Appendix C: Findings of the Environmental Scan

Table C-12: British Columbia Health Authority Service Plans: Strategic Goals, Objectives, Outcomes & Performance Measures

Jurisdiction	Title of Service Plan	Strategic Goals				Equity Reference
		Strategic Goals	Objectives/Strategies	Outcomes/Measures	Operationalized Through	
Health authorities with a provincial mandate						
Provincial Health Services	**2015/16 – 2017/18 Service Plan**	**Goal 1: Support the health and wellbeing of British Columbians.** PHSA embraces a broad definition of health, and in addition to providing specialized treatments for illness when it occurs, PHSA develops strategies to promote wellbeing and the highest quality of life, in alignment with Ministry goals. Working together with the Ministry of Health and the regional health authorities, PHSA has a role in developing health promotion and illness prevention strategies. PHSA is committed to improving the health of British Columbians by supporting the development of healthy communities, informing healthy public policy and providing information and tools that help individuals make healthier choices to prevent the onset of many chronic diseases	**Goal 1: Support the health and wellbeing of British Columbians** **Objective 1.1:** Targeted and effective primary disease prevention and health promotion. Chronic disease is the largest cause of death and disability, represents the largest proportion of the burden of disease, and drives a significant part of downstream health costs in BC. Evidence suggests that, over time, a primary disease prevention and health promotion agenda can make progress in improving the overall health of the population. **Strategies** • Improve Public Health surveillance reporting of health authorities including for the health status of communities by the Medical Health Officers as per requirement under the *Public Health Act*, and for informing policy and practice decision making by BC Centre for Disease Control establishing a Public Health Observatory.			**Health Status:** well-being **Root Causes:** socioeconomic, social determinants (indigeneity) **Populations:** vulnerable, at risk, high risk, remote/rural, hard to reach, marginalized, geographically remote **Interventions:** targeting within universalism; downstream

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		and to assist those living with chronic disease to stay as healthy as possible. **Goal 2: Deliver a system of responsive and effective health care services across British Columbia.**	• To improve the quality and consistency of services across the province, BC Centre for Disease Control will work in close collaboration with regional health authorities and the First Nations Health Authority to standardize universal access for the distribution of harm reduction supplies for people with substance use issues. • Continue to lead the BC Children's Hospital Health Literacy Team's implementation of the Integrated Provincial Strategy to Promote Health Literacy in Mental Health and Addiction in BC. Implementation will build on existing mental health literacy initiatives (Kelty Mental Health Resource Centre & HeretoHelp) and explore new opportunities to support an integrated approach to addressing both physical and mental health literacy in order to promote overall wellbeing and encourage healthy living. Also included will be targeted initiatives that support health literacy among hard to reach populations, rural and remote communities and families from diverse backgrounds **Goal 2: Deliver a system of responsive and effective health care services across British Columbia.** **Objective 2.1:** A provincial system of primary and community care built around inter-professional teams and			

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			functions. British Columbia's health care system has been engaged in a collaborative process to look for ways to improve primary and community care at a community level. Numerous practice and service delivery innovations and initiatives have been introduced at all levels - practice, health authorities, and provincial level - with the intent of meeting the expanding demand for services due to the population demographics. The roles of family physicians, primary and community care professionals and support staff are central to the effort of supporting patients suffering from frailty, chronic diseases, mental health and substance use conditions. A focus on effective team-based practices and healthy partnerships between care providers and health care administrators will facilitate better care for all British Columbians, and particularly those who are more vulnerable, with a key objective of reducing preventable hospitalization. **Strategies** • PHSA to endorse and implement *Embedding Cultural Safety and Humility within First* Nations *Health Services: A Framework for Action.* PHSA will leverage the framework to also achieve the same goals for other			

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			diverse populations in BC. • BC Cancer Agency to develop an Aboriginal Cancer Control Strategy for BC in partnership with the First Nations Health Authority. • In partnership with regional health authorities, communities and non-governmental organizations, PHSA will develop a new program called Trans Care BC to deliver a coordinated system of care for the transgender population in BC at the provincial, regional and local service delivery levels. **Objective 2.3:** Sustainable and effective health services in rural and remote areas of the province, including First Nations communities. Individuals who reside in predominantly rural communities tend to have comparatively poorer health outcomes and socioeconomic status compared to their urban counterparts. The populations of rural British Columbia are often small, dispersed, and fluctuating. Rural British Columbia is home to many First Nations communities and Aboriginal peoples, and a large percentage of the rural population identifies as Aboriginal. Against this health status backdrop, three specific service challenges stand out in the context of rural and remote communities: ensuring access to quality primary care services; ensuring			

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			pathways to accessing specialized perinatal, medical, and surgical services when they are required; and how best to support aging in place. Access to specialized acute care services and access to ancillary health services is especially challenging, so residents are often required to travel for care. Through the Rural Health Strategy outlined in the Rural Health in BC Policy Paper, the Ministry and health authorities will work with communities, including First Nations, to implement a renewed approach to providing quality health services across rural and remote areas. **Strategies** • BC Emergency Health Services in collaboration with the Ministry of Health will pursue changes to the regulatory framework and expand roles for paramedics to enable effective use of Advanced Care Paramedics in rural and small urban communities. The continued implementation of Community Paramedicine, beginning in 2015, will enable appropriately trained and certified paramedics to use their knowledge and skills to contribute to prevention, health promotion and primary health care in rural and small urban communities where there may be a shortage of health care providers. • BC Emergency Health Services in			

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			partnership with the Regional Health Authorities, to support the introduction of paramedics into an interprofessional team of primary care providers in each of the regional health authorities and participating communities. The successful introduction and sustainment of this initiative is predicated on a clear shared understanding of the role and scope of practice of the community paramedicine paramedics and practice accountability through BCEHS. • BC Children's Hospital & Sunny Hill Health Centre, in conjunction with Child Health BC, will enhance opportunities for children living outside of the lower mainland to receive clinical services through use of two-way video conferencing (Telehealth). • BC Renal Agency to increase screening and outreach activities for high risk patients including First Nations and rural/remote communities (Telehealth). • Cardiac Service BC to lead a provincial process to optimize the consistent and standardized use of remote monitoring for follow up/management of appropriate patients (including high risk and geographically remote) with implantable cardiac devices. • BC Emergency Health Services to			

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			conduct a comprehensive strategic & operational review of inter-facility ground patient transfers to improve emergency response capacity & ensure timely, quality pre-hospital care in rural and remote communities to ensure that when patients need to be transferred from one facility to another to access specialized care, transport occurs by the most appropriate method (for example, air or ground ambulance), considering patient acuity, distance and geography, while maintaining emergency response capacity.			
First Nations Health Authority	**Looking Forward:** **2015/2016 FNHA Summary Service Plan**	**Goal 1: Enhance First Nations Health Governance** Strategic Objectives • Develop and align regional-based supports for relevant decision-making over the design, and delivery of health and wellness services and initiatives • Collaborate with the First Nations Health Council and First Nations Health Directors Association to implement the joint commitments in the health plans/agreements to achieve our shared vision • Build and evolve relationships and leverage opportunities with Federal and Provincial	**Goal 1: Enhance First Nations Health Governance** Key Deliverables: • Develop a plan to reorient current community health planning process to a wellness based approach, including interim improvements to the FNHA process. • Develop plans, approaches, projects, initiatives that respond to identified priorities arising from Regional Health and Wellness Plans. **Goal 2: Promote and implement the BC First Nations Perspective on Wellness as a Health and Wellness Champion** Key Deliverables: • Develop a health literacy campaign to			**Health Status:** wellness **Root Causes:** social determinants (all are captured by the First Nations Perspective on Health and Wellness) **Interventions:** upstream

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		health partners to achieve the tripartite shared vision statement Key Strategies: • In partnership with the FNHC and the FNHDA, engage BC First Nations through Gathering Wisdom for a Shared Journey, regional and sub-regional sessions, and local and urban sessions that are equitable, efficient, and cost-effective. • Facilitate health services improvement through community-led health and wellness planning supporting the identification of regional priorities and issues. • Establish effective working partnerships with the Ministry of Health at a senior executive level, including through governance structures such as Leadership Council, to align the FNHA and First Nations health plan implementation within the provincial health system and provincial Innovation and Change agenda and advance the shared principle of reciprocal accountability. • Establish direct working	support First Nations individuals and families to engage with the provincial health system and FNHA services. • Implement personal health and wellness plan templates and tools at flagship events and through regional engagement sessions. • Develop and implement the annual Wellness Implementation Plan outlining activities in: tools and resources; events; and partnerships, and including a commitment to flagship events engaging Elders and youth. • Coordinate 1000 general health screenings/ assessments at various FNHA supported events. • Advance the First Nations Perspective on Wellness with provincially based health system partners through strong relationships and participation in provincial committee processes. • Develop a tripartite cultural safety framework through the Tripartite Committee on First Nations Health. • Implement the FNHA's edition of the international Indigenous Journal focusing on Wellness. • Conduct regional engagement leading to the development of First Nations Health and Wellness Indicators.			

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		partnerships with the provincial service agencies and providers including provincial health authority boards of directors and senior executives. **Goal 2: Promote and implement the BC First Nations Perspective on Wellness as a Health and Wellness Champion** Strategic Objectives • Engage First Nations individuals and families in their wellness journeys • Support communities in their wellness journeys • Facilitate a two-way conversation on health and wellness between First Nations and mainstream health service providers and provincial partners to support the First Nations Perspective on Wellness Key Strategies: • Implement approaches and initiatives to strengthen health and wellness literacy amongst First Nations individuals and families. • Provide support to First Nations individuals and families in their health and	**Goal 3: Improve Health Service and Programs as a Health and Wellness Partner** Key Deliverables: • Leverage opportunities to be at the forefront of implementing the provincial BC Rural and Remote Strategy. • Develop a Primary Health Care approach. • Finalize and implement a series of strategies, including Mental Wellness and Substance Use Strategy, Cancer Strategy, and Heart Health Strategy. • Explore an expanded mandate for the FNHA's environmental public health program. • Informed by findings of reviews, implement improvements in nursing, National Native Alcohol and Drug Addiction Program, and Indian Residential Schools. • Implement a new approach to upstream investment funding to align with the Perspective on Wellness and wellness promotion. • Establish a quality improvement framework for BC First Nations health programs and services. • Develop a new approach for health facility capital investments. • Provide a First Nations Wellness Guidebook to support the integration of traditional and cultural practices			

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		wellness journeys. • Establish health and wellness champions amongst First Nations leadership. • Support and enable community efforts to champion health and wellness. • Engage BC First Nations communities in a Health through Wellness movement by supporting community based wellness events and activities. • Engage in the processes of the provincial health system to promote the First Nations Perspective on Wellness. • Promote cultural humility with service providers in the broader health system in BC. • Work within the provincial system to align research and data work with the First Nations Perspective on Wellness. **Goal 3: Improve Health Service and Programs as a Health and Wellness Partner** Strategic Objectives • Improve access to, innovation of, and integration with the provincial health system and other mainstream health care	into program and service delivery at various levels. **Goal 4: Strengthen the FNHA as a sustainable and effective First Nations Health Organization** Key Deliverables: • Facilitate ongoing cultural opportunities and supports for FNHA staff, centrally and regionally. • Develop and implement a comprehensive plan to successfully complete the Accreditation Canada process in 2016.			

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		providers to achieve high quality, culturally safe, and patient-centred care for BC First Nations • Transform FNHA Health Programs and Services in a manner that incorporates First Nations input and maximizes partnership opportunities • Partner with BC First Nations to support their delivery of high quality health programs and services Key Strategies: • Promote innovative models of care that support sustainable, culturally safe, and integrated programming. • Maintain a focused effort on improving the primary health care system for BC First Nations. • Align FNHA funded and delivered health services with First Nations health and wellness perspectives. • Support organizational capacity development at the community level through professional development, accreditation, and continuous quality improvement methodology. • Provide support and access to				

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		BC First Nations communities of innovative e-health and information management and technology as enablers of better health and wellness services. **Goal 4: Strengthen the FNHA as a sustainable and effective First Nations Health Organization** Strategic Objectives • Foster strong leadership and First Nations organizational culture throughout the FNHA • Create an environment to support staff in developing a safe, healthy and productive workplace • Strive for excellence and client-centredness in serving First Nations people and communities through good organizational governance, redesign and operations Key Strategies: • Build a common FNHA organizational culture founded upon the Seven Directives, the First Nations Perspective on Wellness, and respect and honouring of First Nations values and teachings. • Support employee knowledge of and access to traditional				

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		knowledge and practices. • Establish ongoing learning and professional development as a fundamental building block of organizational success.				
Regional health authorities						
Fraser Health	**Strategic and Operational Plan 2014/15 – 2016/17** **June 2014**	Ten linked areas on which Fraser Health will prioritize and sustain focus to achieve meaningful improvements in population and patient outcomes in the coming years. 1. Capacity for care across all sectors (efficiency and effectiveness) 2. Quality and safety 3. Public health measures 4. Accountability 5. Staff and physicians 6. Patient centredness 7. Governance 8. Operational organization and management 9. Lower Mainland collaboration 10. Budget accountability	**3. PUBLIC HEALTH MEASURES** Fraser Health has a relatively young population, and its public health initiatives need to reflect this through indicators such as immunization rates for MMR (measles, mumps, rubella), and rate of low birth weight infants. Fraser Health also has a number of separate and distinct communities. Programs specific to meeting population and public health needs will be expanded. Indicators such as number of communities with enhanced tobacco reduction bylaws, number of communities with a municipal alcohol policy, and number of communities with a healthy living plan will measure our efforts. Fraser Health will also focus on the rapidly growing older population with targeted measures including active leisure in those 75 years of age or greater, and number of falls in residential care facilities. **6. PATIENT CENTREDNESS** Fraser Health will build on current work to implement a framework and toolkit	Population Health Measures: • Immunization rates for MMR (measles, mumps, rubella) • Rate of low birth weight infants • Active leisure in those 75 years of age or greater • Number of falls in residential care facilities Community Health Measures: • Number of communities with enhanced tobacco reduction bylaws • Number of communities with a municipal alcohol policy • Number of communities with a healthy living plan		**Root Causes:** social determinants (diversity) **Populations:** vulnerable

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			that includes the diverse nature of its population. This means putting the patient and family at the heart of every decision and ensuring that we systematically examine the patient experience when redesigning services and care. It also means measuring the patient experience in a more robust manner			
Interior Health	**Charting the Course: Interior Health's Planning Principles and Considerations for Change** **February 2012** ***service plan not available on website**	**Goal 1: Improve Health and Wellness** **Goal 2: Deliver High Quality Care** **Goal 3: Ensure Sustainable Health Care by Improving Innovation, Productivity, and Efficiency** **Goal 4: Cultivate an Engaged Workforce and Healthy Workplace**	**Goal 1: Improve Health and Wellness** 1.1 Implement health promotion and prevention initiatives 1.2 Work with First Nations and Aboriginal partners to plan and deliver culturally sensitive healthcare services to improve the health and wellness of Aboriginal people 1.3 Assess, recommend and implement actions to improve the health of Interior Health's population 1.4 Deliver patient and family centered care **Goal 2: Deliver High Quality Care** 2.1 With partners, delivery primary and community care to meet population and individual health care needs 2.2 Implement health improvement strategies for targeted populations across the continuum of care 2.3 Provide efficient, effective acute			**Health Status:** wellness **Root Causes:** social determinants (indigeneity) **Populations:** targeted populations

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			services that are linked across the system of care 2.4 Deliver evidence informed quality and safety initiatives and pursue zero never events **Goal 3: Ensure Sustainable Health Care by Improving Innovation, Productivity, and Efficiency** 3.1 Implement innovative service delivery models 3.2 Develop priority plans and implement transparent decision making processes 3.3 Enhance IMIT solutions 3.4 Build research and education capacity **Goal 4: Cultivate an Engaged Workforce and Healthy Workplace** 4.1 Enhance health and safety in the work environment 4.2 Improve employee, physician, and volunteer engagement 4.3 Build leadership capacity			
Island Health	**Island Health Service Plan 2015/16 – 2017/18**	**Goal 1: Support the health and wellbeing of British Columbians** Overall health and wellness is influenced by many factors including education, income, housing and healthy living. Within the context of supporting community	**Objective 1.1: Improve population health and reduce disparities** Strategies • Develop innovative ways to promote health and support people as they take responsibility for their own health. • Develop and implement prevention	**Goal 1:** Performance Measure 1: Healthy Communities • Per cent of communities that have completed healthy living strategic plans **Goal 2:**	**Action Plans/Strategies:** • Healthy Families BC Policy Framework • Healthy Families BC – Healthy Communities Strategy • Community Engagement	**Health Status:** well-being, wellness, inequity, disparity **Root Causes:** risk factors, social determinants (indigeneity) **Populations:**

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		population health needs, Island Health will explore new approaches and opportunities to support health in the future. This involves working with a wide range of public and private partners, including service agencies, local non-profit organizations, all levels of government, the education sector, Aboriginal leaders, businesses and residents. Effective partnerships among these groups provide the collective wisdom and experience to achieve common goals, including new ways to promote health and prevent disease. **Goal 2: Deliver a system of responsive and effective health and care services across British Columbia** **Goal 3: Ensure value for money**	and promotion initiatives focused on children and youth in partnership with community stakeholders. • Focus on improving the health of vulnerable populations, including the chronically ill, seniors and the frail elderly, and those living with mental illness and substance use issues to reduce health disparities. • Continue to implement healthy living and disease prevention services to address the needs of high-risk populations, and reduce health inequities in alignment with the Healthy Families BC Policy Framework. • Continue to implement strategies to address the unique health care needs of Aboriginal peoples in partnership with the First Nations Health Authority and Aboriginal communities. • Provide effective prevention, protection and environmental programs that target food safety, clean air and water, infection control and communicable diseases. • Develop web strategies that improve how health promotion and public health information is made available and accessed in communities **Objective 1.2: Collaborate with communities and strengthen partnerships to improve health and care**	Performance Measure 2: Managing Chronic Disease in the Community • Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and over (age standardized)	Framework • North Island Hospitals Project **Partnerships:** • First Nations Health Authority • Aboriginal communities • Other health sectors • Research and educational	vulnerable, at risk,

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			Strategies • Work with partners to discover new ways of thinking about, and delivering on, health and care services. • Develop a Community Engagement Framework that defines how Island Health will develop and sustain partnerships. • Continue to collaborate with community stakeholders to develop healthy living action plans and advance innovative approaches to improving community health and wellbeing in alignment with the Healthy Families BC – Healthy Communities Strategy. **Objective 2.2: Provide effective and sustainable primary and community focused care to meet the needs of communities and vulnerable populations** Strategies: • Enhance services for those living with mental illness or substance use through implementation of the Mental Health Substance Use Operating Plan with focused efforts on the implementation of new treatment beds and intensive case management teams to support high needs clients. • Work with the Doctors of BC, Ministry of Health and Ministry of Children and Family Development to improve			

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			access to specialty care in acute and community services for children and youth. • Support implementation of the 'Rural Health Services in B.C. Policy Paper' by developing community plans to improve health and wellness and quality of care in rural and remote communities. • Promote excellence in care for frail seniors through timely identification, assessment and care of 'at-risk' seniors, supporting seniors with dementia and their caregivers, and improving the efficiency and effectiveness of home care services. • Continue to implement the Community Focused Health and Care strategy to improve local service alignment, enhance client-friendly service access, and provide support for patients/ clients, to remain healthy and in their homes for as long as possible. • Improve services for individuals with medium to high complex chronic conditions through a service model redesign based on community partnerships and interdisciplinary collaborative practice teams built around primary caregivers. • Continue implementation of the plan to double hospice beds in alignment with the Ministry of Health's end-of-life strategy.			

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			Objective 3.1: Ensure the best value through collaboration and courageous innovation Strategies • Collaborate with health sector partners to advance the information technology infrastructure in the province to support innovation and integration of health services. • Continue the North Island Hospitals Project, including the St. Joseph's General Hospital transition, with a focus on developing a network of care to meet the needs of local communities and First Nations. • Work with research and educational partners to pursue learning, education and research opportunities to support system changes.			
Northern Health	**Northern Health Service Plan 2015/16 – 2017/18**	**Goal 1: Support the health and well-being of British Columbians** **Goal 2: Deliver a system of responsive and effective health care services across British Columbia** **Goal 3: Focus on Our People and Ensure value for money**	**Goal 1: Support the health and well-being of British Columbians** **Objective 1.1: Targeted and effective primary disease prevention and health promotion** Strategies: • Partner with First Nations to implement initiatives that will improve the health of First Nations people. The Northern First Nations Health Partnership Committee (made up of representatives from First Nations Health Council: Northern Regional Caucus, Northern Health, and First	**Goal 1:** Performance Measure 1: Healthy Communities • Percent of communities that have completed healthy living strategic plans **Goal 2:** Performance Measure 2: Managing Chronic Disease in the Community • Number of people with a chronic disease	**Action Plans/Strategies:** • *Northern First Nations Health & Wellness Plan* • *Northern Health Aboriginal Health Plan* • Healthy Communities Strategy • Rural Health Strategy **Partnerships:** • First Nations Health Authority • First Nations communities • Northern First Nations Health Partnership	**Health Status:** well-being, health inequity (implied by "gaps") **Root Causes:** social determinants (indigeneity) **Populations:** rural/remote, vulnerable, at risk

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			Nations Health Authority) have identified a number of action priorities in the *Northern First Nations Health & Wellness Plan*. In collaboration with northern communities and Aboriginal peoples, Northern Health has established an aligned *Northern Health Aboriginal Health Plan*. In 2015/16 Northern Health will work to implement elements of these plans in partnership with the First Nations Health Authority and our northern community partners. • Partner with communities to implement initiatives that will lead to healthier communities with residents making healthier choices. Northern Health's "Healthy Communities" strategy has been highly effective at establishing shared improvement plans with community partners. Northern Health is well on track to meet the Ministry policy requirement for community health plan development and we will continue to implement these strategies with communities. **Goal 2: Deliver a system of responsive and effective health care services across British Columbia** **Objective 2.1: Establish a culture of patient and family-centred care** Strategies: • Develop and implement a strategy to	admitted to hospital per 100,000 people aged 75 years and older (age-standardized)	Committee • Northern community partnerships	

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			enhance patient and family-centred care. • Meet Accreditation Canada required organizational practices (ROPs). . • Meet prioritized improvement goals in targeted areas. In addition to meeting ROPs, Northern Health will identify a small number of regional improvement priorities toward which we can align plans and resources. **Objective 2.2: Integrate primary and community care services** Northern Health will work with physicians to continually improve and better align primary health care and community services so all residents of northern British Columbia are served better. It is believed that frail elderly, people with mental health and substance use issues, people with chronic conditions, troubled children and youth, and families with babies will benefit most from such improvements. Strategies: • Implement an organization structure change that supports integrated services. • Complete the categorization of community services between specialized and those that belong in the primary care home. **Objective 2.3: Optimize patient/resident access to and flow through facility-based care**			

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			Strategies: • Enhance rehabilitative aspects of facility-based care. With an aging underlying population and high incidence of chronic disease and disability, Northern Health must strengthen our approaches to rehabilitation in acute and residential care to optimize quality of life and to help reduce the burden of demand on these high cost, highly specialized services. **Objective 2.4: Effective and sustainable rural health services** Northern Health's region is geographically vast. Our communities are relatively small and rural. In many ways these are our strengths. Historically, however, health services for rural jurisdictions have been planned and implemented based on specialty-oriented urban models – leading to gaps and unmet expectations. Northern Health believes that a high quality sustainable system of care can be established for our rural jurisdiction. In many ways we are well on our way. Yet some aspects of our system can be further improved if we consider them with a "rural lens." The Ministry of Health has prioritized rural health and has established a Rural Health Strategy, which sets out some of the key aspects of a sustainable rural health service			

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			system. Strategies: • Establish and execute strategies to achieve our health human resources (HHR) plan. • Leverage technologies that enable safe and appropriate care closer to home. • Adapt transportation and service pathways to our rural framework. **Goal 3: Focus on Our People and Ensure value for money** **Objective 3.1: Continue to ensure efficiency, collaboration and quality improvement to ensure sustainability of the publicly funded health system** Strategies: • Northern Health will continue to develop and nurture a vast array of partnerships to better enable needs identification, planning and service delivery and to reflect the various roles the organization plays in northern communities (e.g., roles in education, research, employment, etc.). Among others, Northern Health will continue to partner with: First Nations communities through the partnership accord with the First Nations Health Authority, First Nations Health Council - Northern Caucus and Northern First Nations Health Partnership Committee.			

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Vancouver Coastal Health	**2015/16 – 2017/18 Service Plan**	**Goal 1: Support the health and wellbeing of VCH residents.** VCH is committed to helping residents who do not enjoy good health or who are at risk of diminished health, along with supporting residents who enjoy positive health status. In particular, First Nations communities and individuals who reside in rural and remote communities, tend to have comparatively poorer health status relative to urbanites. Through promotion and prevention initiatives that have an impact on the overall health of residents, VCH will support the health of VCH families and communities by encouraging healthier lifestyles and choices and enabling self-management. **Goal 2: Deliver a system of responsive and effective health care services across VCH.** **Goal 3: Innovate to ensure value for money and sustainability**	**Goal 1: Support the health and wellbeing of VCH residents.** **Objective:** Improve the health outcomes of the populations we serve. **Key Strategies:** • Advance the VCH Coastal Urban-Rural-Remote Network (URRN) strategy by leveraging resources and expertise through the networking of urban and rural and remote communities. Share best practices, expertise and innovations. Expand the knowledge network and resources to support recruitment, reduce population health inequities and disparities in access to care, and to advance learning, quality improvement and standardization of evidence-based care. • Drive the ongoing recruitment and retention of health care providers for rural and remote areas with a strong focus on generalist practices. Build greater access for communities through expanded telehealth services and more visiting healthcare providers. • Partner to improve the health of residents, particularly in First Nations communities and rural and remote communities within VCH by engaging with communities, schools, workplaces and health settings to promote healthy lifestyles and healthy	**Goal 1: Support the health and wellbeing of VCH residents.** Performance Measure 1: Healthy Communities • Percent of communities that have completed healthy living strategic plans **Goal 2: Deliver a system of responsive and effective health care services across VCH.** Performance Measure 2: Managing Chronic Disease in the Community • The number of people with a chronic disease admitted to hospital per 100,000 people, aged 75 years and over (age-standardized) Performance Measure 3: Community Mental Health Services • Percent of people admitted to hospital for mental illness and substance use who are readmitted within 30 days, aged 15 years and over	**Action Plans/Strategies:** **Partnerships:**	**Health Status:** well-being, health inequity, health disparity **Root Causes:** risk factors, social determinants (indigeneity, disability) **Populations:** rural/remote, vulnerable, at risk, marginalized **Interventions**

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			communities. • Continue to expand partnerships with the First Nations Health Authority (FNHA) through service linkages, co-location and clinic arrangements, Aboriginal patient navigators, and knowledge exchange and staff training to improve access to services. • Support the continued implementation of ***BC's Guiding Framework for Public Health***. Work with the Ministry of Health, other Health Authorities and partners to support ***Healthy Families BC***, focussing on providing evidence-based programs and interventions to address major risk and protective factors across the life cycle. Support local governments to take leadership roles in the health and well-being of the citizens in their respective communities. • Support the ***BC Healthy Connections*** project and the Nurse-Family partnership program through participation and evaluation to help guide future direction. **Goal 2: Deliver a system of responsive and effective health care services across VCH.** **Objective:** Embed patient-centered practices in the delivery of all care and services.			

Jurisdiction	Title of Service Plan	Strategic Goals				Equity Reference
		Strategic Goals	Objectives/Strategies	Outcomes/Measures	Operationalized Through	
			Key Strategies: • Make coordinated care integral to all professional services and shift to interdisciplinary teams integrated with General Practitioner (GP) practices to improve quality of life and functional status of people living in the community with chronic health conditions and disabilities. • Improve care for medical patients through collaborative efforts to reduce care sensitive adverse events and through support for older adult patients with medical/complex challenges. • Support the full implementation of the BC mental health and addiction plan ***Healthy Minds, Healthy People,*** including the expansion of addictions spaces. Help clients with the most complex form of severe addiction and/or mental illness who present a greater risk to themselves and other individuals (including in Vancouver's Downtown Eastside) through comprehensive care, stabilization and support services. **Objective:** Reduce the demand for acute and residential care through increasingly effective primary, home and community services. **Key Strategies:** • Collaborate with Divisions of Family Practice to create an integrated, inter-			

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			professional primary and community care model of service delivery in each community based on population demographics. Support continued development of full service family practices and team-based family practices. Establish linked community and residential care service practices for older adults with chronic conditions and for patients with mental health and/or substance use issues. Support full service practice teams with access to medical specialist shared care and consultation. • Support the collaborative role of the family physician within hospitals in the care of their admitted patients, as well as for other patients who are not attached to a family physician and/or family practice. • Develop a prioritized plan to address gaps in current VCH community-based services, including enhanced care for frail seniors in the community and in residential care, the role of walk-in clinics and urgent care centres in the continuity of care, better linking of home health providers, nurse practitioners, and specialist teams with local family physicians and family practices, and expanded staff training to support dementia care and end of life care. • Improve patient flow and emergency			

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			department responsiveness by reducing the number of hospital long stay and alternative level of care patients through earlier discharge planning and expanded community support. • Increase community capacity and help prevent emergency visits and acute admissions by shifting to more nursing visits in ambulatory settings and to more telephone contact to support clients and families. • Avoid unnecessary hospital admissions for our frail elders and return them safely to their homes in a timely and well-supported manner through community quick response teams in emergency departments, effective communications, daily emergency department rounds and staff huddles. • Expand mental health and addiction housing partnership projects, in cooperation with BC Housing and other partners. Complete the ***Joseph & Rosalie Segal Family Health Centre*** as a key resource within the continuum of services for people suffering with mental health and addiction issues. Implement new spaces across VCH for addiction treatment, prevention and services.		

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		Strategic Goals	Objectives/Strategies	Outcomes/Measures	Operationalized Through	
			Goal 3: Innovate to ensure value for money and sustainability **Objectives:** Create a workplace where staff and physicians can do their best every day. Partner with physicians to improve patient outcomes and quality. Attract, develop and retain outstanding leaders. **Key Strategies:** • Enhance support to home, community, residential care, and remote and rural areas in forecasting, developing and implementing health human resources plans.			