



**GENERAL BOARD MEETING
WEDNESDAY, April 1, 2009
QUESTIONS & ANSWERS**

Submitted by: Judith Johnson

Q

Allowing the ordering of MRI's by Family Doctors (GP's) for knees was I believe implemented as a way to speed up referrals to orthopedic specialists, so that patients could quickly return to work and active lifestyles. On the surface this privilege appeared to be a step in the right direction. However this initiative may have failed. As long as Family Doctors (GP's) are first required to order a series of X-rays prior to ordering an MRI for what are obviously soft tissue injuries they are adding and not subtracting from wait times and are delaying treatment. This protocol also exposes patients to unnecessary radiation. Does the Board not trust Family Doctors (GPs) and can't they relying on their diagnostic skills and expertise to facilitate the best choices for their patients? Is the Board intending to allow Family Doctors (GP's) to choose and access the full range of diagnostic equipment at some point?

X-rays play a crucial role to help determine whether an injury is a soft tissue injury only, or whether a fracture is involved. There is virtually no wait time for regular X-rays, so this step has no impact on the wait time for an MRI. In fact, the use of X-rays is likely to eliminate the need for some MRI referrals which decreases the overall wait time for MRIs. General Practitioners (GPs) are not "required" to order X-rays, but may, in consultation with the Radiologist, be requested to do this preliminary examination. Appropriate ordering of MRI scans and other high intensity, and costly, diagnostic tests is a collaborative effort between GPs and specialists, and ensures appropriate expertise is considered when determining which is the most appropriate imaging technology to use for a specific test. Imaging technology is limited and expensive, and needs to be accessible to the highest priority cases. Allowing unlimited access to these technologies would have serious implications on fiscal resources and waitlists. VIHA is pursuing an on-line order entry system, which would include a tool to support physicians when making decisions around which diagnostic test to order. There are rapid advances being made in medical imaging, and it is important that the technology is used appropriately and efficiently, and that access is prioritized for those patients most in need.

Submitted by: Lyne England, Chair, Saanich Peninsula Health Assn.

Q

Does the Vancouver Island Health Authority anticipate any positive/negative impact on working staff continuity at various sites scheduling with the most recent implementation of Centralizing Staffing Clerks from various VIHA facilities? Please explain why/why not.

A

VIHA is restructuring its staffing system to improve the way we schedule staff to benefit both staff and patients. The decision to move to a centralized scheduling model with extended scheduler hours was based on the recognition that past scheduling practices had not been

working effectively for our managers and staff or for the delivery of our services. Our goal is to meet staff staffing requirements regularly and consistently for all VIHA programs and services.

A thorough and comprehensive training program is in place to ensure a smooth transition to the new structure and to maintain continuity of service. Knowledgeable staffing service specialists based in the new centres will enhance staff/scheduler communications and provide efficient, consistent and equitable staffing practices. Every unit/program area in VIHA will be served by a designated team of schedulers based in one of the four centres (Campbell River, Nanaimo and two in Victoria). Standardizing staffing practices throughout the health authority will result in more predictable staffing levels, fewer staff having to be called in on their days off and manager/leader time freed up to focus on service delivery, and reduced need for overtime.

Submitted by: Lyne England Chair, Regional Family Advisory Council

Q We have been told that billing costs would not change for the residents who recently moved from various VIHA facilities into private pay facilities. Does this mean that the private pay facilities are bound to honor the use of the monthly resident Enhancement Fee according to the Enhancement Fee Guidelines?

A The Resident Enhancement Fee, a monthly fee charged to residents in most VIHA-operated sites, ranges from \$5.00 to \$10.00 per month. The Resident Enhancement Fee is placed in a unit fund to support special entertainment, celebrations, decorations and activities identified by the residents that are in addition to those activities already provided at the site. The residents of each unit determine how they would like to spend the collected funds, and the activity staff assist in setting up the requested special activity, program or outing.

Some affiliate providers have a similar "recreation fee" which will range in the cost. Such fees are clearly identified at admission to a site (VIHA operated or Affiliate), and residents/families sign documents that outline the fees and how they will be managed.

Submitted by: Mark Willson Harm Reduction Victoria

Q VIHA's 2006 I-Track Survey found that intravenous drug-users (IDUs) accounted for 50% of newly reported HIV infections and 68% of HCV infections: higher rates than in the rest of Canada (13). Concerned that "HIV may be spreading more rapidly among IDUs," and guided by stated core values of dignity, human rights and compassion, VIHA committed to provide "comprehensive needle exchange services" as part of a goal of a "50% reduction in the number of newly reported HIV and HCV infections on Vancouver Island by 2008/09" (Closing the Gap, 2006: 28). How is the current 'No Service Zone,' which bans needle exchange services in the critical area around Pandora and Vancouver streets, in keeping with these concerns and commitments?

A A clarification of the information provided in the above referenced studies is merited. With respect to the I-TRACK study, it states “The percentage of respondents in Victoria who were infected with HIV was slightly higher than the average of all sites in Canada who participated in Phase I of the I-TRACK survey. However, the prevalence of both HIV and HCV in the Victoria survey respondents was lower than in the IDU population who use the safe injection site in Vancouver.”

Having said that, VIHA recognizes the importance of mitigating disease transmission among drug users. Needle exchange services are a key component in the continuum of harm reduction services and addictions programs delivered by VIHA, and we remain committed to needle exchange services. The so called ‘exclusion zone’ in Victoria was not established by VIHA alone, but rather set up by a coalition of agencies, including AIDS Vancouver Island, the City of Victoria, Victoria Police and others. The areas excluded from current mobile needle exchange services include schools, open businesses, residences or community settings such as daycares. Foot patrols do deliver service in the area, but not do exchanges in front of open businesses or near schools or residences.

As is well known, VIHA proposed a new location for needle exchange services on Pandora Street in Spring 2007, but unfortunately that location was not acceptable to the broader community. As a result, an enhanced mobile service was put in place – with a Code of Conduct – to ensure this important public health service continued to meet client needs. The mobile service continues to provide needle exchanges in the downtown area.

Until an acceptable alternative location for a fixed site is found, VIHA continues to use a number of fixed and mobile distribution mechanisms for needle exchange such as: the Cook Street Public Health Clinic, AIDS Vancouver Island, Victoria AIDS Resource and Community Service Society, SOLID, PEERS and our own street nurses.