education for Quality Improvement of Patient Care program. • Vancouver Coastal Health Authority implemented Hospital Access to PharmaNet. • Expanded Drug Benefit Committee to include clinicians. • Implemented Alzheimer's Drug Therapy Initiative.
The best pharmaceutical system in the world	• Held 10 bilateral and 2 multilateral stakeholder sessions. • Actively engaged in development of Health Canada Progressive Licensing framework. • Collaborated with researchers on 3 projects that support research on evidence-based policy development and analysis. • Created drug formulary web page. • Actively partnered with Finance & Corporate Services Division in the development of the PSD budget.
The best place to work, with the best people	• Establish five branches of PSD. • Staffing plan developed and finalized. • Developed retention/succession plan. • Completed all Divisional Employee Performance and Development Plans. • Created training budget.

Pharmaceutical Services Division *Progress Report*

The Pharmaceutical Services 2008/09 Divisional Plan expanded our division's commitment to meet objectives by identifying robust performance measures to evaluate our progress. The following are samples of some of our program objectives and accompanying performance measures:

Strategic Objectives	Performance Measure
Public are supported to have the best possible health	• A formulary information website will be launched, with press releases and appropriate communications. • Wireless access pilot project for Hospital Access to PharmaNet will be completed. • Additional 500 physicians will be enrolled in Medical Practice Access to PharmaNet. • Representatives from PSD will attend one health fair per geographic region and garner a 70 per cent score on attendee evaluation surveys. • Fast Track Submission Review Process will be defined and established.
The best pharmaceutical system in the world	• PSD Drug Review Planning Team will be established to improve efficiencies of PSD drug review process. • 85 percent of drug reviews will be completed within time limits. • Conceptual framework for competitive tendering of multi-source drugs will be developed. • Stakeholder engagement strategy will be approved and implemented for fall multilateral. • Will collaborate with researchers (academic, university) on pharmaceutical outcomes and path finding research for new policies
The best place to work with the best people	• Terms of reference and membership will be established for PSD Healthy Workplace Committee. • Each staff will have completed a minimum of two to three days of personal development/training • Supervisory level management scores on Workplace Survey increased over April 2007 survey.

Please refer to Appendix B for further details on 2008/09 program objectives and accompanying performance measures.

Recommendation 5: ***Work with the College of Pharmacists and others to move custodianship of PharmaNet information to the ministry, and provide timely access.***

Status - Partially Implemented

PharmaNet has been operational for 13 years under the authority of the *Pharmacists, Pharmacy Operations, and Drug Scheduling Act (PPOD*SA*)*. Under the PPODSA, access to PharmaNet data is governed by the College of Pharmacists of British Columbia. Each request for information must be individually submitted to and evaluated by the College's PharmaNet Committee.

On average, the PharmaNet Committee's turnaround time for reviews and decisions on access to PharmaNet data requests is 30-90 days. This average time is based on the assumption that the researcher is seeking access to PharmaNet data only.

Academic requests for data contained in the BC Linked Health Database (BCLHD) must be submitted to the ministry's Data Access, Research, and Stewardship unit (DARS). Academic requests for PharmaNet data must be submitted to the College of Pharmacists of British Columbia. The team has also resolved the majority of the backlog in academic data requests, while the implementation of a project-tracking website where researchers can monitor the processing of their data requests has proved highly successful. This tracking tool is accessible on the ministry website: www.health.gov.bc.ca/das/research/index.html. The DARS team has also strengthened its working relationship with the Center of Health Services and Policy Research, and the BC research community more generally.

With respect to the transfer of custodianship of PharmaNet information to the ministry, Legislation (Bill 82) to repeal and replace PPODSA with the new *Pharmacy Operations and Drug Scheduling Act* (PODSA) received third reading by the B.C. Legislature in the fall of 2003. Under the new PODSA, a "PharmaNet Stewardship Committee" of the ministry will replace the PharmaNet Committee. It will have the same mandate of managing access to the PharmaNet database for the purposes of scientific, health service delivery or drug use research conducted at a university or hospital and health policy research, planning or evaluation related to drug use, PharmaCare or health service delivery.

As the Pharmaceutical Services Division moves toward establishing a ministry "PharmaNet Stewardship Committee," we will continue to work with the PharmaNet Committee to ensure that access to health data is provided in a timely fashion.

This legislation has not yet been brought into force pending the re-designation of pharmacists from PPODSA to the *Health Professions Act*. The legislation will come into force once the College of Pharmacists of BC has the appropriate Bylaws approved and included in the Health Professions Act. This is anticipated to take place in winter of 2008.

Work has also begun on the PharmaNet Access Regulation required for PODSA. Pharmaceutical Services is working with the College of Pharmacists of British Columbia and the Ministry of Health's Strategic Policy, Legislation and Intergovernmental Relations Division to ensure the Bylaws and the PPODS to PODSA transition project continue to progress.

Bill 24, introduced in the House on April 10, 2008, provides a mechanism for health researchers, based on a case-by-case basis with the approval of the Privacy Commissioner, to contact individuals to request their participation in health research studies. Bill 24 also harmonizes the PharmaNet privacy and access provisions with the Health and Personal Information Access and Protection of Privacy Act.

Pharmaceutical Services values research and innovation in B.C. and is committed to ensuring continued access to appropriate health data for the advancement of research and innovation that will improve health outcomes for British Columbians.

Recommendation 6: ***Formally evaluate the MAXIMUS BC contract on a regular basis, to determine its effectiveness.***

Status - Fully Implemented

The ministry reviews the performance of Health Insurance BC (HIBC) monthly and HIBC reports quarterly on key service areas to the public. These reports are placed on the joint Ministry of Health / HIBC website and satisfy the transparency requirements set out by the Alternative Service Delivery Secretariat.

The established service level requirements (SLRs) monitor performance in a number of functional areas that are critical to service delivery for the public and health care providers including: answering calls timely and accurately; processing enrolment, premium assistance applications and account maintenance requests in a timely manner; processing claims and provider requests in a timely manner; and, maintaining technology that supports health care providers in a timely manner.

The July, August, September 2007 quarterly report from HIBC indicates that HIBC met or exceeded all 27 SLRs in this quarter (see Appendix E for details).

HIBC processed the vast majority of public documents within the service level standard since the end of November 2005; answered telephone calls from the public, on average, within less than three minutes for two years straight; and answered telephone calls from service providers, such as doctors and pharmacists, on average within less than one minute, for 25 months straight.

The ministry has provided all relevant documentation to the Office of the Auditor General (OAG), and has met with the Auditor General's staff on several occasions over the past few years, to keep the office apprised of the contract's progress and governance/contract management activities. The ministry has also engaged Deloitte to conduct SysTrust audits and that engagement was expanded in early 2006 to provide the OAG with opinions in regard to financial controls and their operation within HIBC. This is a ten-year contract and the first few years are consumed with change. As MAXIMUS BC undergoes its transformational activities (replacing key legacy systems that support the Medical Services Plan and PharmaCare), it is contemplated that an effectiveness, or value-for-money audit, would not be practical until later in the term of the contract (i.e. year 5 or 6). The ministry will continue to cooperate with the OAG on any audits planned for this contract.

3. Selecting Drugs for Coverage and Managing Their Cost

Recommendation 7: ***Review internal procedures for assessing the cost-effectiveness of new drugs to identify and implement ways to streamline the assessment process, including consideration of a fast-track process.***

Status - Substantially Implemented

Pharmaceutical Services is responsible for developing programs to provide British Columbians with timely access to cost-effective and evidence-based drug therapy. Our goals, objectives and strategies support accessible, sustainable and optimal drug therapy for all British Columbians.

Assessing Cost-Effectiveness of New Drugs

The assessment of cost-effectiveness of new drugs occurs at several levels within the drug review process used by our division.

Common Drug Review (CDR)

- After a new drug has been approved for sale in Canada by the federal government, the manufacturers can apply to the Common Drug Review if they wish to have the drug considered for listing under federal/provincial/territorial drug plans.
- The CDR recommendation is an important and valued addition to the information that we consider when making drug coverage decisions.
- The CDR process includes a cost-effectiveness check consisting of an assessment of the manufacturer's pharmacoeconomic analysis. The CDR process uses this pharmacoeconomic review along with the clinical review when making common formulary recommendations to the participating drug plans.

Pharmaceutical Services Division Review

- Drug submissions forwarded to our division for review undergo assessment of cost effectiveness at two levels:
    - The external Drug Benefit Committee membership includes a health economist who provides cost-effectiveness assessment on drug submissions under review.
    - Internally, Pharmaceutical Services economists review cost-effectiveness of new drugs from a Budget Impact Analysis perspective.
    - Pharmaceutical Services Division has and will continue to obtain additional cost-effectiveness evaluations as needed.

There are limitations to cost-effectiveness assessments of new drugs as they are commonly based upon clinical trial efficacy data (data collected in a research environment). Notwithstanding, assessment of cost-effectiveness of existing drugs is also challenging as 'real world' safety and effectiveness data that includes patient outcomes data may not be readily available. To overcome these challenges, the Pharmaceutical Services Division may make drug coverage decisions but conduct parallel research evaluations to collect additional outcomes data for cost-effectiveness assessments (also known as coverage with evidence development—see Status Update for Recommendation 8).

Improving the Efficiency of the Drug Review Process:

Capacity and Structure Improvements

The Pharmaceutical Services Division completed the following enhancements to address the capacity and structure required to improve the efficiency of the drug review process:

- With an interest in enhancing the transparency of formulary decisions, we recently expanded the membership of the Drug Benefit Committee to include more robust representation and include members with expertise in general medical practice, medical specialties, geriatrics, medical ethics, clinical pharmacy/pharmacology, critical appraisal, and health economics.
- We have expanded the Formulary Management area of the PharmaCare website to inform the public of our drug coverage decisions and the status of drug reviews. Please see www.healthservices.gov.bc.ca/pharme/formulary/index.html

In 2008/09, our division will complete the following enhancements to address the capacity and structure required to further improve the efficiency of the drug review process:

- Increase capacity within the Drug Intelligence branch
- Establish public representation on the Drug Benefit Committee.
- Expand the website information in 2008 to include the Drug Benefit Committee recommendations and reasons for recommendation and more detailed information on the formulary review process.
- Develop a Formulary Management Drug Review Database in 2008 to track documents and correspondence, track submission review status, and establish performance measures.

Process Improvements

In 2008/09, Pharmaceutical Services Division will make the following process enhancements to improve the efficiency:

- Establish a fast track capability in the drug review process in 2008. While the ultimate goal is to ensure the quality and comprehensive review of drug submissions, those that meet the criteria for a fast track review will move through the process at a more rapid pace.
- To improve the transparency and timeliness of drug listing decisions, our division will establish target review timelines in 2008 for drug submission and performance review assessment of these target timelines.
- To ensure that in-depth evidence-based consideration is behind every PharmaCare listing decision, our division will establish and publish a clear set of requirements for clinician-submitted drug listing requests.
- Establish a quality improvement framework for Special Authority program.

Pharmaceutical Services continues to improve its drug review efficiency, as is evidenced by some trends of our drug review decisions.

Submission Type	January 1, 2004 to January 31, 2007	February 1, 2007 to March 31, 2008	Percent Change (based on avg. decisions per month)
CDR Submissions	35 decisions (avg. 1 per month)	18 decisions (avg. 1.3 per month)	+30 percent
Non-CDR Submissions	80 decisions (avg. 2.2 per month)	43 decisions (avg. 3.1 per month)	+41 percent

Recommendation 8: ***Put in place a process to systematically assess the cost-effectiveness of existing drugs in the formulary.***

Status - Partially Implemented

The cost-effectiveness of drugs should be assessed strategically on a targeted basis to ensure appropriate use of the resources required to conduct this necessary but intensive work. To identify priority areas for review, Pharmaceutical Services currently utilize various sources including therapeutic guideline development bodies (such as the Guidelines and Protocols Advisory Committee and the Canadian Optimal Medication Prescribing and Utilization Service) and health technology assessment groups (Health Technology Assessment and Drug Effectiveness Review Project). We also obtain feedback from clinicians, B.C. research groups, professional health associations, pharmaceutical industry, patients and the public.

The 2008/09 Divisional Plan includes the development and implementation of a process to systematically assess the cost-effectiveness of existing drugs on the formulary through a quality assurance framework for the Special Authority program. The Special Authority program currently adjudicates coverage requests for approximately 125 limited coverage drugs. One of the objectives of the quality assurance framework is to develop screening tools to help identify target drugs for further cost-effectiveness assessment. Screening tools may be based on various parameters including high-expense drugs, high-growth drugs, drugs with lower quality of scientific evidence, drugs with evolving clinical data, and/or drugs with identified safety concerns. These screening tools can also be applied to other PharmaCare drugs besides those in the Special Authority program.

Once a target drug or drug class has been identified, the cost-effectiveness evaluation can take the form of a drug class (therapeutic) review or a research-based review.

For drug class (therapeutic) reviews, a cost-effectiveness assessment involves assessing several medications used to treat a particular health condition. The assessment involves critically appraising the clinical evidence, reviewing practice guidelines, soliciting stakeholder input, and reviewing our existing drug policy. Often, reviews of existing drugs may be conducted in parallel to an evaluation of a new drug used for the same disease. An example of a recently completed (March 2008) review was a drug class (therapeutic) review of hepatitis B drugs.

Pharmaceutical Services Division is also conducting research-based reviews, some of which include providing benefit coverage while the clinical data is being collected (coverage with

evidence development). Examples of research-based reviews include: Alzheimer's Drug Therapy Initiative, biologic products for rheumatoid diseases, clopidogrel following cardiac stent placement, and the glitazone medications for diabetes.

Our division is also preparing to participate in Real World Safety and Effectiveness initiatives including those that are expected to come out of the National Pharmaceuticals Strategy. Pragmatic evaluations of academic detailing and other educational programs are being designed to include a cost-effectiveness component.

Whenever possible, sufficient scientific rigour will be employed to show impacts on health outcomes, cost, and cost-effectiveness. These assessments will then be used to inform policy decision-making and guide educational initiatives, to ensure optimal and cost-effective drug utilization.

Recommendation 9: ***Explore and implement ways to ensure best prices are paid for drugs by the province.***

Status - Substantially Implemented

In the past year, the Business Management, Supplier Relations and Systems branch within Pharmaceutical Services has been established and the Executive Director hired. This branch has primary responsibility for negotiations and other commercial initiatives to ensure that the Province obtains the best possible value for the drug, supplies and services subsidized by the PharmaCare program.

As a central element of the Pharmaceutical Services Division's strategy to deliver on the above objective, we are actively negotiating with pharmaceutical companies to moderate the cost of new patented drugs submitted for inclusion on the PharmaCare formulary. Increasingly, we have achieved success in obtaining added value from manufacturers as a condition for listing new products. While the nature of the value delivered through such agreements varies by product, negotiated benefits include rebates, expenditure caps and other risk-sharing mechanisms, and funding for costs associated the administration of specific drugs. Expressed as a consolidated figure including cost savings, cost avoidance and other added value, the estimated net value accruing to the Province from executed listing agreements[1] is as follows:

Year	Total Estimated Value
2006/07	$658,000
2007/08	$4,315,000
2008/09 *	$12,866,000

* projected net value accruing from agreements concluded to March 31, 2008

Working within the parameters of expert clinical guidance delivered by the Common Drug Review and the Drug Benefit Committee, Pharmaceutical Services will continue to pursue product listing agreements as a critical cost management tool. In 2008/09 and ongoing, with

[1] Including all payments received from vendors, the gross revenues generated from PLAs are as follows:
2007/08 $7,984,000
2008/09 $18,776,000

added capacity within the Business Management branch, we expect to advance an increasingly assertive position in discussions with manufacturers.

Complementing our division's efforts to obtain optimal value for expenditures on patented medicines, we are also evaluating strategies to manage the significant cost of multi-source drugs (i.e. generics). Competitive tendering is a mechanism that has been utilized effectively in other jurisdictions and has been the subject of detailed consideration by Pharmaceutical Services. To test this approach in the B.C. context, we issued a Request for Proposals (RFP) for the supply of olanzapine, a high-cost psychiatric drug, for PharmaCare beneficiaries. The RFP was issued in December 2007 to the two Canadian suppliers licensed to market olanzapine and offered exclusive access to the formulary for the proponent offering to supply olanzapine at the lowest net cost to PharmaCare. The projected savings generated through this RFP are included in the above-referenced total.

Incorporating the experience gained from this initial case, preparations are underway for the expanded implementation of competitive tendering as a tool to reduce the cost of multi-source products.

In developing Pharmaceutical Services Division's cost management strategies, we are diligently investigating experience from other jurisdictions which may be transferable to the B.C. market. Of note, two of the division's executives traveled to Australia and New Zealand in March 2007, to meet with senior officials responsible for the administration and oversight of those nations' respective pharmaceutical benefit systems. Both countries are considered global leaders in the delivery of cost-effective public drug coverage for their citizens. In particular, we established a strong, collaborative relationship with New Zealand's Pharmaceutical Management Agency, PHARMAC, including an agreement for the exchange of key personnel. Pursuant to that agreement, a senior PHARMAC representative recently concluded a three-month secondment to our division during which he provided invaluable insight regarding PHARMAC's strategy and operations.

With respect to other Canadian jurisdictions, our division is engaged in ongoing dialogue with drug plan managers from other provinces and continues to investigate the potential for two or more jurisdictions to benefit from the joint exercise of leverage in the pharmaceutical market.

In the 2008/09, our division will complete its cost management strategies framework and execute a pricing strategy.

4. Monitoring Drug Use and Encouraging Cost-Effective Prescribing

Recommendation 10: ***Use PharmaNet information to identify trends in prescribing practices and to inform physicians about their own prescribing practices and the projected results had currently recognized clinical best practices been followed.***

Status - Substantially Implemented

All three components of this recommendation are being accomplished by a new program called Education for Quality Improvement of Patient Care (EQIP):

1) EQIP uses PharmaNet information to identify trends in prescribing practices that can be improved.
2) EQIP informs physicians about their own prescribing practices by means of *confidential* prescribing portraits that they can choose not to receive.
3) EQIP makes projections concerning what would result if recognized clinical best practices were followed, and the confidential portraits include concise statements of evidence juxtaposed with data showing the prescriber's adherence or non-adherence to best practices.

EQIP is funded by Pharmaceutical Services as a joint initiative of the BC Ministry of Health, the BC Medical Association and the University of British Columbia Faculty of Medicine's Division of Continuing Professional Development and Knowledge Translation (please refer to Appendix F for a draft copy of EQIP's Annual Report).

EQIP is launching its first program in Spring 2008, and plans one other educational topic for 2008/09.

Pharmaceutical Services Division is also working with the College of Pharmacists of BC on research concerning pharmaceutical services delivery by electronic mechanisms. This collaboration will involve monitoring trends in electronic prescribing and electronic forms such as Special Authority, informing physicians of these trends and measuring and projecting their impacts on outcomes.

Pharmaceutical Services Division *Progress Report*

Recommendation 11: ***Significantly increase support for PharmaCare-sponsored programs that encourage appropriate drug use through physician best practices in prescribing (such as Therapeutics Initiative Letters, physician access to PharmaNet, and the academic drug detailing program).***

Status - Fully Implemented

Pharmaceutical Services has created the Drug Use Optimization branch that is responsible for educating prescribers, other health care professionals, patients, and the public on the appropriate use of medications to achieve improved health outcomes in a fiscally responsible manner. It is expected that this branch will have great effect on the demand side of drug utilization in B.C.

The Education for Quality Improvement of Patient Care (EQIP) program described above contributes to the fulfillment of this recommendation as well, since not only is PharmaNet data being used to increase awareness of physicans, prescribing trends, but the program also distributes educational messages to assist with moving towards best prescribing practices.

Pharmaceutical Services recently launched a state-of-the-art "coverage with evidence development" initiative for Alzheimer's medications through the Alzheimer's Drug Therapy Initiative. This initiative unites best practices in drug policy, education, and access for the people of B.C.

The division has recently established a Provincial Academic Detailing program. Academic detailing is an effective means of impacting prescribing behaviour and has received strong endorsement from the BC Medical Association policy report (*A Prescription for Quality: Improving Prescription Drug Policy in B.C.*) and the Health Council Safe and Sound Optimizing Prescribing Behaviours symposium and report.

Under the newly launched Provincial Academic Detailing program, a pharmacist or other health professional will visit physicians and offer one-on-one, evidence-based education through face-to-face and virtual meetings. The Province's investment in the new detailing program will establish such services across British Columbia at a cost of approximately $2.25 million annually for five years. Program funding will be provided to regional health authorities for 10 full-time pharmacists in total, and will support personnel and equipment in visiting up to 2,000 practitioners throughout the province. Selected pharmacists have already participated in a 3.5-day workshop held in March 2008, to learn how to provide academic detailing services. Next steps include signing partnership agreements with health authorities to facilitate service delivery throughout the province. The program is planned to start in early summer.

To reach more physicians and areas of the province, there are plans for collaboration with UBC Continuing Professional Development and Knowledge Translation to offer technology-enabled academic detailing as part of the provincial program.

Pharmaceutical Services continues to actively participate in Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) initiatives. COMPUS, one of three core programs under the Canadian Agency for Drugs and Technologies in Health, is a collaborative, pan-Canadian program funded by Health Canada with a mandate to identify and promote optimal drug prescribing and utilization through provision of strategies, tools, and services that encourage the use of evidence-based clinical and cost-effectiveness information in decision

making among health care providers and consumers such that medication use is optimized and health outcomes are improved. COMPUS contributes to the quality and effectiveness of the Canadian health care system by providing a collaborative national approach, creating efficiencies, reducing duplication of effort and coordinating and building on existing jurisdictional initiatives.

The first evidence-based topic on proton pump inhibitors has been released with a tool kit of educational resources. These are currently being analyzed and adapted to the B.C. context so that they can be used as part of a coordinated educational launch, the impacts of which can be evaluated. Work on the second evidence-based topic, diabetes, is underway. As part of the COMPUS Advisory Committee, Pharmaceutical Services Division is also influencing plans to educate Canadians regarding awareness of context including issues such as: How are coverage decisions made? What does cost-effective mean to tax payers? What does investing in health outcomes mean?

The Therapeutics Initiative continues to be a source of rigorous evaluation of the evidence and supports the Drug Benefit Committee (DBC). The Therapeutics Initiative continues to release its newsletter, offer its annual conference, and improve its website. The group is also working together with the e-Drug initiative to make drug prices available to prescribers. An IMS[2] report recently covered in the media states that physician knowledge of drug prices can have a profound impact on their choices and thereby on overall drug expenditures.

In collaboration with the College of Physicians and Surgeons of BC, the College of Pharmacists of BC, the eDrug project has expanded access to patient medication profiles by providing PharmaNet access to authorized health professionals working in physician private practices and clinics as well as hospitals and designated mental health facilities. Both these services are stepping stones to the provincial Electronic Health Record (EHR).

In January 2006, access to medication profiles was made available to physicians from their medical offices. To date, more than 1650 physicians at over 650 individual medical practices have registered for this service. A survey of physicians using this service indicated that having access to PharmaNet does provide clinical value to physicians in their medical practices by providing point of care access to all drugs that have been dispensed to a patient.

In January 2008, Hospital Access to PharmaNet service was made available. Timing for implementing this new service will vary based on the priorities and plans of each B.C. health authority or facility. Both Vancouver Island Health Authority and Vancouver Coastal Health have started deploying the service, with 14 locations using it so far and over 350 physicians registered for the service. Hospital Access to PharmaNet assists the physicians of the province by streamlining the medication reconciliation process and reducing both the time to determine each patient's current drug treatment and the need to call community pharmacies for medication clarification, all of which improves patient safety and care.

[2] IMS is a provider of business intelligence and strategic consulting services for the pharmaceutical and healthcare industries.

Recommendation 12: ***Support greater involvement of physicians in developing actions to promote appropriate drug use.***

Status - Fully Implemented

Pharmaceutical Services has always recognized the value of physician knowledge and input into many aspects of the drug review process and Special Authority program. We recently expanded the membership of the Drug Benefit Committee to include more robust representation of physician members. The Drug Benefit Committee makes recommendations on new drug listing submissions and advises on other drug policy matters to encourage the appropriate use of medicines in B.C.

Physician expert consultants and physicians on Pharmaceutical Services Division's Special Authority adjudication committees are essential resources for the development of our Special Authority forms and criteria which also help promote appropriate drug use. The physician specialists who make up the membership of the various Drug Benefit Adjudication Committees (rheumatoid arthritis, Crohn's disease, hepatitis and Alzheimer's disease) help adjudicate Special Authority requests that fall outside of the established use criteria.

Pharmaceutical Services is working with groups such as the BC Medical Association and the Division of Continuing Professional Development and Knowledge Translation of the UBC Faculty of Medicine. EQIP, described earlier, is a joint initiative between the aforementioned groups that is poised to release its first mailing, with two more topics ready in the queue.

We will also be collaborating with the Division of Continuing Professional Development and Knowledge Translation on a project funded by the Canadian Institutes of Health Research. This project will integrate physicians, knowledge brokers and information technology in order to improve the frequency and quality of adverse reaction (AR) reporting by physicians. The collaboration will explore ways to optimize the utility of such reports, as well as physician engagement. It will facilitate the incorporation of AR reporting into physicians' daily workflow– a process that should ultimately lead to improved patient safety.

Pharmaceutical Services continues to work with the Guidelines and Protocols Advisory Committee (GPAC), co-chaired by the BCMA, as well as its working groups. The working groups are largely made up of practicing physicians. We collaborate to ensure that evidence-based, best practice GPAC guidelines are aligned with Pharmaceutical Services' policy.

The Provincial Academic Detailing program is engaging physicians. Members of the EQIP working group, including BCMA representatives and practicing family physicians, have agreed to form the core advisory body to the program. With the addition of Health Authority representation, this group will be well-placed to facilitate stakeholder input and assist with topic selection. In addition, provincial and regional specialists will be approached to comment on and endorse educational materials.

Pharmaceutical Services Division *Progress Report*

Through the Alzheimer's Drug Therapy Initiative, Pharmaceutical Services is working with clinical specialists, general practitioners and the University of British Columbia's Division of Continuing Medical Education and Knowledge Transfer to develop and introduce a comprehensive province-wide dementia education program for family physicians and general practitioners. Through this initiative we plan to help physicians and other health professionals achieve optimal care for patients suffering from dementia, including the appropriate use of dementia medications.

Pharmaceutical Services values the input from the BC Medical Association, including their recent policy paper entitled *A Prescription for Quality: Improving Prescription Drug Policy in B.C.*, as well as contributions at bilateral and multilateral stakeholder meetings.

5. Ensuring Eligibility of Insured Persons

Recommendation 13: ***Review Plan G – No-Charge Psychiatric Medication Plan and the supporting policy framework, to ensure they are consistent.***

Status - Fully Implemented

A full review of Plan G (No-Charge Psychiatric Medication Plan) has been completed. As a result of the review, the policy has been revised, in collaboration with the Internal Audit and Advisory Services of the Office of the Comptroller General, to address both the issues and recommendations raised by the Auditor General, as well as gaps identified during the review. The revised program policy ensures that procedures are both accountable and auditable, and are aligned and consistent with the policy framework. The report also included extensive input from stakeholders (e.g., Mental Health Services Centres).

Recommendation 14: ***Ensure that eligibility criteria for Plan G – No-Charge Psychiatric Medication Program are clear, and that eligibility is being assessed in accordance with the criteria.***

Status - Substantially Implemented

As a result of the completed review of the Plan G—No-Charge Psychiatric Medication Plan, revised policy now clearly states financial and clinical eligibility criteria, which can be summarized as follows:

Clinical Criteria: To be eligible for Plan G, the client;

1. must have been hospitalized for a psychiatric condition

   OR

2. without the medication the client is likely to require hospitalization

   OR

3. Other serious consequences are very likely (e.g. unemployment, child neglect, etc.)

Financial Criteria: In addition to the clinical criteria, the client;

1. must sign an application form to declare that the cost of the prescribed psychiatric medication(s) is a barrier to treatment and that they have no other financial coverage

   AND

2. must have an annual family net income of $37,500 or less (the amount reported on Line 236 of their income tax return less the amount of any Universal Child Care Benefit payments received).

Exception Criteria: For clients not meeting the financial criteria, exception criteria has been established and may be applied at the discretion of the Mental Health Service Centre (MHSC) based on specified clinical or circumstantial conditions.

To ensure continued coverage while eligible, the client must complete the Fair PharmaCare registration process before or within 90 days after applying for Plan G.

Eligibility is presently being assessed against these criteria as follows:

1. An application form must be completed and signed by a physician or psychiatrist certifying the client's clinical eligibility.
2. Upon receipt of the signed clinical eligibility certification, the Mental Health Service Centre is responsible for determining if the client meets the financial criteria by contacting Health Insurance British Columbia (HIBC) to confirm MSP premium assistance eligibility. A telephone line has been established for this purpose.

System and process improvements are underway to strengthen Plan G eligibility assessment by removing the dependence on MSP Premium Assistance data, the associated manual processes, and the current legacy system.

Business analysis for these improvements is complete, providing for a new process, broadly summarized as follows:

1. An application form must be completed and signed by a physician or psychiatrist certifying the client's clinical eligibility (no change)
2. Upon receipt of the signed clinical eligibility certification, the Mental Health Service Centre will enter a request for Plan G eligibility into a patient management system.
3. The Patient Management System will transmit a request for Plan G coverage to an HIBC computer application that will assess financial eligibility based on the client's Fair PharmaCare eligibility derived from CRA income data. If the client is found to meet the financial criteria, Plan G coverage will be established on the PharmaNet system. If the client does not meet the financial criteria, the request for coverage will be declined.
4. Temporary eligibility will be established for clients who have not completed Fair PharmaCare registration (90 days).
5. Requests for Plan G coverage based on exception criteria will be accepted in all cases.
6. All requests for Plan G coverage will be recorded in a database for reporting purposes.
7. MHSC patient management systems will periodically produce a report on clients whose eligibility is due to expire.

The business design for the new process is provided as an addendum to this document (please refer to Appendix G). However, the system to implement the revised policy is not yet in place.

The desired timing for the new system development runs concurrent with the timelines established for PharmaNet-eRx implementation. This adds a significant degree of complexity to both the technical and planning aspects of this initiative. However, Maximus BC Health Inc., the

Ministry's outsourced business partner, is currently exploring technical design options for the new process, and plans for development and implementation phases have been established as follows:

From time of writing:

Near Term (4-6 months)

- Develop Technical Design for existing PharmaNet architecture solution
- Refine cost estimates and work plans accordingly
- Analyse PharmaNet-eRx Architectural, Implementation and Resourcing Impacts
- Explore alternate technical solutions

Medium Term (6-9 months)

- Develop detailed implementation plan
    - Deliverables
    - Infrastructure
    - Business Implementation
- Start development

Pharmaceutical Services continues to meet regularly with our outsourced partner on this systems project and is actively monitoring progress to ensure completion in the shortest timeframe possible, given the system coordination complexities. We will complete this project in 2008/09.

6. Reporting to the Legislative Assembly and the Public

Recommendation 15: ***In its annual report, move toward reporting in a manner consistent with the British Columbia reporting principles on the performance of the PharmaCare program.***

Status - Fully Implemented

Since the Auditor General's report, we have released two Annual Performance Reports.

The **Annual Performance Report for 2005** was released in May 2007. The report provided PharmaCare usage data, divisional expenditures, and highlighted specific activities and accomplishments (please refer to Appendix H for a copy of the 2005 Annual Performance Report).

The **Annual Performance Report for 2006** was released on March 18, 2008. Although the Pharmaceutical Services Division was established in February 2006 and had not had the opportunity to develop a full strategic plan with accompanying performance measures, the 2006 report complied with many of the reporting principles: it clearly explained the public purpose the division serves (reporting principle #1); linked goals and results in so far as it defined what we intend to achieve in the future and what we actually achieved during the year (principle #2); and focused on selected key aspects of its performance (principle #3). The information presented is credible and fairly interpreted (principle #7). The financial information and other data were supported by information on the limitations and considerations necessary to understand the information (principle #8). The report clearly communicated the structure and intent of the new division, defining the specific role that the division's five branches will play in meeting ministry and divisional priorities in the future (please refer to Appendix I for a copy of the 2006 Annual Performance Report).

For 2007, reporting will shift from calendar to fiscal year. **The Annual Performance Report for 2007/08** is scheduled for release in August 2008 and, by using the divisional plan and accompanying performance measures as its foundation, the report will adhere to all eight reporting principles.

Section 7

Update on the implementation of recommendations from:

The Child and Youth Mental Health Plan: A Promising Start to an Urgent Need –

June 2007

October 2008

September 3, 2008 Ref: 176842

John Doyle
Auditor General
Office of the Auditor General
of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Mr. Doyle:

I am pleased to provide the progress report on implementation of the recommendations within *The Child and Youth Mental Health Plan: A Promising Start to an Urgent Need.* The ministry continues to make progress on these recommendations, with many of them being substantially or fully completed.

The Ministry of Children and Family Development's *Strong, Safe and Supported: Operational Plan* which was developed in 2008 will guide increased effectiveness, efficiency and accountability for supports and services for children, youth and their families served by the ministry. In addition, the ministry has appointed an Assistant Deputy Minister for Quality Assurance who will lead regular internal and external evaluations to ensure that minimum standards are met and sustained. The ongoing delivery of evidence-based training, including Dual Diagnosis (mental disorder and developmental disorder) training, is moving us closer to ensuring that evidence-based practice is implemented across the regions. The FRIENDS program continues to be well received in school districts. Recent consultations with school districts will assist the ministry to better understand key factors that influence the uptake and sustainability of FRIENDS in school districts, and an action plan will be developed by September 30, 2008.

The Child and Youth Mental Health Plan for BC Progress Report was announced by the Minister on May 20, 2008, and this information is now available to the public. The ministry has recently completed the consultation on the review of the Child and Youth Mental Health (CYMH) Plan, and the report will be completed by Fall 2008. The review includes surveys, focus groups, and individual interviews with key stakeholders. This review will identify how the CYMH Plan has impacted the mental health service system in serving Aboriginal and non-Aboriginal children and youth and their families. It will also identify remaining gaps in mental health programs and services, and will recommend next steps in order to continue to build on the work already accomplished through the plan.

…/2

The ministry remains committed to working collaboratively with our partners to realize the common goal of improved mental health outcomes and optimum opportunities for healthy development for children and youth in British Columbia.

Sincerely,
ORIGINAL SIGNED BY
Lesley du Toit
Deputy Minister

Enclosures (2)

fc: Correspondence Management
ADM's Office, Integrated Policy and Legislation
Executive Director, Child, Youth and Family Policy
Director, Child and Youth Mental Health

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION

The Child and Youth Mental Health Plan: A Promising Start to Meeting and Urgent Need

As at June 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Self-Assessed Implementation Status				
	Fully	**Substantially**	**Partially**	**Alternative Action**	**No Action**
Child and Youth Mental Health Plan					
1. The ministry ensure that clinical staff clearly understands the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder to ensure a consistent approach across the province.	X				
Organization Changes to Integrate Services					
2. The ministry: • Ensure that adequate accountability mechanisms continue to exist between the ministry's regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation	X				
• Ensure that there continues to be a strong ministry leadership for child and youth mental health services;	X				
• Address stakeholder concerns about the reorganization; and		X			
• Begin forming new strategies that will build on the accomplishments achieved under the province's first Child and Youth Mental Health plan			X		
Coordinated Approaches On All Levels to Address Deficiencies					
3. The ministry develop a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians.			X		

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Auditor General's Recommendations	Self-Assessed Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
Planning and Monitoring Implementation					
The ministry: 4. To improve implementation of the initiatives, we recommend the ministry: • Ensure that all clinicians receive core, evidence-based practices training, that clinical supervisors consistently review staff application of the concepts, and that evidence-based practice parameters be integrated into services;		X			
• Develop school-based FRIENDS champions in under-represented regions, develop strategies to mitigate key risks and establish mechanisms to monitor penetration of the program throughout the province; and		X			
• Take steps to increase staff acceptance of the Brief Child and Family Phone Interview clinical intake screening tool.			X		
Reporting to the Legislative Assembly and the Public					
The ministry: 5. To improve accountability for the Child and Youth Mental Health Plan, we recommend the ministry: • Report to the Legislative Assembly and the public on the plan's implementation progress; and	X				
• Develop an approved accountability framework capable of evaluating the plan's impact on patient outcomes			X		

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

***The Child and Youth Mental Health Plan: A Promising Start to Meeting and Urgent Need* at July 2008**

(Please provide the information noted below)

Cover Letter:

This should include a signed representation that the enclosed self-assessment has been reviewed and approved by the Deputy Minister or equivalent.

General comments about progress since the report release June 2007: *(one to two paragraphss)*

Progress on each Recommendation

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
The Child and Youth Mental Health Plan			
Recommendation 1: The ministry ensures that clinical staff clearly understands the ministry's policy on treating patients with both a mental disorder and a developmental or learning disorder to ensure a consistent approach across the province. ***Actions taken at June 2007:*** *The ministry's Expert Table on Dual Diagnosis (mental and developmental disorders) recommended providing training to better equip CYMH staff to work with children and youth with co-occurring mental illness and disabilities and their families, and to improve collaboration with other professionals. This training will contribute to clearer policy direction on providing services to this population and build capacity to do so. Curriculum is currently under development.* ***Actions planned:*** *Training in the area of dual diagnosis is planned for Spring of 2008.*	• Dual Diagnosis (DD) training was delivered in March 2008. • Group clinical consultation through videoconference is being planned for early 2009.	• Staff who participated in the DD training enhanced their knowledge and skills, which will be shared with local teams. • Improved expertise in DD throughout the province has strengthened community capacity to work effectively with children and youth	F S

[1] F or S – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
Organization Changes to Integrate Services			
Recommendation 2.1: The ministry ensures that adequate accountability mechanisms continue to exist between the ministry's regional operations and the provincial office so that plan objectives remain a priority, at least during the final year of implementation. ***Actions taken at June 2007:*** *Each region submits a monthly status report in any circumstance when the region has made a decision to vary or change the approved CYMH plan. Currently, these reports are reviewed by both the CYMH policy area and the Regional Support Secretariat.* ***Actions planned:*** *The ministry is currently developing a Quality Assurance Framework which will be presented to the MCFD Leadership Team by the end of June 2007. Specific outcomes for children and youth receiving mental health services will be included.*	• The Ministry of Children and Family Development (MCFD) *Strong, Safe and Supported: Operational Plan* was developed in 2008. • A comprehensive strategy for monitoring and reporting on child and youth outcomes is being planned for early 2009 in conjunction with other ministry partners. • Preliminary outcome data is available from the Brief Child and Family Phone Interview (BCFPI). • An accountability framework for the Child and Youth Mental Health Plan, developed in the form of a program logic model, was approved by the Assistant Deputy Minister, Provincial Services, in February 2006. The framework identifies key implementation strategies, expected outputs and outcomes. Intended outcomes are specified at both the client and system level. • On behalf of MCFD, CYMH, the Children's Health Policy Centre	• This document will guide increased effectiveness, efficiency and accountability for supports and services for children, youth and their families served by the ministry. • Additional information will be available when the implementation of CARIS is completed and CARIS reports become available. • Additional work is required to more fully implement the program logic model across all regions • Much of this data has not yet been made available to CHPC and this is being addressed at a	P P P P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
	(CHPC) at Simon Fraser University is working on a monitoring project to measure trends in the mental health of children in British Columbia using data from MoH, MoEd, Pharmacare etc.	senior management level.	
Recommendation 2.2: The ministry ensures that there continues to be a strong ministry leadership for child and youth mental health services. ***Actions taken at June 2007:*** *There will continue to be strong leadership for CYMH provincially and regionally. Although there may be structural differences between regions, each region has identified continued CYMH leadership as a priority. The hiring of additional CYMH Team Leaders as part of implementation of the CYMH Plan has increased leadership at the community level.* ***Actions planned:*** *No further action is planned.*	• Provincial leadership continues to be provided by the Leadership Team. • Directors of Operations, Directors of Integrated Practice, and Community Service Managers continue to collaborate and play a pivotal role in the leadership and decision making regarding CYMH.	• All regions work to ensure CYMH leadership is a priority of the regional management team.	S P
Recommendation 2.3: The ministry addresses stakeholder concerns about the reorganization. ***Actions taken at June 2007:*** *Many key CYMH stakeholders are members of the CYMH Network, which continues to meet three times per year. The Network has provided a forum for these stakeholder representatives to air concerns and develop solutions. In many regions, regional CYMH Networks have provided a similar function.* ***Actions planned:*** *MCFD will continue to consult with the network and other stakeholder groups as required.*	• The CYMH Review has provided an opportunity for stakeholders to express any current concerns or recommendations they may have with regard to the delivery of child and youth mental health services. • The CYMH Network continues to meet regularly	• Consultations were completed end of July 2008, and the report will be available in October 2008. • The Network will meet in September 2008 to review priorities and develop a workplan.	S S

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
Recommendation 2.4: The ministry begins formulating new strategies that will build on the accomplishments achieved under the province's first Child and Youth Mental Health plan. ***Actions taken at June 2007:*** *The CYMH Network and the External Advisory Committee on Child and Youth Mental Health continue to meet regularly.* ***Actions planned (including timeframes):*** *By the end of 2008, MCFD will conduct a systemic review of services for children and youth with, or at risk of developing, mental illness that examines accomplishments, progress to date, gaps in service, and next steps. New strategies will continue to be developed as MCFD continues to improve and integrate services.*	• The CYMH Review has been completed and includes surveys, focus groups and individual interviews with key stakeholders in May, June and July 2008. The report will be completed by October 2008.	• New strategies will be developed following a review of the report by the ministry in collaboration with community partners.	P
Coordinated Approaches On All Levels to Address Deficiencies			
Recommendation 3: The ministry develops a clear strategy to bring about meaningful inter-sectoral collaboration, particularly with physicians. ***Actions taken at June 2007: Inter-sectoral collaboration across government ministries and offices is achieved through the Child and Youth Mental Health Network. Collaboration with physicians specifically has occurred in relation to individual projects such as the dissemination of self-help and other resources through the College of Family Physicians of BC, physician input on expert advisory tables, and Ministry participation in a BCMA/government committee to develop clinical practice guidelines for general practitioners. At the outset of the Child and Youth Mental Health Plan, more active involvement of the medical community was envisioned as a means of fostering linkages between primary health care and community-based child and youth mental health services. Ongoing engagement of professional medical organizations has proven very challenging, in part because most of the physician initiatives and incentives to improve mental health care in general practice are initiated and coordinated through the Ministry of Health. As yet, there is no formal channel for MCFD to collaborate in these endeavours.*** ***Actions planned: Senior executives from MCFD will continue to reinforce the importance of inclusion of CYMH in primary heath care initiatives that influence how physicians practice in relation to children with mental illness and their families. In particular, effort will be made to ensure a focus on children's mental health is part of a new proposed physician fee incentive to encourage improved***	• Physicians have been included through participation in Expert Tables as part of the CYMH Plan, contributions to training initiatives and participation in training opportunities. • More action is required to engage physicians, for example, in relation to primary health care initiatives.	• With the conclusion of the expert tables, an ongoing vehicle for participation by physicians has not yet been determined. • There is an ongoing challenge in engaging physicians and potential strategies need to be explored. MCFD will be meeting with the Ministry of Health to discuss issues including the physician fee structure.	P P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
mental health care planning.			
Planning and Monitoring Implementation			
Recommendation 4.1: The ministry ensures that all clinicians receive core, evidence-based practices training, that clinical supervisors consistently review staff application of the concepts, and that evidence-based practice parameters be integrated into services. ***Actions taken at June 2007:*** *To date, over two-thirds of clinicians have taken at least one evidence-based clinical training course since inception of the CYMH Plan; one quarter of clinicians have taken two or more of the four core training components. A plan for continued training in fiscal year 2007/08 has been developed in conjunction with CYMH regional transition managers. To reinforce application of new evidence-based principles in practice, three training sessions on supervision skills were held for clinical supervisors in Fall of 2006 and will be repeated in Fall of 2007.* ***Actions planned:*** *A policy is currently under development that establishes evidence-based training as the standard in CYMH and that identifies training that is considered "core". A gap analysis will be carried out by April 2008 to determine additional needs for core training. On the basis of this analysis, a training plan for 2008/2009 will be prepared to address the additional evidence-based and other core training requirements. Further, new information systems will permit tracking of rates of evidence-based interventions in clinical practice will be routinely tracked beginning in 2008/2009.*	• The delivery of "core" evidence-based training has continued through 2008/2009, including cognitive behavioral therapy, dialectical behavior therapy, interpersonal psychotherapy, infant mental health, dual diagnosis, suicide, aboriginal cultural sensitivity, and clinical supervision,. • An inventory of completed training has been completed in summer 2008 to assist in determining future training priorities. • The CYMH training plan for 2008/09 has been developed in conjunction with CYMH Regional Managers/Consultants and in consultation with MCFD Learning and Development and the Regional Support Council. • An issue paper related to ongoing	• Evidence based practice is being more consistently implemented across the regions. • To further support the implementation of specialized clinical approaches, clinical supervisors will receive supervision training related to specific treatment modalities during 2008/2009. • Ongoing training is planned for this fiscal based on identified priorities in the training plan.	S S F

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
	CYMH training needs has been developed to facilitate training planning and implementation in the regions.		
Recommendation 4.2: The ministry develops school-based FRIENDS champions in under-represented regions, develops strategies to mitigate key risks and establishes mechanisms to monitor penetration of the program throughout the province. ***Actions taken at June 2007:*** *A FRIENDS liaison in each school district has been appointed. In addition to assistance with program communications and coordination of local training events, these individuals help to promote the program with teachers in their district. Given the limited uptake in Greater Victoria school districts, the FRIENDS Consultant/trainer has met with the three CYMH teams in Victoria so that clinicians within these teams may also act as champions for the program and be available to teachers as a local resource. In addition, communication was sent to all British Columbia Superintendents and elementary school principals emphasizing the value of FRIENDS in the classroom and reiterating that FRIENDS addresses Ministry of Education prescribed learning outcomes for social responsibility. It is hoped that these efforts will result in district level commitment to the program.* ***Actions planned:*** *The FRIENDS Consultant/trainer will meet FRIENDS liaison personnel from large urban districts, such as Surrey, Vancouver and Victoria by November 2007 to identify strategies to improve elementary school participation in the program in urban centres for the 2007/2008 school year. In school districts that have mandated FRIENDS delivery in all elementary schools, Ministry staff will explore the factors responsible for greater program support and work with other districts to promote factors which facilitate uptake. This will also be completed in fall of the 2007/2008 school year.* ***Actions taken at June 2007:*** *The FRIENDS program has included funding in the 2007/2008 budget to cover costs of all program materials (Leaders Manual and Student Workbooks) for teachers and students. MCFD has covered these costs since the program was launched in 2004 and recognizes that this is a key component to the success of the program.*	• FRIENDS liaisons continue to represent and champion the program in each district. • Consultations with urban districts and focus groups were conducted to better understand key factors that influence the uptake and sustainability of FRIENDS in school districts. Review of the focus groups results will be completed by July 31, 2008 and an action plan will be developed. • Joint communications with the Ministry of Education are sent to Superintendents, Principals and Special Education Coordinators at the beginning and end of each school year.	• Parent liaisons are becoming more involved in the FRIENDS program through the parent training component and they are working with schools to champion and support the program. • Focus Group process is complete. Due to challenges of connecting with school personnel at the end of the school year and also holidays, the review of the focus group results and an action plan will occur by September 30, 2008. • Joint communications were sent out in June 2008 with more to follow in September, 2008.	F P F

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
Actions planned: *MCFD will continue to cover the costs of all program materials for schools participating in the program. Regarding the risk of an increase in teacher coverage costs, the FRIENDS program will work with each FRIENDS school district liaison to deliver the one-day FRIENDS training during district professional development days, when possible, and offer late afternoon/evening trainings upon request, thereby avoiding the need for the district to incur salary replacement costs.* ***Actions taken at June 2007:*** *To date, program penetration throughout the province has been roughly tracked on the basis of teacher participation in training events and the number of manuals and workbooks ordered by schools. Recognizing the limitations of this, the Ministry, in collaboration with academic research partners and BC Stats, created a program evaluation team to design a valid approach to monitoring program implementation and program impact.* ***Actions planned (including timeframes):*** *By the end of this school year, BC Stats will conduct a survey of teachers who participated in FRIENDS training to ascertain where the program is being delivered. This implementation mapping exercise will be completed by August 31, 2007.*	• Over 90% of school districts have participated in the FRIENDS program to date, including many independent schools and the First Nations Schools Association schools. • Program materials have been translated into French and will be available for use in September 2008. • The FRIENDS Youth program, targeted at grade 7, will be introduced in 2008/2009, and will be reviewed at the end of school year. • The FRIENDS Aboriginal research project will be completed by June 30, 2008, with a related plan by July 31, 2008.	• A plan will be developed to establish a formal partnership with Ministry of Education regarding mental health promotion and supporting school-based prevention programs such as FRIENDS. • A French trainer from School District #93 has joined the FRIENDS training team and will deliver the FRIENDS training in the French language to French teachers/school personnel from SD#93 and French immersion schools, thus increasing the reach of the program to French speaking elementary students. • To date, 24 youth trainings have been scheduled province-wide in the 2008/2009 school year. MCFD will provide resources for up to 30 trainings during the first year of rolling out the Youth version. • There was a delay in the completion of the research report due to staffing challenges and therefore an extension was	AA F S P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
		provided. A plan will be completed by September 30, 2008	
	• An effectiveness evaluation of the FRIENDS program with British Columbia students will begin in 2008/2009.	• In addition to an effectiveness evaluation, implementation of a program monitoring system will be considered. Meetings will be set up with key evaluators in the Fall.	P
	• Meetings will be held with CYMH Regional Managers and Consultants in summer and fall 2008 to develop a plan to increase involvement of CYMH staff with the FRIENDS program in school settings.	• A meeting in July took place and another will follow in the Fall.	P
	• MCFD is continuing to cover the cost of all program materials for schools participating in the program. Additionally this year, the FRIENDS program will cover the costs for a maximum of 30 FRIENDS Youth trainings (Grade 7) as well as program materials for those trained teachers and their students.	• MCFD is providing FRIENDS program materials to CYMH clinical teams who are using the program individually or in groups. This will increase the use of FRIENDS by clinicians who can thereby support teachers/school personnel who are using the program in the school setting.	S
	• To reduce teacher coverage costs, the FRIENDS program will continue to work with each FRIENDS school district liaison	• Cooperation between the FRIENDS program and school district liasons continues.	F

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
	to deliver the training during district professional development days, when possible, and will offer late afternoon/evening trainings upon request. • In 2006/2007 the Ministry, in collaboration with academic research partners and BC Stats, conducted a Feedback Survey designed to measure FRIENDS training levels, teacher satisfaction and program uptake with 551 teachers/counselors who received FRIENDS training during the 2006/2007 year.	• Among the 228 teachers (44%) who responded, 80% had offered FRIENDS in the classroom. 88% of those teachers who were delivering the program felt FRIENDS had benefitted their students. • This survey, in addition to the results of the Focus Groups, will contribute to the framework for future monitoring and planning.	F P
Recommendation 4.3: The ministry take steps to increase staff acceptance of the Brief Child and Family Phone Interview clinical intake screening tool. ***Actions taken at June 2007:*** *Consistent with best practice, MCFD has established use of the Brief Child and Family Phone Interview (BCFPI) as the standard screening tool for CYMH. The ministry acknowledges there have been some growing pains as practice shifts to incorporate use of the BCFPI, and has taken steps to solve immediate problems and establish processes for addressing future ones. Specific measures have included holding a forum, attended by all CYMH Clinical Supervisors, was held in February 2006 to review field experience with the BCFPI and address any emerging issues. Individual consultation with regional staff including intake workers is currently underway. From these consultations, a BCFPI Reference group is being created as a problem solving resource for BCFPI users.* ***Actions planned:*** *Consultation with regional staff regarding BCFPI implementation will be*	• Implementation consultations with Regional Managers/Consultants, clinical supervisors, and intake staff completed in all five regions, in fiscal year 2007/2008. Feedback and recommendations were incorporated into policy development and local procedural recommendations, and will be considered in the next software upgrade (BCFPI 4.0--Aug. 2008). • An Intake Policy Reference Group	• Regional feedback and recommendations regarding software performance and user satisfaction were communicated to BCFPI, Inc. The BCFPI 4.0 software upgrade release slated for July 2008 was delayed due to lack of compatibility within the CARIS application. The new projected release of BCFPI 4.0 is early spring 2009. • The provincial policy team is in	P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
completed by September 2007 resulting in recommendations to the Ministry. BCFPI Aggregate Reports are currently under development. Access to these reports will substantially improve the ability to understand current CYMH usage and to plan future services at the local, regional and provincial level. These reports will be available July 2007.	was formed to develop intake policy and clarify the role of the BCFPI in the context of intake. • All BCFPI single-case, comparative, and aggregate reports are fully functional allowing all levels of the organization, from policy and management to supervisors and line staff, access to all levels of data for outcome & service delivery analysis. Additionally, reports will allow analysis of shifts in intake prevalence rates, local and regional differences in presenting problems, trends, and specific gaps in service delivery. • Full implementation of the BCFPI has been negatively impacted by technical infrastructure difficulties related to the implementation of the new Community and Residential Information System (CARIS). These problems have interfered with clinician access to the BCFPI and the consistent use of the follow-up survey and use of reports.	the final stages of revision of the Intake Policy. • CYMH continues to test all reports within BCFPI for functionality and accuracy of data. Implementation targets were communicated to operational staff by provincial office and regional CYMH managers and consultants. Communications have occurred with operational staff regarding completion of Follow-Up Surveys to inform service outcome studies. A recent BCFPI provincial survey, as part of the CYMH Review, provided an opportunity for Team Leaders and provincial office to collaborate in the Follow-Up Survey process. • Technical problems ranging from server and bandwidth issues, to security and software issues have negatively affected the performance of CARIS and BCFPI. Problems continue to occur, though the frequency has dropped considerably. Because of these challenges the number of BCFPI screening interviews	S P P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
	• Further consultation sessions are being planned in each region to improve the use of aggregate reports and implementation of the follow-up survey to measure service outcomes.	has fallen significantly in some areas. Provincial BCFPI reports were sent to regional CYMH managers/ consultants for review and planning. • In 2008/2009 regions will receive training in the use/interpretation of BCFPI data and will target Team Leaders, Regional Managers/ Consultants, and selected Community Services Managers. There are provisions for phone based training and support to all regions. Provincial office will establish quarterly reporting protocols for the regional offices defining demographic and population shifts, service delivery and outcome studies, and service gaps within specialized populations. Strategies are being discussed at the CYMH regional table to increase compliance in completing screening interviews and use of BCFPI in intake meetings, aggregate data for service planning, and for pre-service groups on waitlists, and Follow-up Surveys.	P

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
Reporting to the Legislative Assembly and the Public			
Recommendation 5.1: The ministry reports to the Legislative Assembly and the public on the plan's implementation progress. ***Actions taken at June 2007:*** *A report on implementation of the CYMH Plan was submitted to Treasury Board in September 2006. This report was prepared after only one full year of base funding and hence does not provide a complete assessment of implementation progress.* ***Actions planned:*** *At this time, there has been no request for the Ministry to submit an implementation progress report to the Legislative Assembly. A summary report for external stakeholders and the public based on the report to Treasury Board is underway and will communicate progress in relation of key CYMH Plan strategies. The report is expected to be completed by October 1, 2007.*	• The CYMH Progress Report was announced by the Minister on May 20, 2008. The report is available on the CYMH website and was distributed by mail to key stakeholders. • A more detailed report will be produced following completion of the CYMH Review of the implementation of the CYMH Plan and the impact on the system of mental health services for children and youth.	• Information about the Child and Youth Mental Health Plan is available to the public. • The CYMH Review will be available in October 2008	F S

OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions and Actions planned (with information on implementation)	Self-Assessed Status F/S/P/AA/NA[1]
Recommendation 5.2: The ministry develops an approved accountability framework capable of evaluating the plan's impact on patient outcomes. ***Actions taken at June 2007:*** *An accountability framework for the Child and Youth Mental Health Plan, developed in the form of a program logic model, was approved by the Assistant Deputy Minister, Provincial Services, in February 2006. The framework identifies key implementation strategies, expected outputs and outcomes. Intended outcomes are specified at both the client and system level.* ***Actions planned:*** *Client outcome data can be generated once the Brief Child and Family Phone Interview (BCFPI) and the Community and Residential Information System (CARIS) are fully implemented. These administrative systems will provide information on clients' clinical and functional status at intake and discharge and thus yield treatment outcome data for children served through community-based child and youth mental health services. In addition to reporting on outcome for children and families who are recipients of CYMH services, population level mental health status information will be acquired and reported annually through a monitoring project led by the Children's Health Policy Centre at Simon Fraser University.*	• The Ministry has appointed an ADM for Quality Assurance • BCFPI data will allow preliminary analysis, however follow-up surveys have not been consistently implemented due in part to Information Systems infrastructure difficulties. • Children's Health Policy Center at Simon Fraser University continues to work on the Monitoring Project; however, much of the required data has not yet been made available for analysis.	The ADM for Quality Assurance will work with program areas to develop an accountability framework. As the technical difficulties are addressed we expect to see improved completion of BCFPI surveys This is being addressed at a senior management level	P P P

Section 8

Update on the implementation of recommendations from:

Government's Post-secondary Expansion – 25,000 Seats by 2010 –

December 2006

October 2008

BRITISH COLUMBIA
The Best Place on Earth

MEMORANDUM

September 24, 2008

To: Malcolm Gaston
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Our Ref. 72548

Re: Follow-up of our Report on Government's Post-Secondary Expansion 25,000 seats by 2010

Thank you for your letter of September 5, 2008, clarifying that you intend to publish the Status Report for all follow-up exercises, and offering the opportunity to submit an amended report.

In order to meet your publication deadline, I have provided a revised Status Report from the Ministry that incorporates information provided by institutions. We should discuss the need for further institutional details that could potentially be published in subsequent Office of the Auditor General follow-up reports.

If you have any questions, please contact John Fuller, Director, Operating Unit, at (250) 387-6142, or Joe Thompson, Executive Director, Funding and Analysis Branch, at (250) 387-8820.

Robin Ciceri

Robin Ciceri
Deputy Minister
Ministry of Advanced Education and Labour Market Development

Enclosure

pc: Distribution List Follows

.../2

Ministry of Advanced Education and Labour Market Development
Office of the Deputy Minister
Mailing Address:
PO Box 9884 Stn Prov Govt
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Mr. Joe Thompson
Executive Director, Funding and Analysis Branch
Ministry of Advanced Education and Labour Market Development

.../3

Mr. John Fuller
Director, Operating Unit
Ministry of Advanced Education and Labour Market Development

Mr. Craig James
Clerk Assistant and Clerk of Committees
Office of the Clerk of Committees

I. General comments about progress since the report release:

- In May 2007, the Ministry made a presentation to the Public Accounts Committee on the progress made in relation to the Office of the Auditor General's (OAG) recommendations regarding government's post secondary expansion. The committee endorsed the direction the Ministry was taking in regards to OAG's recommendations.
- Having reached the goal of ensuring anyone with a "B" or better average can gain entrance to university programs, the Province is refocusing investment from general system growth to high priority areas such as:
  - Health and Medical programs,
  - Skills programs,
  - Graduate programs; and,
  - Aboriginal Access.
- This refocusing has challenged institutions to shift some resources from programs with lower student demand to higher student and employer demand. However, no institution will receive less operating grant funding in 2008/09 than they received in 2007/08.
- Significant investments in the post-secondary sector since 2004 have resulted in improved access to education:
  - Regional program expansion throughout the province; and,
  - Increased diversity of program offerings and student choices such as more classes and new courses and programs.
- The Ministry has implemented government letters of expectations (GLE) with all post-secondary institutions in 2008/09.
  - These letters are intended to be an agreement of the accountabilities, roles and responsibilities between the Ministry and each institution; and,
  - The letters are modeled after the GLE which is used by the Ministry of Health and the Regional Health Authorities.

II. Self Assessed Monitoring Report Summary

Recommendation	Status
1 Manage Risks	I
2 Respond to Enrolment	I
3 Fund transparently	I
4 Cost programs	N/A
5 Plan for succession	I
6 Report targets and actuals	I

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will address OAG finding
NA – No substantial action has be taken to address this recommendation

III. Status Report – Actions Taken and Results

Government's Post-secondary Expansion

Recommendation 1: The ministry and institutions should each introduce or strengthen formal risk identification and management practices across their organizations in order to support the successful achievement of results.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**[1]
Ministry	➢ Implemented Government Letters of Expectation; these state that monitoring service delivery performance is key in maximizing efficiency and effectiveness of service delivery. Ministry and PSI will monitor on a regular basis. Output and results are the focus with contingency plans developed based on risk assessment. ➢ Institutions have implemented risk management plans that include enrolment issues. Strategies to ensure that risks are mitigated have been identified and have been or will be implemented.	➢ Government expectations and accountabilities of both government and institutions are more clearly defined and agreed to. ➢ The risk management processes are helping ensure that the strategic risks of the institutions are identified, assessed and reduced to acceptable levels.	I
Recommendation 2: The ministry should lead and collaborate with all of British Columbia's public post-secondary institutions to develop a coordinated response for remediating combined risk factors that contribute to softening post-secondary student enrolments.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**
Ministry	➢ Significant reallocation of planned growth based on performance in both 07/08 and 08/09. E.g. Aboriginal, Health and Grad seats were allocated after working with PSIs on their ability to deliver these seats. ➢ ALMD is currently working with institutions to gather	➢ ALMD now has more flexibility in allocating growth dollars, and more data to determine which institutions have the ability to deliver growth FTEs in priority programs. ➢ FTE utilization results were used to inform budget and FTE reallocations for fiscals 2007/08 and 2008/09 resulting in	I

[1] **I – Recommendation has been fully or substantially implemented**
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

	information on enrolments – projections for 08/09 and 09/10, by institution. This information will be used to determine seat expansions for 09/10. ➢ Strengthened monitoring tools around FTE utilization – Data e.g. Data Warehouse information; Fall interim FTE reports and other tools. ➢ Annual budget and accountability meetings with each and every institution. ➢ Colleges have developed recruitment strategies to deal with softening demand in their regions.	changes to expansion plans with an increased focus on priority programs to address labour and skills shortages.	
Recommendation 3: The ministry should fund public post-secondary institutions transparently, showing clearly how much funding is being provided to meet the 25,000 seat expansion plan and how much is covering inflationary pressures.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**
Ministry	➢ ALMD provided greater detail in the 2007/08 and 2008/09 budget letters (GLE) on the derivation of operating grants. This included system-wide summaries of allocations of operating grants, FTEs and capital information. ➢ In 2008/09 the ministry targeted 1,810 FTEs for government priorities through an Access Fund. The Access Fund FTEs and funding allocations are clearly identified in institutional GLEs. ➢ Indicated the amount of funding specifically earmarked for collective agreement increases.	➢ Increased transparency by providing the sector with system wide summaries of operating grants, FTEs and capital information.	I
Recommendation 4: The ministry should establish a process to determine, and periodically review, the actual cost of delivering programs by institution, and then use this information to better inform its block funding decisions.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**
Ministry	➢ Acquiring the in-depth program cost and student demand projections centrally about the thousands of programs at institutions is inconsistent with the relative roles of the ministry and post secondary institutions. The accountability	• n/a	N/A

	framework employed by the ministry in it's role of sector management focuses on outputs and outcomes. ➢ Inputs in terms of funding allocations to institutions are more appropriately determined through a modified block funding model. ➢ Modified block funding balances the public policy goal of ensuring a small number of high priority programs are delivered, with institutional flexibility and autonomy.		
Recommendation 5: All institutions should develop human resource succession plans so that resource needs for the future are better identified and managed.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**
Ministry	➢ The following actions have been taken: 1. There have been increased efforts by institutions to recruit and retain quality faculty. 2. BC College Presidents report that all public colleges have succession management plans. 3. Universities have developed faculty renewal plans and human resource strategies that address recruitment and retention challenges.	➢ Actions taken contribute to better identification of resource needs and allow institutions to better respond to changes in the workforce.	I
Recommendation 6: The ministry should require that institutions present, in their service plan reports, growth targets and actual results over time and explain variances.			
Respondent	**Actions Taken Since Report Issued**	**Results of Actions**	**Self-Assessed Progress**
Ministry	➢ Beginning in 2007/08, institutions now prepare a combined Service Plan/Service Plan Report, which includes results for the previous year and targets for the upcoming three years. In prior years, these reports were separate documents.	➢ Institutions have now submitted these combined service plans for 2007/08. ➢ In addition, institutions have been asked to provide enrolment projections for 2008/09 and 2009/10 at a slightly more detailed level. This will assist ALMD in determining capacity levels as well as existing and projected student and labour market needs.	I

Section 9

Update on the implementation of recommendations from:

IT Audits of the Corporate Accounting System (CAS)

- Part 1: Audit of the Government's Corporate Accounting System June 2005
- Part 2: Audit of the Government's Corporate Accounting System December 2006

October 2008

BRITISH COLUMBIA
The Best Place on Earth

Ref: 50138

February 5, 2008

Bill Gilhooly, CA
Assistant Auditor General
Office of the Auditor General
PO BOX 9036 STN PROV GOVT
Victoria BC V8W 9A2

Dear Mr. Gilhooly:

Re: Follow-up to Corporate Accounting System Audit
Part 1: Audit of the Government's Corporate Accounting System, June 2005

In response to your letter of January 3, 2008, Corporate Accounting Services has completed the attached self-assessment report provided by your office, which updates the status of the recommendations of the Part 1 June 2005 audit.

All recommendations have been implemented.

Recommendations in this self-assessment were presented to the Select Standing Committee on March 5, 2007.

Please contact me with any questions you may have on the attachment.

Sincerely,

Lori Wanamaker, CA
Deputy Minister

cc: Richard Poutney, Assistant Deputy Minister, Common Business Services
Nashater Sanghera, Executive Director, Corporate Accounting Services
Cheryl Wenezenki-Yolland, Comptroller General, Office of the Comptroller General
James Capron, Acting Executive Director, Financial Management Branch

Ministry of Labour and Citizens' Services | Office of the Deputy Minister | Mailing Address: Box 9440 Stn Prov Govt Victoria BC V8W 9V3 | Telephone: 250 387-8842 Facsimile: 250 387-8561

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Pro Forma Format for Monitoring Ministry Progress:

Cover Letter:

This should include a signed representation that the enclosed self-assessment has been reviewed and approved by the Deputy Minister or equivalent.

General comments about progress since the previous response or report release:

(one to two pages)

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
1	Regularly review and update policies and procedures in order to provide current and accurate information to *(internal)* users. A history should be maintained to inform users of the changes and the current approved version in use.	• Corporate Accounting Services performs regular reviews to ensure that documents are current and meet documentation standards and versioning controls. • Established a review schedule for all policies and procedures.	• Controls and reviews in place	I
2	Develop a process to monitor compliance with *(internal)* policies and standards.	• Corporate Accounting Services performs regular reviews to ensure that processes to monitor compliance with policies and standards are current. • Documented applicable process for Corporate Accounting Services systems development lifecycle.	• Controls and reviews in place	I

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
3	Regularly review job descriptions to make sure that the roles and responsibilities are still current and the skills and experience required are clearly specified.	• The audit identified job descriptions that were not current. Corporate Accounting Services has made all the adjustments as identified in the audit. • Corporate Accounting Services is developing a Human Resource strategy that will include the regular review of all job descriptions.	• Controls and reviews in place	I
4	Perform a Business Continuation Plan (BCP) risk analysis and testing annually (or when significant changes occur) and update the plan regularly to ensure its contents are complete and accurate.	• Business Continuity Plan and Disaster Recovery Plan (DRP) updated and tested annually to ensure critical functionality is not compromised. • A full time BCP/DRP position was created and is filled.	• Controls and reviews in place	I

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P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
5	Prepare a quality management plan, defining the quality assurance process and how it will be implemented, for each system project as required by the adopted standards.	• A quality management plan, defining the quality assurance process, and schedule for implementation has been completed.	• Under continuous review and refinement.	I
6	Develop a process to monitor overall information technology performance by comparing actual performance to the capacity and technology plan on a regular basis.	• Corporate Accounting Services follows a regular review process with emphasis on the heaviest load period, which is year end, or during major project implementation activity.	• Controls and reviews in place	I
7	Set the passwords for production servers to different passwords from those in the test and development environments.	• Workplace Technology Services changed all the production passwords to be different from development / test in compliance with the best practice recommendation of the audit report.	• Controls and reviews in place	I

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
8	Identify high-risk information in the Oracle database, implement an audit log—that cannot be altered—that records changes made to this information and assign an individual to review the audit logs regularly and follow up on any unusual activity.	• Corporate Accounting Services has identified and incorporated methods for protecting the audit log. • A new Enterprise Security Officer (ESO) position was created January 2005, to review the roles, monitor the audit log and to maintain a security framework within Corporate Accounting Services. The ESO actively reviews known high-risk tables. • Corporate Accounting Services has identified the high-risk information and is monitoring the table audit log daily.	• Controls in place	I

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
9	Restrict access to the test and development servers to only those IP addresses that require access.	• Access is restricted as appropriate. • Corporate Accounting Services has individually identified those resources that require access to the Dev and Test servers and implemented redundant firewall rules that block all other access.	• Controls in place	I
10	Determine the appropriate IP addresses for access to Corporate Accounting Services and restrict the firewall rules accordingly.	• Corporate Accounting Services and Workplace Technology Services have worked together to meet this requirement. • Identification of appropriate IP addresses for access to Corporate Accounting Services, and restrictions to firewall rules have been implemented.	• Controls in place	I

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
11	Add a rule to the IP filter that allows only the mainframe IP addresses to use the FTP port on the database server and disables the service on the other servers.	• Corporate Accounting Services has added the appropriate rule(s) to IP Filter and blocked or disabled the service on the other servers.	• Controls in place	I
12	Add a rule to the IP filter that allows only the TELNET port to be used on the servers that require TELNET.	• Corporate Accounting Services has added the appropriate rule(s) to IP Filter and blocked or disabled the service on the other servers.	• Controls in place	I
13	Develop a process to notify support staff when the firewall is not running.	• A process is in place where I.T. Security Branch (Workplace Technology Services) performs manual and automated spot checks on access logs. Workplace Technology Services checks the logs at least once a day.	• Controls in place	I

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 1, June 2005
Self Assessment Report: January 31, 2008

Aud Ref #	OAG Recommendations	Actions Taken Since Report Issued All actions completed as of December 20, 2006	Results of Actions	Self-Assessed Progress I / P / AA / NA
14	Review, along with Workplace Technology Services, the current firewall single-point of failure configuration to determine if a more secure configuration can be devised.	• Access through the Internet Gateway to the Corporate Accounting Services Servers has been completely blocked. This puts the Corporate Accounting Services' firewall rules in two separate locations in addition to the perimeter monitoring done by Workplace Technology Services. Additionally Corporate Accounting Services has procured and installed a hardware firewall for an additional measure of security.	• Controls in place	I

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BRITISH COLUMBIA
The Best Place on Earth

Ref: 50138

February 4, 2008

Mr. Bill Gilhooly, CA
Assistant Auditor General
Office of the Auditor General
PO BOX 9036 STN PROV GOVT
Victoria BC V8W 9A2

Dear Mr. Gilhooly:

Re: Follow-Up to Corporate Accounting System Audit
Part 2: Audit of the Government's Corporate Accounting System, December 2006

In response to your letter of January 3, 2008, Corporate Accounting Services (CAS) has completed the attached self-assessment report provided by your office, which updates the status of the recommendations of the Part 2 December 2006 audit. To date, one recommendation is completed and five of CAS' recommendations are in progress. The Office of the Comptroller General (OCG) has completed three recommendations, one is in progress and one has been undertaken using an alternative solution.

Recommendations in this self-assessment were presented to the Select Standing Committee on Public Accounts on March 5, 2007. Although the self-assessment report reviews only the key recommendations of the Part 2 audit, both CAS and the OCG are addressing all recommendations in the audit.

Please contact either of us with any questions.

Sincerely,

Lori Wanamaker, CA
Deputy Minister
Ministry of Labour and Citizens' Services

for Chris Trumpy
Deputy Minister
Ministry of Finance

cc: Mr. Richard Poutney, Assistant Deputy Minister, Common Business Services
Ms. Nashater Sanghera, Executive Director, Corporate Accounting Services
Ms. Cheryl Wenezenki-Yolland, Comptroller General, Office of the Comptroller General
Mr. James Capron, Acting Executive Director, Financial Management Branch

Ministry of Labour and Citizens' Services | Office of the Deputy Minister | Mailing Address: Box 9440 Stn Prov Govt Victoria BC V8W 9V3 | Telephone: 250 387-8842 Facsimile: 250 387-8561

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

Pro Forma Format for Monitoring Ministry Progress:

Cover Letter:

This should include a signed representation that the enclosed self-assessment has been reviewed and approved by the Deputy Minister or equivalent.

General comments about progress since the previous response or report release:

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
4	Corporate Accounting Services take a more proactive role in ensuring all access is appropriate by alerting ministries of possible problems with user access.	• Corporate Accounting Services is preparing a document to describe all responsibilities by role and a list of associated available functions. • As well, a responsibility matrix is being prepared that will identify responsibility combinations that present a possible risk. • These documents will be distributed to ministries when completed.	• Not applicable as report is not yet completed. • Monitoring processes and targeted for implementation in September 2008.	P

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
5	Procedures be established to communicate staff changes to security administrators in a timely manner to ensure effective user access change management and to periodically review user access levels to ensure access granted remains appropriate based on users' positions.	• Corporate Accounting Services continues to refine its procedures for monitoring employees' movement between ministries and job functions. • A report identifying employee movements is being developed to assist ministries with initiating user access changes.	• Monitoring processes and employee movement report targeted for implementation in September 2008.	P

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AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
30	Corporate Accounting Services establish formal policies restricting further set-up of generic suppliers and formalize a plan to establish a well-defined approach for using, managing and updating existing generic supplier records.	• Corporate Accounting Services has implemented this control and generic suppliers are no longer created. The Corporate Accounting Services internal procedures manual for supplier file management will be updated to reflect this directive by May 2008. • Supplier maintenance documentation now contains a formalized process for identifying, clean-up and removal of all generic suppliers in the supplier file.	• New generic suppliers can no longer be created. • Corporate Accounting Services is actively reviewing supplier records to identify and remove generic suppliers from the supplier file. • Targeted completion date for removal of all generic supplier records is March 2009.	P
34	Policies and procedures be established to define clearly a ministry's role and responsibilities in the bank account maintenance process, and to govern the extent of ministry review required for ensuring the completeness and accuracy of banking information obtained.	• A review of the bank account maintenance and business process has been completed. • New supplier bank account maintenance procedures have been prepared but not yet shared with ministries.	• New policies and procedures regarding ministries' roles and responsibilities will be shared with ministries by September 2008.	P

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
37	Management at Corporate Accounting Services formalize procedures to monitor all supplier linkages to bank accounts and compare the details of the reported activities to source documents to ensure there are no unauthorized or inappropriate bank account linkages.	• A review of the bank account maintenance and business processes that monitor supplier record linkages to bank accounts has been completed. • New procedures and supporting reports have been developed but are not yet implemented.	• New procedures and supporting reports will be implemented by September 2008.	P
49	Corporate Accounting Services explore the feasibility of requiring approval from expense authorities when manual changes are made to suppliers' cheque mailing addresses to prevent unauthorized changes. Guidance should also be established to ensure proper validation procedures are carried out when approving these changes.	• The feasibility review determined that the data and system functionality was available to provide exception reporting on manual override activities.	• Exception reporting available.	I

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
12	Monitoring activities be formalized and carried out by the Office of the Comptroller General (OCG) to ensure the chart data remains current and relevant.	• OCG has implemented this control by incorporating the routine monitoring of the chart master database into monthly tasks to ensure it remains up to date and accurate.	• Part of OCG's month end process is to check for any information fields that are not in a rollup and to check for open chart of accounts alerts. Reports are run in Oracle to ensure Budget and Chart of Accounts and Oracle are in sync for chart of accounts. More monitoring will take place once Audit Command Language software is fully implemented.	I

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P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
32	OCG establish clear criteria for monitoring and compliance activities to ensure that the block supplier data remains current and relevant.	• This is being addressed in the OCG's overall assessment of block supplier coding.	• OCG is leading a project to address linkages with block suppliers and legal encumbrance obligations. As part of the project, OCG has closed 181 of the original 318 block supplier codes. Research is still being performed on many of the others. Policy will be updated to incorporate reasons for use of block supplier once the project is complete. In addition, OCG verifies 100% of block supplier expenses on a post-payment basis.	P

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Audit Report Title and Date: Audit of Government's Corporate Accounting System: Part 2, December 2006
SELF ASSESSMENT REPORT: JANUARY 31, 2008

AUDIT Ref #	OAG Key Recommendations	Actions Taken Since Report Issued	Results of Actions	Self-Assessed Progress I / P / AA / NA
36	OCG effectively communicate to ministries the risks associated with banking activities and advise them how to detect the potential threats and to ensure that controls are functioning properly to address them.	• OCG has communicated the risks associated with changes to banking information to the financial community. The issue has been discussed at both the Senior Financial Officer Council (SFOC) and the Financial Officer Advisory Committee (FOAC).	• Comptroller General directive to ministries, September 15 2006 re: requests to change banking information was implemented. The identity and authority of the requestor, as well as the validity of the information requested must be verified by ministry and Provincial Treasury staff before processing changes. In addition, adequate documentation supporting the request must be retained. OCG has ongoing interactions with Corporate Accounting Services, Provincial Treasury and ministry stakeholders for banking items, including EFT payments to suppliers and employees.	I

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

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50	Management require expense authorities to review procurement transactions when supplier information is subsequently added to purchase orders or changed, to ensure the appropriateness of the suppliers used for procuring the goods and services.	• OCG has determined the enforcement of policy and the post audit review of approval activity are considered adequate controls to support the control framework. The expenditure authority is within their authority to make changes to the purchase order prior to approval. The key controls over the purchase are the qualified receiver's certification of what was ordered was received and the three-way matching of goods ordered and received to the supplier invoice. In many cases buyer specialists manage this process and deal directly with the supplier community to select the appropriate supplier for goods or services.	• Training and communication of expense authority responsibilities and accountabilities is an ongoing government best practice and a key component of maintaining the financial framework, including recognition of compensating controls to mitigate risk for exceptions to standard business processes.	**AA**

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		• There are controls in place to preclude changes that increase the dollar limits of transactions over pre-approved limits.		
51	OCG take on the initial responsibility of effectively communicating with ministries the risks of potential fraud in purchase and accounts payable transactions and advising them on how to detect potential threats resulting from these risks.	• OCG agrees that the expense authority must be supported by having access to the information available to them. OCG, through FOAC and input into the expense authority training syllabus, will continue to promote education and understanding of the accountability of the expense authority role, including the risks of loss or misappropriation.	• OCG has updated the training bulletin for expense authorities and linked it with related core policy. OCG is working with the contracted training consortium to continue workshops for expense authorities, and to fully implement this training in the new financial curriculum program. In addition, OCG continues to provide SFOs with 3CMB compliance reports for feedback and to assist with regular monitoring of ministry expenses.	I

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