Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources

Executive Summary

Strategic Context

A key proposition set out in Setting Priorities for the B.C. Health System and a subsequent document on B.C. Health System Strategy Implementation: A Collaborative and Focused Approach is that the current utilization of hospitals is neither sustainable nor the best delivery system for meeting the needs of several key populations. The documents argue the need to radically rethink and reposition hospital care by providing a more effective range of services in the community. A suite of strategic policy papers – primary and community care, surgical services, and rural health services - produced by the Ministry of Health are intended to address this shift in service delivery. This will have a significant impact on health human resources management.

The province currently lacks a coherent, comprehensive and sustained health human resource strategy. The Health Human Resource Strategy advanced here is a key enabling strategy identified to support the priorities of the health system and to produce an engaged, skilled, well-led and healthy workforce that can provide the best patient-centred care for British Columbians.

This policy paper sets out both a framework and direction for health human resources in British Columbia. The proposed framework is designed to structure and align our actions across different levels (practice, regional/organizational, and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote). The policy paper is also proposing a number of specific key actions to implement a comprehensive health human resources strategy that will drive the change required to achieve quality services and health outcomes for British Columbians over the coming decade, starting in 2015.
The goals and objectives of the framework and direction align with the strategic direction for the health system in *Setting Priorities for the B.C. Health System* (Priorities 1, 2, 3, 4, 5, 6, 7, and 8) and the areas of focus set out in the April 2014, the Ministry of Health published *B.C. Health System Strategy Implementation: A Collaborative and Focused Approach*. They also align with the three overarching goals of the *Triple Aim* (developed through the Institute of Health Improvement):

1. Improving the health of populations;
2. Improving the patient experience of care (including quality and satisfaction), to which B.C. has recognized the additional requirement of improving the experience of delivering care for providers and support staff as critical to patient-centred care built on efforts of those who deliver and support health services; and
3. Reducing the per capita cost of health by focusing on quality (especially effectiveness and appropriateness) and the efficiency of health care delivery.

**The Case for Change**

The health care needs of the population in B.C. are grouped into four areas: Staying Healthy, Getting Better, Living with Illness or Disability, and Coping with End of Life.

*Staying Healthy:* This dimension accounts for 16 per cent of the provincial population, who account for nine per cent of expenditures for minor episodic health needs and maternity care services.

- Healthy Non-User (14% of population; 0% of expenditures)
- Healthy with Minor Episodic Health Needs (34% of population; 5% of expenditures)
- Maternity and Healthy Newborns (2% of population; 4% of expenditures)

*Getting Better:* This dimension accounts for only three per cent of the population and uses six per cent of services. The majority of patients in this category have major or significant, yet time-limited, health needs (three per cent of population; six per cent of expenditures).
Living with Illness or Disability: This dimension accounts for over 40 per cent of the population and almost 50 per cent of all health system expenditures accounted for in the matrix ($5.2 billion). This group requires significant, sustained, and co-ordinated effort on the part of health service providers to achieve the best possible health outcomes. The Living with Illness or Disability dimension is subdivided as follows:

- Low Complex Chronic Conditions (29% of population; 15% of expenditures)
- Medium Complex Chronic Conditions (9% of population; 12% of expenditures)
- High Complex Chronic Conditions (4% of population; 12% of expenditures)
- Mental Health and Substance Use Needs (2% of population; 5% of expenditures)
- Cancer (1% of population; 5% of expenditures)

Coping with End of Life: The population in this category is dealing with health challenges that will likely not diminish. While accounting for less than two percent of the provincial population, this group uses 35 per cent of all services accounted for in the matrix ($3.7 billion):

- Frail in Community (<1% of population; 9% of expenditures)
- Frail in Residential Care (1% of population; 21% of expenditures)
- Palliative Care (<1% of population; 5% of expenditures)

Responding to this evolving and changing profile of population and patient needs requires expanding and developing primary and community care services while appropriately delivering needed acute hospital care needs, these changes have health human resource implications at the practice and service delivery level; at the organization level in terms of enabling effective change and operational management; as well as at the provincial levels in terms of consultation and buy in from associations and unions, aligning education, training and regulatory frameworks, improving forecasting and recruitment capacity, aligning compensation and working regimens.

In this context, the strategic policy paper identifies key HR related themes linked to the directions outlines in the Primary and Community Care strategic policy paper, the Rural Health policy paper, the Surgical Services policy paper. It also highlights the need for continuous improvement across the scope of health services to meet population and patient health care needs and its implications for health human resource management. Successfully supporting these kinds of directional changes requires an aligned strategy across different levels (practice, regional/organizational, and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote).
The strategic policy paper proposes a conceptual model for health human resource management and assessment of current capacity for the purpose of achieving target health outcomes and, in the process, enhancing the quality of the health care delivery experience. The conceptual model is based on the micro (practice), meso (organizational) and macro (provincial) context descriptions commonly used in the social sciences. These inputs or levels of analysis are not isolated from one another. More frequently than not, they interact across the three levels.

- The **micro** layer is where the health human resource deployment efforts of operational service planners take shape in the form of individual and team work design.
- At the **meso** layer, service delivery is impacted by interventions that take place at organization level, often but not always through human resource departments.
- At the **macro** layer, service delivery is impacted by the province’s health human resource infrastructure; such as health professional education, credentialing, and regulation.

The policy paper argues that any health service delivery team must have five core characteristics in order to provide quality patient care. Health service providers must be **accessible** to the patient. They must be **engaged and motivated** to achieve health service delivery goals. They must possess the **skills and competencies** required to deliver patient-centred health services. They need a workplace environment that is **safe and healthy**. Finally, they must receive the **support and leadership** they need from the organization to deliver service effectively. The role of health human resource management is to enable those five characteristics.

**Practice Level Input**

The practice level inputs include HHR deployment, professional and inter-professional culture and motivation/engagement.

The **HHR deployment** model focuses on **staff mix** and on **skill management**. The most common approaches for optimizing staff mix are adjusting the number of personnel, mixing qualifications (i.e., basic versus advanced credentials), balancing junior and senior staff members (i.e., experience), and mixing disciplines (i.e., inter-professional care teams). Evidence for the effectiveness of inter-professional primary care teams, especially in the context of chronic disease management, is particularly promising. Staff-mix within primary care teams typically includes nurses, physicians, specialists, pharmacists and (more rarely) social workers, non-clinical staff and volunteers.
In addition to addressing staff mix, there are approaches for managing the skills of individual health service providers and distributing tasks between them. The policy paper identifies a number of models - role enhancement, role enlargement, skill flexibility and role delegation - which have been applied in practice with various degrees of success.

HR deployment also raises the issue of optimizing scope of practice as a strategy to better utilize health professionals. Enabling effective team work will require experimentation and a cross level approach to remove barriers and building enablers to optimizing scopes of practice. While there have been multiple experiments with team designs across the health system in B.C., the structured consideration of the elements set out above and the cross level need for co-ordinated action has been lacking to date. Linked to effective team work at the practice level is the issue of culture. Health professions such as nursing, medicine and pharmacy, have distinct cultures, including differing beliefs, language, values, customs and knowledge. It is important for health system stakeholders to be aware of how these distinct cultures might impact the direction and success of patient-centred health system change.

When different professions work together, a shared inter-professional culture can emerge at the practice level; but equally as each profession brings its own culture to the team this can equally be a cause of conflict. The human resource management challenge is to build on this common ground so different professions can work as a collaborative, effective health service delivery team.

Health professionals do recognize collaborative (inter-professional) care as the new way going forward. One of the most important interventions for promoting inter-professional culture has been to provide inter-professional training. Such programs are already producing results. Inter-professional (IP) interventions create a collaborative culture and increase provider satisfaction, and strong evidence that IP interventions reduce the cost of patient care. There is also sufficient evidence that students are attracted to clinical placements in rural communities when there are IP opportunities.

Although professional and inter-professional culture is most often experienced at the practice level, it impacts (and is impacted by) all levels of the health system. While this is not a new issue in B.C., there is still a significant distance to go in enabling this approach at a practice level supported by organizational and provincial actions.
Provider motivation and engagement are essential during times of change. Motivation exists when there is alignment (a matching up) between the health service provider’s individual goals and the organization’s goals. Engagement is important to HHR management because it has an impact on productivity, turnover, employee safety incidents, absenteeism, patient safety incidents and quality.

The policy paper identifies a number of best practices for preserving (or enhancing) provider motivation when change is implemented. It also explores the issue of physicians’ engagement because it is different from engaging other health service providers. Engaging physicians in health system decision-making is seen as critical to successfully executing on health system strategies. Physicians possess specialty (medical) information that is required to make strategic decisions about the health system. They are also in the best position to interpret and analyze medical information.

Motivation and engagement are seen as critical issues at the practice level and are influenced by action or inaction taken at both the organizational and provincial levels of the health system. The impact of health sector change on health service provider motivation and engagement will be mediated by activities that go on at the organizational and provincial levels as is addressed below under the need for change management.

Organizational Level Inputs

The organizational level inputs discussed here include self-efficacy recruitment and retention practices; transition from education to practice; health human resource management; change and leadership management; workplace health and safety; and corporate learning and development.

Recruiting and retaining health service providers is key to ensuring that British Columbians continue to have access to the health services they need. The drivers of recruitment and retention vary from salary and benefits to other factors other factors such as opportunities for advancement, working with talented co-workers and the overall work environment mattered much more. These different values have implications for how recruitment and retention initiatives should be designed.
The recruitment and retention of health service providers in rural and remote parts of B.C. is crucial for ensuring adequate access to health services in these communities. These challenges may be overcome by knowing what counts to employees and practitioners – for example, by improving professional development opportunities or adopting tele-health and other distance technologies for recruiting and retaining occupational therapists (Wielandt & Taylor, 2010).

Supporting ill and injured providers through effective disability management contributes to the retention of employees with valuable skills. Health service providers invest a significant amount of time, effort and money in their chosen occupation. When disability removes a health service provider from the workplace, it has negative impact on both the provider and the patient.

The transition from education to practice is crucial for recruiting and retaining younger workers and ensuring safe and high-quality patient care. Professional education programs prepare students with the basics, but the academic setting is different from the workplace.

B.C. has experimented with a number of models and tools to close the gaps in knowledge and experience such as pre-registration (student) placements and formal transition programs.

Transition to practice is also a concern for health professionals that have been educated outside of Canada. Helping internationally-educated doctors transition to practice in Canada increases the number of family doctors available to B.C. citizens.

In 2015, the Government of B.C. will launch a pilot program for internationally-educated doctors who have completed their residency program in another country. The Practice Ready Assessment-British Columbia program will provide qualified family physicians with a pathway to being licensed in British Columbia. Similarly, the province is working collaboratively with the province’s three nursing regulatory bodies to develop a “nursing community” assessment service for internationally educated nurses who may qualify to practice in B.C. as registered nurses, licensed practical nurses or care aides.

Health human resource management (HHRM) is a key organizational building block which warrants further careful review and consideration with respect to the system’s current capacity both in the formal sense of the HHRM organizational units in health
authorities (including physician health human resource management) as well as the distributed capacity and competencies of operational managers.

Change leadership and management are critical to any successful change process – from local initiatives to wide-scale reform. Organizations must build capacity within their senior management, line managers and front-line workers to plan, implement and sustain change in a manner that meets their overall goals.

Three essential elements of change management (defined in this paper) have been found to require attention in health care: power dynamics, organizational capacity and process for change (Antwi & Kale, 2014). In addition, the change process includes three phases: preparation, implementation and sustainment (Antwi & Kale, 2014). Preparing for change requires a clear understanding of the reason for change and an assessment of the organization’s environmental context, including political forces, economic influences and financial capabilities. It also includes an analysis of social trends, technological innovations, ecological factors and legislative requirements (if applicable). The purpose of this analysis is to determine readiness for change.

The paper identifies key challenges during the three phases of change management. For example, preparation and implementation of change initiatives without proper attention to sustainment inevitably lead to results that fail to live up to potential, while key challenges during the implementation phase included altering well-established patterns of care and a lack of communication and co-ordination.

Building change leadership and management capacity within the health system’s leadership structure is essential across the micro, meso and macro levels of the system. The policy paper discusses the value of driving this agenda using a provincial collaborative for health system leadership development - “Leadership Linx – A Provincial Pathway to Leadership Development” which consists of a comprehensive suite of leadership programs focusing on five key areas: coaching, mentoring, new managers (Core Linx), experienced leaders (Experience Linx) and senior leaders (Transforming Linx). The Linx curriculum ties in with the five domains of LEADS:

- Leads Self
- Engages Others
- Achieves Results
- Develops Coalitions
- Systems Transformation
The BC Health Leadership Development Collaborative continues to evaluate and assess the effectiveness of the Leadership Linx programs.

A safe and healthy workplace is a vital requirement for a healthy, engaged and productive healthcare workforce. Health care workers are one-and-a-half times more likely than the average Canadian to be off work due to illness or disability (Canadian Healthcare Association, 2013).

In B.C., occupational health and safety standards are established at the macro (provincial) level through provincial legislation and WorkSafeBC regulations, guidelines and policies; however, health care workers experience workplace health and safety culture at the practice level. WorkSafeBC monitors employers to make sure they comply with these standards.

Psychological workplace health is also a focus at the national level. Although a psychologically healthy and safe workplace is a clear priority for enabling a healthy, engaged and productive healthcare workforce, efforts to address this issue have thus far been limited to the local/regional health authority level. British Columbia currently lacks a common approach to creating a psychologically healthy and safe workplace (e.g., collectively adopting the CSA standard).

Currently, each health authority is accountable for corporate developing learning and development programs for their staff, while physicians independently pursue required continuing medical education. While continuous improvement is identified as critical to the health care agenda in B.C., there is no overarching collaborative framework in place to drive this strategy. In 2012, the Government of B.C. implemented an evidence-based corporate learning strategy for the B.C. public service. While the public service differs from the health sector in many ways, the underlying evidence and research does apply.

Corporate learning and development programs must respond quickly to learning needs that result from rapid technological, demographic and social change. Also, they must be accessible and responsive to enable responsive learning.
Technology’s role in the health system is to enable health service providers to provide quality patient-centred care. Technology is used in the context of medical, surgical and diagnostic procedures. It is also used to manage information. Information technology is usually broken down into administrative data (e.g., human resource data, scheduling data, patient accounts) or clinical data (e.g., patient records, diagnostic tests, care plans, etc.) (Blackwell, 2008).

Provincial Level Inputs

The provincial level inputs include professional education, professional legislation and regulation, labour organization and bargaining, funding and remuneration, health human resource planning and governance, and provincial engagement.

There has been increased recognition of the interdependence between professional educational planning and access to consistent and appropriate healthcare across the province. The Ministry of Health is working with education and service delivery partners to ensure education programs and continuing professional development meet the needs of practitioners and health care system.

The self-regulating professions are governed by 22 regulatory colleges under the Health Professions Act while the emergency medical assisting and social workers are a self-regulating profession governed by under a specific regime set up by two other pieces of legislation.

Professional self-regulation is a model that allows government to have some control over the profession’s activities (e.g., services provided), without having to maintain in-depth knowledge of the profession’s practice (Balthazard, 2010). The primary functions of the professional colleges are to ensure their members are qualified, competent and following clearly defined standards of practice and ethics. All colleges administer processes for responding to complaints from patients and the public and for taking action when it appears one of their members is practicing in a manner that is incompetent, unethical, illegal or impaired by alcohol, drugs or illness.
The policy paper discussed a number of issues related to labour organization and bargaining, including: the structure of the bargaining organizations and units; the parties to the bargaining process; and the challenges arising from the provincial collective agreements. It concludes that this is a complex area but one which through a candid recognition of competing interests, combined with a willingness to work together to navigate those interests, we can leverage the significant skills and professional commitment of the health sector workforce to support the required health system change.

The majority of the health care budget is spent on compensation for health human resources. Compensation for service delivery represents approximately 70 cents of every health care dollar spent in the public system (Setting Priorities, pg. 14). The total compensation\(^1\) cost for the public health sector is roughly $12.6B a year, which covers over 170,000 health professionals including physicians, nurses, allied health workers, supporting staff, community workers, dentists, optometrists, midwives and managements/excluded staff.

In order to plan ahead to ensure citizens have access to the health services they will need in the future, planners and policy makers must be able to predict, as accurately as possible: a) what health services will be required; b) how many health professionals (and what type) will be needed to provide those services; and, c) how many health professionals (and what type) will be available to provide those services. Once both supply and demand are known, strategies can be developed to fill any projected gaps, such as an anticipated shortage of certain health professionals.

The Ministry of Health and the Health Employers Association of BC (HEABC) are now developing a new Integrated Health Human Resource Planning model that will further improve the province's health human resources planning ability. The model will use information on the health of the population, utilization of health services from the Health System Matrix, and data from the Ministry of Health and HEABC to generate specific health service provider information geographically and by designation (i.e. metro, urban, rural and remote). The model will forecast the number, type and location of providers required to provide appropriate health care services on an annual basis over a five and 10 year projection.

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\(^1\) Total Compensation is defined as all costs associated with employment, including wages, overtime, premiums, allowance, pension and benefits.
Setting Priorities identifies the need for refreshed governance and standing committee structures to facilitate greater engagement and collaboration among the ministry, health authorities and other health system partners in support of key strategic priorities, including health human resources. A new Standing Committee on Health Human Resources reporting to Leadership Council is required to drive the health human resources strategic agenda.

The opportunity for health service provider groups to provide feedback to senior decision makers at the provincial level has clear benefits in terms of engagement and addressing issues of concern to all parties at a policy level. A provincial engagement framework has been established with the Doctors of BC in order to give effective voice for physicians on policy matters at the senior levels of government. This model will be proposed to other associations and unions to give their members the same opportunity.

The Next Steps

The recommendations put forward in this paper push the boundaries of what we have been doing so far and emphasize a need for timely, short and longer term action. I want to emphasize that we are putting forward a range of proposed actions that we think will improve our health services in a number of important areas and better position our health system to meet increasing demand from key patient populations. The actions proposed would be undertaken opportunistically building on initiatives and innovative service delivery already underway across B.C., but also will require a systematic approach to change that builds a truly patient-centred system of care (The British Columbia Patient-Centered Care Framework).

You may have different views on the proposed action, how to improve the system or how to implement these recommendations and that is precisely what we are testing out by posting these papers. Your feedback will be part of a healthy and thoughtful discussion of these recommendations. Over the coming three months my aim is for us to achieve a good level of consensus across key partner and stakeholder groups of what the final set of specific actions should be; and then, for us to move forward collaboratively to figure out the detail, the how and the timing of implementation linked to better meeting current and emerging needs in a timely way. Patients as Partners will be an important part of this process.
I want to assure you the implementation of the final set of recommendations will allow enough flexibility for a diversity of implementation approaches across communities but that I also intend to push us to create a truly integrated system of health care that works for patients and not just for us. Your input, creativity and innovation in shaping and implementing the final set of recommendations at the local, organizational and provincial levels will bring new solutions and enrich our B.C. health system.

The implementation of a health human resource management strategy will be an ongoing multi-year process, and the directions set out here are intended as the more immediate actions to be undertaken over the next two fiscal years (2015/16 - 2016/17) to shape and enable implementation of the HHRM strategy over the longer term.

1. Establishing a Coherent Policy Framework

1.1 The Ministry of Health in collaboration with health authorities, colleges, associations and unions, educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and co-ordinate go-forward actions and initiatives.

The starting point for consultation will be the framework used in this paper subject to modification and development but with an expectation that the consultation will be completed and the framework start to be used in the spring of 2015 for planning, co-ordinating action and quality assurance.

2. Enabling Effective Cross Sector Health Human Resource Management

Taking a series of co-ordinated health human resource management actions across different levels (practice, regional/organizational, and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote) to support continuous improvement linked to strategic priorities for the health system.
2.1 Leadership Council will establish a Standing Committee on Health Human Resources as B.C.’s senior level health human resource governance structure, reporting into Leadership Council.

*Setting Priorities* identifies the need for a refreshed governance structure to facilitate greater engagement and collaboration between the ministry, health authorities and other health system partners in support of key strategic priorities, such as health human resources. To facilitate health human resource planning and policy across all professional groups, Leadership Council will establish a Standing Committee on Health Human Resources as the province’s senior level governance structure.

The committee will report to Leadership Council, and consist of core membership from the Ministry of Health, the health authorities, HEABC and the First Nations Health Authority. Health authority representatives will consist of vice presidents, human resources; vice presidents, medicine; chief nursing officers, and other representatives as determined. Ad hoc participants will include other government agencies, regulatory agencies, educational institutions, professional associations, unions, non-profit organizations and patient representatives.

Draft terms of reference for the committee are currently out for consultation with the parties affected. The standing committee will be established by March 31, 2015.

2.2 Develop and implement a Health Human Resource Deployment methodology linked to an effective, thoughtful workplace redesign methodology.

By Sept. 30 2015, the standing committee, in collaboration with health professional colleges, associations and unions and other relevant provincial stakeholder groups, will develop a provincial approach to managing HR deployment and thoughtful workplace redesign processes in support of the directions set out in the policy papers. As there is currently no evidence-based, prescriptive approach in B.C., the methodology will be built on the elements set out in this paper, as well as examples from other jurisdictions, and through meaningful consultation, and will involve evaluation and action learning principles. This framework will guide specific change management initiatives going forward.
2.3 By Sept. 30, 2015, health authorities will complete an organizational change management assessment of their organization’s current capacity, approaches and infrastructure. This assessment will form the basis for taking action to implement the HR Deployment methodology linked to an effective, thoughtful workplace redesign methodology set out above.

Each health authority will submit a report summarizing its self-assessment (a) change management capacity building plan, and (b) action taken to implement the HR deployment and workplace redesign methodology to the Ministry of Health as part of its year accountability reporting in March 31, 2016.

2.4 By Sept. 30, 2015, health authorities will complete an HHRM (including physician human resource management) assessment of the organization’s current capacity, approaches and infrastructure. This assessment will form the basis for taking action to implement the HHRM framework set out above.

Each health authority will submit a report summarizing its self-assessment (a) health human resource management capacity building plan (b) and action taken to implement the HR management plan to the Ministry of Health as part of its year accountability reporting in March 31, 2016.

2.5 The Ministry of Health and the Health Employers Association of BC (HEABC) will complete the development of a new Integrated Health Human Resource Planning (IHHRP) model to improve the province’s health human resources planning ability.

The IHHRP model will use information on the health of the population, utilization of health services from the Health System Matrix, and data from the Ministry of Health and HEABC to generate specific health service provider information geographically and by designation (i.e., metro, urban, rural and remote). The model will forecast the number, type and location of providers required to provide appropriate health care services on an annual basis over a five and 10 year projection. Authorized staff from the Ministry of Health, HEABC, and the health authorities will be able to adjust the forecasts according to real or hypothetical changes in service delivery approaches and trends. The tool will be ready to use starting April 2016.
2.6 **Inventory of public and private post-secondary education and training programs, including clinical placement capacity.**

The ministry, in partnership with Advanced Education and other health system partners will undertake an inventory and assessment of current education and training programs for health professionals and use the inventory in concert with workforce planning models to identify opportunities to re-align these programs with population health needs. The inventory will be completed by September 2015.

2.7 **Patient-centred, culturally sensitive and inter-professional learning opportunities.**

In conjunction with the inventory above, the ministry will work with Advanced Education and other stakeholders to ensure curriculum for health care workers supports development of patient-centred, culturally sensitive and inter-professional professional and organizational cultures.

2.8 **Enable effective transition to practice in the B.C. health system.**

Health authorities, in partnership with academic institutions, the colleges, and the associations and unions representing health professional staff; will form a task force on transition to practice and develop recommendations with respect to a) priority objectives for improving transition to practice, b) an action plan of strategies and tactics for achieving those objectives and c) methods, indicators and success criteria for measuring achievement of those objectives.

The task force will consist of representation from the health authorities, academic institutions, the colleges, and the associations and unions representing professional health staff. The task force will consider relevant research/evaluations or initiatives that have taken place (including Rush et al.’s (2013) evaluation of B.C.’s nursing transition programs), to develop recommendations with respect to:

a. Priority objectives for improving physician, nurses, and allied health professionals’ transition to practice. The objectives chosen must be:
   i. Measurable and achievable within three years, with reporting starting by March 31, 2017.
   ii. Justified by existing evidence (i.e., best available research evidence, evaluations, experiential evidence).
   iii. Explicitly linked to the province’s target population health outcomes and service delivery goals.
b. An action plan that includes strategies and tactics for achieving those objectives.

c. The methods, indicators and success criteria for evaluating the province’s achievement of those objectives.

The task force will report its recommendations to the Leadership Council by March 31, 2016.

2.9 The Standing Committee on Health Human Resources (SCHHR) will lead the development and implementation of a leadership and management development framework for both the senior management and senior executive management of the B.C. health system.

A key priority in the Setting Priorities document is the development of a leadership and management framework for the health system. The underlying principle for this framework is ensuring B.C. health care leaders have the right skills at the right time to achieve meaningful and sustained transformation of the health system.

Using any required contracted resources, health authorities will conduct a current state inventory of health leadership and management operational capacity; programs being used to develop leadership and/or management skills; as well as a comprehensive literature review and analysis of best practice and emerging trends in health leadership and management development nationally and globally with a specific focus on health care transformation. An ad hoc Leadership and Management Development Working Group will be brought together with representation from health authorities, academia and key partner organizations to assess the current state of leadership and management development in the B.C. health system, review and validate best practices and emerging trends and make recommendations for continued or new actions. The working group, through SCHHR, will report its recommendations to the Leadership Council by January 2016, with action being implemented starting in the 2016/17 fiscal year.
2.10 The Standing Committee on Health Human Resources, in collaboration with the Doctors of BC and health unions, will round out and ensure the implementation of an inter-professional multilevel engagement strategy that builds from existing agreements and processes to support the creation of inclusive, vibrant and healthy workplaces across the health sector.

As set out in Setting Priorities (pg. 37), there is a commitment to ensure the development and implementation of a provincial engagement, influence and accountability framework in collaboration with health authorities and unions to support the creation of inclusive, vibrant and healthy workplaces across the health sector. The framework will ensure rigorous discussion with physicians, nurses, allied health workers, and health support staff about healthcare practices and change. Clearly articulated, specific and measurable healthy workplace objectives linked to the engagement framework will be developed by each health authority. Achievement of these objectives will be monitored, measured and reported to Leadership Council on a quarterly basis. This approach is to be fully implemented by March 31, 2016. Linked to these objectives, Health Authorities will adopt the National Standard of Canada for Psychological Health and Safety in the Workplace as their own standard.

3. Enabling Strategic Policy Paper Directions

3.1 The Standing Committee on Health Human Resources, in collaboration with Health Professional Colleges, the Doctors of BC, health unions and other relevant provincial stakeholder groups, will undertake specific planning to take co-ordinated HR actions across different levels (practice, regional/organizational, and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote) in support of the directions set out in the Primary and Community Care, Surgical Care and Rural Health policy papers.

The enabling strategic action plans will be developed in tandem with the relevant consultation processes.