MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938113

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health - **FOR INFORMATION**

TITLE: Smoke-Free Housing and the Real Estate Sector

PURPOSE: The Minister of Health is meeting with the Fraser Valley Real Estate Board and may discuss working with realtors on smoke-free housing issues on July 30, 2012.

BACKGROUND:

In 2008, the Heart and Stroke Foundation of BC & Yukon surveyed organizations representing owners of multi-use dwellings (e.g. Rental Owners and Managers Association, BC Apartment Owners and Managers Association, Condominium Home Owners Association of BC) and other organizations. The survey found that there is a strong market for smoke-free housing:

- 82 percent of all respondents believe that there is either a "very big" (54 percent) or "some" (28 percent) market demand for smoke-free housing.
- 88 percent of strata corporations and 74 percent of apartment owners/managers expect the issue of smoke-free housing to become more important.

Realtors have a good understanding of the market demands and changes, including the issues that affect individuals as they make their purchasing choices. Some real estate listings now include non-smoking status as a feature.

There may be additional costs related to a home where smoking occurs:

- Insurance costs may be higher for smokers (due to fire risk).
- Cleaning/paint costs (walls, carpets, furniture) presale.

DISCUSSION:

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ADVICE

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Program ADM/Division: Arlene Paton, ADM, Population and Public Health
Telephone: 250-952-1731
Program Contact (for content): Shelley Canitz, Director, Tobacco Control Program, 250 952-2304
Drafter: Shelley Canitz, Director, Tobacco Control Program, 250 952-2304
Date: July 20, 2012
File Name with Path: z:\cdipbe\hl_cd prevention\briefing notes - 280-20\2012 - briefing notes\cdipbe\938113 - smoke-free housing and the real estate sector.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936616

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR INFORMATION

TITLE: City of Abbotsford Environmental Operator Certification and Training Issues

PURPOSE: To provide background on the proposed letter response to Mayor of Abbotsford Bruce Banman related to his issues with the Environmental Operators Certification Program.

BACKGROUND:
Under the *Drinking Water Protection Act*, drinking water supply systems are required to be operated, maintained, or repaired by persons certified by the Environmental Operators Certification Program. The Ministry of Environment has similar requirements for operation of municipal wastewater treatment plants. The basic requirements for water treatment operators in British Columbia are equivalent to virtually all the Canadian provinces and the United States. The program generally requires increasing levels of operator competency as the complexity and risks of water systems increase. The program also requires that operators maintain 24 hours of continuing education units over two years to ensure competencies are maintained.

The Mayor of Abbotsford, Mr. Bruce Banman, issued a letter to Honourable Michael de Jong, dated December 7, 2011 (see attached Appendix A, 908188), indicating that the requirements for Environmental Operator Certification are too onerous for the City to achieve. The letter identifies three issues:

1. Professional Engineers and Technologists perform many of the functions related to the work of certified operators and should be recognized under legislation.
2. The continuing education requirements for operators are excessive compared to industry standards.
3. While discussions between the Ministry of Health (MoH) and municipal representatives have taken place, no resolution has been reached. There is also a reference to a position paper by Metro Vancouver Regional Engineers Advisory Council from 2004.

The Fraser Health Authority has granted Abbotsford a deferral until 2017 to comply with their operator certification requirements. MoH has also received a complaint from an Abbotsford water operator that the municipality is not supporting the training of operators, and therefore, not taking advantage of a training registry that has been set up by the Environmental Operators Certification Program to facilitate training opportunities for local government. Abbotsford has apparently taken the view that since they only need one trained operator under the Drinking Water Protection Regulation, they are not supporting training of operators.

Although a meeting has taken place between Minister de Jong and Mayor Banman with respect to the Mayor's letter, the Director of Utility Operations in Abbotsford has requested a formal response to the letter.

DISCUSSION:

The position stated in the Abbotsford letter is outdated and does not acknowledge progress achieved through collaboration with the Regional Engineers Advisory Council municipal representatives. This progress is as follows:

- Over the past few years, MoH and the Environmental Operators Certification Program have developed and implemented a program so that municipalities can develop in-house training to more readily meet continuing education requirements. Regional Engineers Advisory Committee representatives have acknowledged these positive steps towards meeting continuing education requirements. Some municipalities are currently developing in-house training opportunities that can be shared between neighbouring local governments.
- MoH proposed several iterations of a "team approach" that would acknowledge the contributions of professional engineers and would be supported by regulatory amendments. However, the proposal was discussed with Alberta Environment representatives overseeing the program of certification for water operators in Alberta. Alberta representatives have indicated that there would be issues with the proposal under the Trade, Investment, and Labour Mobility Agreement and the New West Partnership Trade Agreement. This position has delayed adoption of that specific proposal.
- Currently, MoH is working with the Environmental Operators Certification Program to establish improvements to make it easier for operators to get credits towards moving to higher level classifications by redefining credits that can be achieved through workplace experience under the concept of "direct responsible charge". MoH has discussed that proposal with the Regional Engineers Advisory Council and has had a favourable response from those local government regional engineers.

ADVICE:

It is recommended that a letter outlining the improvements to the Environmental Operators Certification Program and a description of the current initiative under review be issued to the City of Abbotsford to update the Mayor and his staff on the progress in this area (letter attached).

Program ADM/Division:	Arlene Paton, ADM, Population and Public Health
Telephone:	250 952-1731
Program Contact:	Tim Lambert, Executive Director, Health Protection
Drafter:	Mike Zemanek, Director, Healthy Community Environments
Date:	July 11, 2012

File Name with Path: W:\Health Protection\Protection\BRIEFING NOTES\2012\936616 City of Abbotsford Environmental Operator Certification and Training Issues.docx

Pages 5 through 6 redacted for the following reasons:
- -
S. 13

936616 Appendix A

ABBOTSFORD

December 7, 2011

File:5600-01

Via email and post

Honourable Michael de Jong, Minister of Health
#103 - 32660 George Ferguson Way
Abbotsford, BC V2T 4V6

and

Honourable Terry Lake, Minister of Environment
618 Tranquille Road
Kamloops, BC V2B 3H6

Dear Minister de Jong and Minister Lake:

Re: Drinking Water Protection Act and Environmental Management Act - Operator Certification and Continuing Education

The Drinking Water Protection Act and the Environmental Management Act (the Acts) are important pieces of British Columbia legislation in the protection of public health and the environment. The Acts are applied through the Drinking Water Protection Regulation and the Municipal Sewer Regulation (the Regulations), respectively. Both Regulations designate the Environmental Operators Certification Program (EOCP) as the authority for establishing operator certification requirements. The EOCP process is not overseen by any government agency, and the EOCP is able to change how the Regulations are implemented without input from provincial officials.

The EOCP certifies operators according to experience and education, up to a maximum certification of Level IV. In addition, the EOCP sets out continuing education requirements that operators must meet in order to remain in good standing. Under the current requirements, large municipal systems must include personnel with Level III and IV certification among their operations staff.

The City agrees with the importance of having water and sewer systems operated by qualified personnel; however, the EOCP requirements present two distinct challenges for large municipal systems. The first concern is that operator certification requirements do not account for the management and planning performed by professional staff, instead requiring higher level operators to perform these functions. The second concern is that the current continuing education requirements are not sustainable for the water and sewer industry.

Large municipal systems represent a significant portion of the water and sewer industry, serving approximately 80% of British Columbia's population. Many of these systems are out of compliance with the Regulations as a result of these challenges. Steps have been taken to find a workable solution, including discussions involving provincial staff, municipal representatives and the EOCP. To date, the EOCP have been unwilling to modify their requirements, and a solution is still required that will accommodate the operating structure of all systems in the province.

The challenges presented by the EOCP requirements are the result of the operating structure found in large municipal systems, and discussion is required with respect to the following areas:

1. Operator Certification Requirements

Current requirements are structured on the premise that operators are responsible for both the operation and management of water and sewer systems. In large municipalities, system management and planning are the responsibility of professional staff. These Professional Engineers and Technologists are regulated by and accountable to professional associations in British Columbia.

The current Regulations overlook the expertise and responsibilities of professional staff, requiring large systems to certify operators to higher levels than necessary. This is in contrast to many locations in Canada and the United States, where the contributions of these key team members are acknowledged as an integral part of the overall system.

In order to resolve this issue, it is recommended that the Regulations be amended to recognize the contributions of professional staff.

2. Operator Training Requirements

The City supports the need for training and continuing education; however, the current requirements are problematic for municipal water and sewer systems. The EOCP requires all operators to complete the equivalent of four training days every two years, regardless of certification level. These requirements are disproportionate to the responsibility level of Level I and II operators, and are in excess of the industry standard.

In addition, the continuing education requirements for Level III and IV operators are redundant for large municipal systems. The majority of this training pertains to tasks carried out by professional staff and provides little additional value.

The EOCP remains steadfast in their opposition to changing the continuing education system, and adjustments to the requirements will only occur through Ministry direction.

3. Resolving the Concerns

The two challenges have resulted in many municipal systems falling out of compliance. Provincially designated officers are obligated to enforce the legislation, and are notifying large system operators that they must adhere to the Regulations.

Many steps have been taken to resolve these issues, with the majority focused on the water industry. The Metro Vancouver Regional Engineers Advisory Committee (REAC) represent the lower mainland municipal water system managers, and have been active in pursuing changes

to the EOCP requirements. Discussions have been ongoing between Ministry of Health staff, REAC, and the EOCP. Several proposals have been discussed, but none are currently being considered. In addition, the EOCP has resisted any proposed changes, and discussions have reached an impasse.

The current situation leaves large municipal systems in a state of uncertainty. The City recommends the EOCP be required to establish a working group including representation from large municipal water and sewer systems. The working group would review current requirements, and determine workable solutions that accommodate the operating structure of all systems in the province. REAC has endorsed the recommendations to change the requirements and have written the attached letter of support **(Appendix A)**.

If a working group is unable to come to a resolution, it is recommended that the respective Ministries consider an alternate model of certification and continuing education, similar to those in other Provinces and the United States. The City also recommends that a moratorium be placed on both requirements until a solution is reached, thereby preventing large municipal systems from being subject to non-compliance penalties.

British Columbia legislation requires water and sewer operators to meet the requirements of the Environmental Operators Certification Program (EOCP). Conformance with these requirements is a challenge for large municipal systems, and many attempts have been made to find a resolution. To date, a workable solution has not been attained, and Ministry intervention is requested. It is recommended that the Mayor of Abbotsford meet with the Honourable Michael de Jong and the Honourable Terry Lake requesting priority be given to resolving these challenges. In addition, the City recommends that a moratorium be placed on the two problematic requirements, protecting large municipal systems from the penalties associated with non-compliance.

In conclusion, I would like to recommend meeting requesting that priority be given to resolving the issues that the operator certification requirements in the Drinking Water Protection Regulation and the Municipal Sewage Regulation present for large municipal water and sewer systems in British Columbia. Enclosed is a fact sheet for your review.

Please contact my office at 604-864-5500 to arrange the requested meeting.

Yours truly,

R. Bruce Banman
Mayor

encl.

c. Council Members
Frank Pizzuto, City Manager
Jim Gordon, General Manager, Engineering and Regional Utilities
Len Stein, Director of Utility Operations

For Consideration by the Minister of Health

Lower Mainland Municipal Water System Managers are very supportive of the Drinking Water Protection Act (DWPA) and we believe that certified operators are an important component of assuring safe drinking water for the public.

However, the Waterworks Managers for the Lower Mainland Water Systems have been working with various Directors in the Ministry of Health, and the Ministry of Healthy Living and Sport since 2004 to resolve two significant implementation problems resulting from the DWPA:

1) the Classification of Water Systems and the associated Level of EOCP Operator required under the DWPA
2) the Continuing Education Units (CEU's) required by the Environmental Operators Certification Program (EOCP) for certified operators to remain in good standing.

Water System Classification and EOCP Operator Certification Levels:

The Act, under Section 12 "Qualification Standards for persons operating water supply systems", stipulates that "a person is qualified to operate, maintain or repair a water supply system if the person is certified by the Environmental Operators Certification Program for that class of system as classified under the Environmental Operators Certification Program".

This requirement is based on the premise that only EOCP Certified Operators are responsible for water systems in the Province, which is not the case for large Municipal Water Distribution Systems - particularly those in the lower mainland, and similarly sized systems elsewhere in the Province.

In many large Water Distribution Systems, Professional Engineers and Technologists with expertise in the Water Industry are responsible for the design and operating standards for the water system. In those systems, Operators are typically responsible for field maintenance duties or infrastructure replacement under the supervision of managers and technical staff. These EOCP Operators only need to be certified to the level of work and responsibilities they are providing, which is generally at levels lower than the water system classification.

However, the act doesn't recognize the role of Professional Engineers and Technologists when determining the level of operator required under the legislation. Drinking Water Protection Officers and Medical Health Officers who are responsible for the conditions for granting Water System Permits are obligated to follow the legislation when setting out the conditions in the permit, and are presently notifying large system operators that they are not complying with the DWPA.

Therefore, we are recommending the following changes for Section 12 Clause (2):

(2) Subject to subsection (3) and (6), a person is qualified to operate, maintain or repair a water supply system if the person is certified by the Environmental Operators Certification Program for that class of system as classified under the Environmental

ABBOTSFORD

Date: November 22, 2011

FACT SHEET

SUBJECT: Drinking Water Protection Act and Environmental Management Act - Operator Certification and Continuing Education

- British Columbia legislation governing municipal water and sewer systems designate the Environmental Operators Certification Program (EOCP) as the authority for system classification and operator certification. The EOCP also establishes mandatory continuing education requirements for operators.

- Operators are certified according to experience and education, up to a maximum certification of Level IV. The EOCP requires large municipal systems to include Level III and IV operators among their operations personnel.

- The City agrees with the importance of having systems operated by qualified personnel, but faces challenges meeting the existing requirements given its operational structure as a large municipality.

- There are two challenges facing the City and other large municipal systems :

    - The EOCP only permits Level III and IV operators to perform system management and planning, while these functions are carried out by Professional Engineers and Technologists in large systems; and,

    - The EOCP continuing education requirements are excessive when compared to industry standards.

- Many steps have been taken to resolve these issues, including discussions between the Ministry of Health, municipal representatives and the EOCP. To date, no resolution has been reached, and many large municipal systems are out of compliance with the Regulations.

- It is recommended that the Regulations be amended to recognize the operating structure of large municipal systems.

- It is also recommended that a moratorium be placed on the two problematic requirements, preventing large municipal systems from being subject to non-compliance penalties.

Operators Program, ***or is working under the direction of a qualified Professional Engineer and/or Applied Science Technologist registered in the Province of British Columbia.***

In addition, Clause 6 needs to be revised to read:

(6) Subsection (2) does not apply to a person with specialist knowledge immediately relevant to maintenance or repair of a water supply system provided the maintenance or repair is conducted following procedures approved by a person certified by the Environmental Operators Certification Program, ***or a qualified Professional Engineer or Applied Science Technologist registered in the Province of British Columbia.***

We expect these revisions will also likely require that the definition of a qualified Professional Engineer or Applied Science Technologist be included in the Act.

Continuing Education Units Requirement for Level I and II Water Operators

The second issue concerns the Continuing Education Unit (CEU's) requirements for Level I and II Water Distribution Operators (Operators range from Level I to IV). We support that Operators should be certified for the level of the work they perform. However the current CEU requirement for Level I and II Operators by EOCP isn't sustainable by the Water Industry. We estimate that the majority of Certified Operators at Level I and II are "Not in Good Standing" with EOCP. ECOP is requiring 2.4 CEU Credits every two years (equivalent to 4 days of training) regardless of their Certification level, which is comparable to the initial training course taken by water system employees to obtain their level I and II certification.

For highly technical positions requiring Level 3 or 4 operators in a complex Water Distribution System or Treatment Plant, this CEU requirement is supportable. For Level I or II Operators (typically undertaking field tasks such as hydrant and valve maintenance, water main and service installations) the industry standard for ongoing safety and technical training is 2 days every 2 years (equivalent to 1.2 CEU Credits). We believe this is a sustainable and appropriate level of training for Level I and II Operators.

The 2.4 CEU requirement was established by the EOCP with very little input from the Water Industry in BC. EOCP has subsequently been vigorous in their opposition to any change in their CEU requirements. This issue requires intervention on the part of the Ministry of Health to mandate a change, as a stalemate seems to have developed with regard to this issue.

Therefore we are recommending that the Ministry of Health require EOCP to establish a Working Group, which includes representation from lower mainland municipal water systems, to review both the required level of operator certification and the appropriate CEU requirements for ongoing Operator Certification.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #937681

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR INFORMATION

TITLE: Seniors Advocacy

PURPOSE: Call with Surrey Councillor Barbara Steele on Monday, July 23, 2012 at 11:00 am to discuss seniors advocacy.

BACKGROUND:

As part of *Improving Care for BC Seniors: An Action Plan*, released February 2012, government committed to establishing a new Office of the Seniors Advocate. Public consultations are currently underway on the role of this new Office. To date 22 public meetings have been held in nine communities around the province, including sessions in a residential care facility and an independent living complex. A series of bi-lateral meetings were also held with key stakeholder organizations, and written submissions are being solicited from the general public until July 31, 2012.

Through this process, participants are being asked to provide their input on the potential role of the Seniors Advocate (eg. "what should it do?") and the potential key functions (eg. "how should it do this?"). Initial ideas and a series of key questions are contained in a discussion paper, which has been disseminated through various provincial networks and posted on the SeniorsBC.ca website.

Surrey Councillor Barbara Steele has requested a meeting with Minister de Jong to discuss seniors advocacy. Councillor Steele attended a public meeting in Surrey on June 1, 2012 as part of the consultation process, and followed up with a written submission on the role of the Seniors Advocate. In addition to her role with the City of Surrey, she is the Past President of the Union of BC Municipalities and is their representative on the Seniors Healthy Living Advisory Network, which is led by the Seniors Healthy Living Secretariat in the Ministry of Health.

DISCUSSION:

During the consultation meeting in Surrey, much of the discussion centred on the need to support the work that communities and local governments are already doing concerning seniors. The City of Surrey has a Seniors Accessibility and Advisory Committee which brings together various community, government and business organizations with an interest in seniors' issues. Under the auspices of this committee, the City has been hosting full-day forums on elder abuse and neglect.

Councillor Steele's written submission states that the role of the Seniors Advocate should be "one of education and engagement for seniors and for communities" and notes that "providing provincial support to the existing community resources should be an essential part of this office, and would allow services to be delivered in the community".

Based on feedback from the public and bi-lateral meetings, written submissions and consultations with government partners, the Ministry of Health will be developing options on the mandate, role and structure for the Seniors Advocate for government's consideration this fall.

ADVICE:

It is recommended that Minister de Jong take this opportunity to learn more about initiatives already underway for seniors in Surrey, as well as Councillor Steele's perspective on how a new Seniors Advocate could support these local efforts.

Program ADM/Division: Heather Davidson, Planning and Innovation
Telephone: 250-952-2569
Program Contact (for content): Silas Brownsey, Executive Director, Seniors' Action Plan Team
Drafter: Silas Brownsey
Date: July 17, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\937681 - Minister's call July 23 w Surrey Councillor Barbara Steele re Seniors Advocacy.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938751

PREPARED FOR: Honourable Minister Michael de Jong, QC – Minister of Health -
FOR INFORMATION

TITLE: First Responders in Surrey, British Columbia

PURPOSE: To provide information in advance of an August 3, 2012 Minister's meeting with Surrey Mayor Dianne Watts.

BACKGROUND:

- Provision of pre-hospital emergency health services in BC is the exclusive jurisdiction of the EHSC.
- FR agencies are legally permitted to provide pre-hospital care provided they have the consent of the EHSC. FR agencies (which mostly consist of volunteer and professional firefighters) provide basic first aid, such as CPR and defibrillation, while paramedics are en route.
- Participation in the FR program is voluntary and each municipality determines the extent of their participation.
- The City of Surrey renewed its FR consent and indemnity agreement with the EHSC in July 2010. The Agreement was signed by Barbara Steele, A/Mayor and Jane Sullivan, City Clerk. Consent agreements do not specify the level of response for the FR agency.
- The Medical Priority Dispatch System or MPDS is a telephone triage protocol with codes ranging from Echo and Delta calls (highest priority and usually indicate "immediately life-threatening"), Bravo and Charlie calls (serious but not life-threatening), and Alpha and Omega calls (neither serious nor life-threatening).
- For the highest acuity calls, BCAS is supported by FR agencies that give basic first aid to the patient while the ambulance is en route.
- The Resource Allocation Plan (RAP) indicates which MPDS codes should alert first responders. All RAP calls are sent by BCAS to the first responder agency's dispatch centre where requests are screened and BCAS is informed if their crews are attending.
- Some agencies provide a response to all RAP calls and others provide response to only a proportion of the calls (for example just chest pain calls). All cities in BC with populations over 25,000, including the City of Surrey, respond to all RAP calls.
- In an email dated July 19, 2012 City of Surrey staff indicated that Surrey Mayor Dianne Watts would like to discuss costs incurred by the city of Surrey while participating in the Emergency & Health Services Commission's (EHSC) First Responder (FR) program.
- S. 17
- Surrey Fire Chief Len Garis has participated in discussions with several Members of the Legislative Assembly regarding expanding fire department first responder roles.
- Chief Garis is also currently president of the Kelowna-based Fire Chiefs Association of BC (FCABC). The FCABC has called for greater provincial/EHSC funding of all aspects of First Responder training, supplies and operations.
- A joint pilot study with Surrey Fire Services was conducted to investigate the possibility of First Responders who arrive first at the scene of a motor vehicle accident 'calling off' paramedics if it is determined that no medical intervention is required.

- The pilot and analysis at Surrey has been completed, with fewer than originally anticipated opportunities for 'call-off' being identified when evaluated against clinical criteria. An 8 percent false negative rate (i.e. being inappropriately called-off) was also identified.
- These results are currently being reviewed within the EHSC and its medical oversight program to determine if development of a policy for call-off of paramedics by First Responders is viable within the context of the patient safety.

DISCUSSION:

Staff and Fuel Costs

- The voluntary nature of the FR program and the fact that municipalities choose the extent of their participation in the FR program ensures that municipalities have the ability to manage all costs associated with participation in the FR program.
- FR agencies are municipally funded and in BC municipalities have always covered the cost of sending FR agencies to emergency calls.

Licensing and Training

- EMA-FRs are currently required to renew their license every three years. This typically requires successful completion of training as well as the Board-approved examination.
- A train-the-trainer instruction model for EMA-FRs called the Instructor Evaluator Course has been developed. The EHSC reimburses municipal fire departments (who have consent) for the costs of putting up to three members through the Instructor Evaluator Course per year.
- Municipalities that choose to use an alternative training model are not reimbursed.

Medical Oversight

- The provision of emergency health services requires a medical oversight program in place (e.g. the EHSC Medical Programs Division provides medical oversight to paramedics in the provision of quality patient care).
- FR agencies can choose to provide their own medical oversight (including a physician medical director) or may work with the EHSC's Medical Programs Division.

First Aid Supplies

- The EHSC recognises the need to ensure that volunteer FR agencies have the support required to perform their duties and to be able to respond in their communities.
- As a result, the EHSC is presently replacing all consumable First Aid supply used by FRs in communities with populations under 25,000. At this time it cannot financially support supplies for larger agencies.

ADVICE:

- The City of Surrey possesses tools to manage the costs related to the City's voluntary participation in the Emergency & Health Services Commission's First Responder program.
- A Joint EHSC / First Responder Engagement Committee has been established by the EHSC to improve communications, collaboratively set strategic directions, and problem solve as required. This committee reports directly to the BC EHS Provincial Executive Council and is an appropriate venue for comments and concerns regarding the EHSC's First Responder program.
- Alternatively, the Director, First Responder Services is another appropriate contact for comments or concerns regarding the EHSC's First Responder program.

Program ADM/Division: Heather Davidson, Assistant Deputy Minister, Planning and Innovation Division
Telephone: 250 952 2569
Program Contact (for content): Carolyn Bell, Executive Director, Stakeholder Relations & Transformation Branch
Drafter: Erik Wanless, Manager, Priority Projects, Stakeholder Relations & Transformation Branch
Date: July 30, 2012
File Name with Path:

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936553

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health - **FOR INFORMATION**

TITLE: Bill 48 – *Emergency & Health Services Amendment Act, 2012*

PURPOSE: To provide information on the current status of Bill 48 for the Minister's meeting with Mr. Wynne Powell, PHSA Board Chair and Ms. Lynda Cranston, PHSA CEO, on July 9, 2012

BACKGROUND:

- In March 2010, after a consultation process, government announced a new ambulance service model for British Columbia that transferred operational responsibility for the Emergency & Health Services Commission (EHSC)/BC Ambulance Service (BCAS) from the Ministry of Health to the Provincial Health Services Authority (PHSA).
- Development of supporting legislation was delayed.
- In the spring of 2012 the *Emergency Health and Services Amendment Act, 2012* (Bill 48) was introduced in the legislature by the Minister of Health. Bill 48 did not complete passage during the Spring session. It remains on the Order Paper in the Legislature and its passage can be pursued at the next available opportunity.
- Bill 48 is designed primarily to provide the right organizational and legal framework for the provincial coordination of ambulance services, facilitate the alignment of emergency health services with the PHSA and to enable the optimization of emergency health services to improve rural and remote service delivery.
- Under the proposed legislation the EHSC will continue as British Columbia Emergency Health Services (BCEHS), and will be aligned with PHSA.
- BCEHS' core mandate will continue to be provincially-coordinated ambulance and emergency health services oversight.
- The proposed legislation also helps:
  - Set the stage to expand health care employment opportunities for paramedics. (e.g. paramedics could be used in rural and remote areas to both triage and transport patients when no doctors or nurses are available).
  - Strengthen the quality of pre-hospital emergency care by mandating closer cooperation between BCEHS and health authorities.
  - Better enable paramedics to participate in quality improvement activities similar to those utilized by other health care professions.

DISCUSSION:

Many elements of the shift to the new emergency health and ambulance services model are likely to be hampered without the statutory changes proposed in Bill 48. It is expected that the PHSA representatives will raise many of these issues.

Barriers To Transformation

Initiatives that cannot proceed without the proposed statutory changes include:

- Charitable fundraising - As an agent of the crown it is unclear if the EHSC is permitted to establish a charitable foundation. Therefore it may not be able to leverage the expertise of PHSA's other agencies in this area, nor adopt a key feature of the Alberta STARS model.
- EHSC control of assets - Bill 48 contains transitional provisions which enable the wholesale transfer or re-assignment of buildings, leases, and contracts to BCEHS by regulation. To transfer these items piecemeal could present a cost to government.
- Closed board meetings for the EHSC - The current statute does not clearly provide the EHSC with the authority to hold in-camera meetings for the same reasons as PHSA and the regional health authorities.

In addition, government's commitment to improve ambulance service delivery and employment opportunities for rural/remote paramedics will prove significantly more difficult without Bill 48. The effectiveness of the following initiatives may be limited:

- Health sector integration (paramedics working in health sector) – Bill 48 signals governments commitment to this by giving BCEHS an expanded mandate to provide services beyond the traditional ambulance and emergency health services.
- Patient transport network – Implementation requires significant cooperation from health authorities, something that is mandated by the changes proposed in Bill 48.

It should be noted that emergency health services transformation may also be constrained by the outcomes to be achieved from the conclusion of the current collective bargaining process with CUPE 873 (represents a majority of the paramedics in British Columbia).

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Program ADM/Division: Heather Davidson/ Planning and Innovation Division
Telephone: 250 952-2569
Program Contact (for content): Carolyn Bell, Executive Director, Stakeholder Relations and Transformation
Drafter: Erik Wanless
Date: July 5, 2012
File Name with Path:

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936501

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR INFORMATION

TITLE: Status of Cameron Report recommendations and an update on constituent concerns.

PURPOSE: To provide information for a Minister's meeting with MLA Thornthwaite on Wednesday July 11, 2012 at 2:00pm.

BACKGROUND:

- Ministry of Health representatives have previously met with MLA Thornthwaite and provided information on North Vancouver ambulance services, as well as government's direction with respect to the integration of fire and ambulance services.
- Some of these discussions have been tied to concerns expressed by S. 22 with respect to ambulance response times in his area.
- In 2006, the Emergency Health Services Commission (EHSC) contracted Mr. Peter Cameron to review challenges related to emergency health services delivered by First Responders. The report focused on fire agency First Responders (FR) who deliver the vast majority of FR services in British Columbia and who interact frequently with BC Ambulance Service (BCAS) paramedics.
- In March 2007, the EHSC accepted Mr. Cameron's report titled *First Responders, Fire Services and Pre-hospital Emergency Care in British Columbia*. This report included 30 recommendations that were intended to help resolve problems and improve service to the public.
- On June 6, 2012 S. 22 ent an email to MLA Thornthwaite requesting information on:
  - The completion of Cameron Report recommendations; and,
  - A quality review being conducted by the Patient Care Quality Office (PCQO) of Provincial Health Services Authority (PHSA) for service he received on November 29, 2011.

DISCUSSION:

Cameron Report

- The Cameron Report included 30 recommendations, of which 17 have been completed, 12 are actively underway, and only 1 (a specific pilot) was not addressed. Please see Appendix A for EHSC's report on their progress. Some of the recommendations included:
  - Completing the Resource Allocation Plan and dispatch practices for First Responder call determinates;
  - Identifying opportunities for community engagement in the First Responder program where current BCAS capacity is lacking (e.g. the Nisgaa Nation and the village of Gold River);
  - Addressing scope of practice issues for First Responders through use of a Joint BCAS / FR Scope of Practice Working group; and,
  - Updating First Responder consent and Indemnity Agreements.

- Recommendations that require regulatory change are planned to be addressed following the passage of *Bill 48 - Emergency Health Services Amendment Act, 2012* (Bill 48) which was introduced in the legislature in the Spring of 2012 by the Minister of Health.
- Bill 48 did not complete passage during the spring session. It remains on the Order Paper in the Legislature and its passage can be pursued at the next available opportunity.

Constituent Concerns

- S. 22 recent concerns regarding ambulance response times were managed through the PCQO of the PHSA, which also supports the EHSC and ambulance services.
- On May 9, 2012, S. 22 sent an email to the PCQO in whicl S. 22 outlined concerns regarding the service provided to s.22
- On June 29, 2012, the PCQO provided a response via email to S. 22 to address S. 22 specific concerns. See Appendix B for the PCQO response to S. 22 concerns.
- S. 22 quality complaint has been reviewed and closed by the PCQO.
- If S. 22 remains unsatisfied with their respons S. 22 :an ask to have the matter independently reviewed by the Patient Care Quality Review Board. The Review Board can be contacted by phone at 1-866-952-2448 or by email: contact@patientcarequalityreviewboard.ca.

ADVICE:

The EHSC has completed or is actively working to complete all but one of Cameron Report recommendations. The EHSC will continue to look at innovative options for service delivery within a provincially coordinated framework that recognizes the most appropriate role of all emergency service providers, including fire departments.

Program ADM/Division: Heather Davidson / Planning and Innovation Division
Telephone: 250 952-2569
Program Contact (for content): Carolyn Bell, Executive Director, Stakeholder Relations and Transformation
Drafter: Erik Wanless
Date: July 6, 2012
File Name with Path:

Appendix A

BC EMERGENCY HEALTH SERVICES
CAMERON REPORT RECOMMENDATIONS

Updated – March 2011

GOVERNANCE	
RECOMMENDATION	**STATUS**
#1. EHSC should accept responsibility for ensuring appropriate medical oversight.	Accepted, with FR medical oversight being incorporated into BCEHS medical oversight program currently being developed as part of transition to the health sector
#2. EHSC should develop a registration of FR agencies and FR license status.	Done through the work of the Director of First Responder Services
#3. EHSC should declare its role in governance of FRs except Industrial First Aid and the necessity to bring agencies under the regulatory framework.	Done
#4. EHSC should develop criteria necessary for EHSC consent to function as a FR Agency.	Consent agreement signed by most agencies. Current agreement to be reviewed and updated as required to ensure consistency with desired involvement of FR Agencies in the emergency response system
#5. EHSC should confirm its position as the agency to contact for consent to be a FR Agency.	Done

MEDICAL OVERSIGHT	
RECOMMENDATION	**STATUS**
#7. Medical Programs should be independent but work closely with BCAS. The VP of Medical Programs should report to the EHSC.	Done
#8. EHSC should ensure that resources are available to carry out Medical Oversight of FRs.	Being addressed as part of the implementation of the enhanced Medical Oversight program
#9. The FCABC and the BCPFFA should each be asked to send a representative to PMLC.	Done
#14. EHSC should adopt a standard policy for roles of first responders and paramedics in all response scenarios.	Treatment guidelines are framed and subject to ongoing review.
#16. EHSC should continue to support active participation in First Responder research and evidence-based practice.	Many FR agencies directly involved in the Resuscitation Outcomes Consortium cardiac arrest trial and registry
#21. The Resource Allocation Plan should be consistent with the scope of practice of FRs.	Done
#26. The EHSC should direct BCAS to review the RAP.	Done

COMMUNICATIONS	
RECOMMENDATION	**STATUS**
#10. The EHSC's Fire Service/BCAS Coordinating Committee should remain in effect to review and improve interagency communication.	Done

RECOMMENDATION	ACTION
#12. EHSC should reduce delays in FR notification.	New CAD systems have significantly reduced delays. Policy is enforced to contact FR agency ASAP when call is categorized and FR response is part of the RAP
#13. Each Dispatch Center should have a clear mechanism for feedback and resolution of interagency conflict.	done
# 25. BCAS should consider and pilot a layered response of FR and ACPs when suitable.	No specific plans but BCAS is reviewing and committed to trying new ACP deployment models

EMALB LICENSING RECOMMENDATION	ACTION
#17. EMA Regulation should be amended to include AED use and spinal immobilization.	Done
#18. EMA Regulations should be amended to include one category of FR to include airway management, oxygen administration and glucose administration.	Done
#19. EMR should not be adopted as the FR minimum standard.	Agreed. Pilots underway in PG and Sun Peaks to assess the value of EMR scope
#20. EMA Regulations should be amended to allow an EMR acting under the umbrella of a FR Agency to perform services in the EMR scope of practice	Agreed and recommendation to government for regulation change
#22. EHSC should determine the policy for scope of practice allowed when a paramedic is acting as a FR.	Under discussion at the FR Scope of practice working group

RECOMMENDATION	ACTION
#23. EHSC should advocate for a 5 year instead of a 3 year license term when an agency can demonstrate the experience and CME are adequate (requires definition).	Agreed and recommendation to government for regulation change
# 24. EHSC should advocate that the 90 days AED re-examination be extended to one year	Agreed and recommendation to government for regulation change
# 29. EHSC should support streamlining examining and licensing of first time applicants.	Significant improvements made
# 30. EHSC should support development of a licensing process that is not perceived to be biased.	Done

TRAINING RECOMMENDATION	ACTION
#27. FR Training Committee should review and recommend a new training plan and resources required.	Underway to conform to new scope

OTHER RECOMMENDATIONS	ACTION
#6. The EHSC should write a report of under-serviced areas and solution for the shortfall.	Being addressed as part of transition process of EHS to the health sector
#11. EHSC should prioritize improving access to under-serviced areas.	Many new FR agencies in small communities; ongoing work of Director, First Responders
#15. EHSC should establish a policy for financial assistance for remote and rural agencies to support training.	Guideline supporting volunteer agencies adopted by the EHSC. Budget realigned and controlled by Director, First Responders to support small volunteer agencies
#28. EHSC should establish a policy of paying the tuition, and consider a policy of bursaries for other training-related costs, for the EMR bridging courses for FRs in specified rural and remote areas where prehospital service would particularly benefit from EMR-trained responders.	Move of the EHSC to the PHSA includes strategic direction to integrate EMS functions in small communities. No specific action yet

Pages 27 through 40 redacted for the following reasons:
- -
s. 15
s. 22

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 937226

PREPARED FOR: Honourable Michael de Jong, QC, Minister
- FOR INFORMATION

TITLE: Nurse Practitioner-Anesthetists

PURPOSE: To provide an update regarding creating a Nurse Practitioner-Anesthetist (NP-A) role in British Columbia.

BACKGROUND:

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DISCUSSION:

The Ministry is proceeding with the introduction and implementation of the NP role. Progress to date includes:

- Ongoing consultation and discussions with CRBNC to scope out and define the NP-A roles. CRNBC has the statutory authority to develop the necessary qualifications, appropriate practice standards and quality assurance requirements to introduce all new nursing roles in BC. CRNBC has identified initial resources and is currently gathering information on the American Certified Registered Nurse Anesthetist (CRNA) role, implementation challenges faced in US, and regulatory considerations. CRNA's are the US version of the NP-A.

S. 13

- Discussions with organizations representing Respiratory Therapist and Anesthetist Assistants are underway to determine if these professionals could also play a part in anesthetic service delivery models.

- Both CRNBC and Ministry senior staff will be attending the American Association of Nurse Anesthetists annual meeting on August 4-8, 2012 in San Francisco. The conference is a forum where research pertinent to the specialty of nurse anesthesia is presented and includes the latest medical equipment, technology, and pharmacological products, as well as discusses education, workforce planning, promoting and the role of CRNA, and workplace challenges. The meeting also provides the opportunity to connect directly with educators, regulators and clinicians from across the US.

- A multi-phased NP-A implementation plan is in draft:

    - Phase One pulls together a small working group with clear objectives to deliver upon over the next 90 days (see Appendix A - Terms of Reference and 30/60/90 Day Plan). The focus will be on information gathering to address key policy questions related to projected anesthesia service requirements, service delivery options/models, initial workforce planning forecasting implications (e.g. will we have enough nurses to implement), and providing advice on how best to move forward with an initiative that considers the introduction and implementation of a new nursing role, NP-A, in an interdisciplinary environment.
    - Phase Two requires broader working group representation and will focus on role definition, competency development, educational delivery options, stakeholder consultation, and implementation requirements (e.g. funding, communications, marketing, etc.).

- It will take approximately 2 years for a NP-A to begin practicing within the BC health care system.

- The Ministry is currently analyzing data reports that explore the proportion of services billed by Anesthesiologists for broad service groups such as surgery, acute pain, chronic pain, and critical care. This will assist with discussions regarding future anesthetic service delivery model options, as well as areas of need/system gaps to inform initial areas of focus (e.g. maternal care).

- The Ministry is reviewing the proposed changes to the federal *Controlled Drug and Substances Act* to identify if the changes will support the new role or identify if there are additional barriers that would need to be addressed.

- A multi-stakeholder working group will be meeting in late August early September 2012. Representatives will include the Ministry, CRNBC, Health Authority Chief Nursing Officers, and potentially two CRNA members.

CONCLUSION:

The Ministry had identified the key deliverables to be completed in the next 30/60/90 days for the roll out of the NP-A role.

Program ADM/Division:	Nichola Manning, ADM, MSHHRD
Telephone:	(250) 952-3465
Program Contact (for content):	Sharon Stewart, Executive Director, HHRP (Nursing & Allied)
Telephone:	(250) 952-3656
Drafter:	Sharon Stewart
Date:	July 24, 2012
Filename:	Z:\Clinical\Admin 100-499\Executive Services 280\20 Bns, Bullets & ADM Asgnmts\2012\Briefing Notes\937226 - INFO BN For The Minister - Nurse Practitioner-Anaesthetist Role, Update - Jul 25 2012 - ED APRVD.Docx

Pages 43 through 46 redacted for the following reasons:
- -
Not Responsive
s. 13, s. 17

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938602

PREPARED FOR: Honourable Michael de Jong, QC, Minister - **FOR INFORMATION**

TITLE: Health Care Worker Immunization Policy

PURPOSE: To provide background information and an overview of a new health care worker immunization policy being implemented Fall 2012.

BACKGROUND:

- Each year, influenza causes serious complications – including death – for many British Columbians. People with underlying illnesses and those in long-term care facilities are among the hardest hit.
- The primary and most effective method of symptom reduction and prevention of influenza is vaccination.
- There is an existing voluntary Facilities Immunization Policy currently in place (non-immunized employees can be sent home in the event of an influenza outbreak). However the policy has not increased the level of Health Care Worker (HCW) immunization rates.
- Influenza immunization coverage among HCWs in acute care facilities gradually declined from 2005/2006 to 2008/2009. In 2009/2010, the rate of uptake was as low as 34.7 percent while the uptake of the pandemic H1N1 was as much as 46.3 percent. In 2010/2011, seasonal influenza immunization coverage increased over 2009/2010, reaching 39.8 percent which is a continuation of the observed downward trend from 2005/2006.
- BC will be the first jurisdiction in Canada to implement an immunization or mask policy as a condition of employment, and is targeting a 95 percent compliance rate, similar to results achieved in the United States (US).
- There is sufficient vaccination available to meet the increased demand need and a variety of vaccination options will be available to staff (e.g., on site/off site clinics, peer to peer injections, pharmacists, physicians). Costs to implement the policy will be borne by the health authorities.
- Health care unions will be a crucial component of a successful roll out, and unions will be engaged prior to the public announcement.
- We anticipate that the unions may have questions regarding the new policy; however, we do not believe that they will challenge a policy put in place to address patient safety. The new policy is consistent with the various collective agreements.
- A provincial working group has been created and has been tasked with developing materials/processes that will support a consistent approach to implementation across the province. Individual health authorities are responsible for implementation at the local level.

DISCUSSION:

- Fall 2011 – Leadership Council discussed implementing a new policy to increase HCW immunization rates. Given that discussions commenced close to the time that implementation would need to occur, the decision to implement was deferred to 2012.
- April 2012 – Leadership Council agreed to implement a new HCW immunization policy that would require anyone working with, or in proximity to, patients in a health care facility to either be immunized or wear a mask for the duration of the influenza season - typically December to the end of March.

S. 14

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- Communications will begin by notifying the unions of the new policy (they were advised last year that the policy was being considered). Chief Executive Officers will be advising their staff of the new policy and a News Release will be issued to the general public.
- Communications will enforce the message that the policy is about patient safety and that HCWs have an ethical duty to provide safe care to their patients/clients.

CONCLUSION:

- HCWs are one of the most common sources of flu transmission to patients in health care settings, and their patients are often the most vulnerable to serious consequences as a result of illness.
- Voluntary immunization programs have proved to be ineffective in increasing the percentage of HCWs being immunized. More directed programs (e.g., mandatory immunization in the US) have raised immunization rates to 95 percent and higher.
- The flu vaccine is safe and effective – when used in conjunction with other infection control practices, such as hand washing and remaining home when sick, it is extremely effective at preventing illness.

Program ADM/Division:	Nichola Manning, ADM, MSHHRD
Telephone:	(250) 952-3465
Program Contact (for content):	Sharon Stewart, Executive Director, HHRP (Nursing & Allied)
Telephone:	(250) 952-3656
Drafter:	Sharon Stewart
Date:	July 24, 2012
Filename:	Z:\Clinical\Admin 100-499\Executive Services 280\20 Bns, Bullets & ADM Asgnmts\2012\Briefing Notes\938602 - INFO BN For The Minister - HCW Immunization - Jul 26 - ED APRVD.Docx

Pages 49 through 98 redacted for the following reasons:
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MINISTRY OF HEALTH SERVICES
INFORMATION BRIEFING NOTE

Cliff #937500

PREPARED FOR: Honourable Mike de Jong, QC, Minister of Health –
FOR INFORMATION

TITLE: Minister's Meeting with British Columbia Medical Association President Dr. Shelley Ross.

PURPOSE: The Minister is scheduled to meet with British Columbia Medical Association (BCMA) President Dr. Shelley Ross, on July 17, 2012. The meeting was requested by the BCMA to allow the incoming president an opportunity to meet individually with the Minister.

BACKGROUND:

Dr. Ross received her medical degree from the University of Alberta S. 22 Her focus was on primary care with an emphasis in obstetrics when she set up practice in Burnaby. This remained an emphasis with Dr. Ross delivering about 300 babies each year. She recently closed her private practice to focus on medical administration.

Dr. Ross joined the Medical Women's International Association while a resident in family practice to help promote and support medical women, gender equality in health care and better health care for women world-wide. She has been president of this association, as well as the Canadian division, and is currently its Secretary-General.

Dr. Ross has also been actively involved for more than 20 years with the Burnaby Hospital, including being its Chief of Staff. Since the mid-1990s, she has been engaged with the BCMA by first becoming a board member and then member of the executive. She chaired the BCMA's policy development committee, the Council on Health Economics and Policy, where she worked on issues around access for Attention Deficit Hyperactivity Disorder (ADHD) patients, better coordinating BC's home and community care, and improving services for patients with depression.

In her speech at the BCMA Annual General Meeting on June 9, 2012, Dr. Ross recognized the work done to conclude the new Physician Master Agreement (PMA) emphasising that the agreement maintains the strong collaborative relationship.

She stated S. 22 and acknowledged the dissatisfaction of some specialties in the province (i.e. Anesthesiology). Dr. Ross went further to state that "we must play by the rules and that agreements are in place to protect doctors and ensure everyone is treated fairly and equitably."

Dr. Ross's speech recognized the work being done by the General Practice Services Committee (GPSC) and Specialist Services Committee (SSC). She questioned the increased scope of practice of other health professionals. Dr. Ross raised the need for physician extenders and more specifically physician assistants. She raised issues around physician supply and referenced the BCMA policy paper "Doctors Today and Tomorrow: Planning British Columbia's Physician Workforce" with reference to the aging of the physician workforce.

DISCUSSION:

S. 13

Program ADM/Division: Nichola Manning, ADM, Medical Services Health Human Resources Division
Telephone: 250-952-3166
Program Contact (for content): Rod Frechette/Kelley McQuillen, PHRM/Primary Health Care and Specialists Services, MSHHRD
Drafter: Kevin Warren, Director, Director, PHRM, MSD
Date: July 14, 2012
File Name with Path: S:\PHRM ARCS\Admin 100-499\Executive 280\20 BN's\2012\937500 Minister Meeting with BCMA President Dr Ross.doc

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 934973

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR DECISION

TITLE: Provincial Dementia Action Plan - Approval for Release

PURPOSE: To receive Minister approval of final document for public release and posting online

BACKGROUND:

- The Provincial Dementia Action Plan (the Dementia Action Plan) was developed by the Ministry of Health (the Ministry) to identify priority actions to address the needs of people with dementia, and improve outcomes for clients, families and the health care system.
- The Dementia Action Plan builds on previous collaborative work between health authorities, health care providers, clinical experts, and stakeholders such as the Alzheimer Society of British Columbia, and incorporates a dementia lens into the development of integrated primary and community care services for persons with dementia and their families.
- The final content was updated to have straightforward language expressed in a manner that aligns with the Seniors' Action Plan.
- The Dementia Action Plan will be used by the Ministry to prioritize work underway with health authorities and other stakeholders, and to report out publicly on improvements in support of people with dementia and their families.

DISCUSSION:

- The Dementia Action Plan reflects service redesign and quality improvement work underway across the province and does not require additional targeted funding.
- Upon release the Ministry will work with health authorities to ensure their service plans align with the priorities identified in the Dementia Action Plan, in collaboration with physician groups.
- The Ministry held a meeting in June, 2012 with the Alzheimer Society of BC to receive their feedback on the final version. They were supportive of the Dementia Action Plan and offered suggestions to help with implementation.

S. 13

Approved/Not Approved
Michael de Jong
Minister of Health

Date Signed

Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
Telephone:	250-953-3547
Program Contact (for content):	Leigh Ann Seller, Executive Director
Drafter:	Pauline James, A/Director HCIC
Date:	June 26, 2012
File Name with Path:	Z:\HAD General\Briefing Notes\2012\HCIC\934973_Dementia Action Plan Decision to Release_June 26 2012 - Approved by Barbara Korabek July 17.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 935754

PREPARED FOR: Honourable Michael de Jong, QC, Minister
- FOR INFORMATION

TITLE: MLA Margaret MacDiarmid re: Mental Health Questions / Obsessive Compulsive Disorder (OCD)

PURPOSE: To provide the Minister's Office with information to respond to a citizen request.

BACKGROUND:
The request is for information on access to group homes accommodating individuals with severe OCD, with the requirement of a private bathroom.

DISCUSSION:

- There are a variety of residential care and supportive housing options available in the health authorities (e.g. residential care for people with a history of psychosis and supported independent living programs for people with various mental health and substance use disorders live independently with appropriate support). Appropriate residential care options are determined based on the individual needs, individual care plan, and availability of appropriate facilities and services in a given community.
    - Typically, support workers, a case manager and psychiatrist would all be involved in the care of someone with severe OCD so treatment and support are integrated.
- Residential care or 'group homes' as requested by the writer are not generally established for individuals with specific diagnoses such as OCD, but all attempts are made to consider resident mix and needs with staffing resources.
- In some communities, Assertive Community Treatment teams provide intensive community-based care to individuals with severe forms of OCD to support them living in their own home/apartment or in supported housing arrangements. These teams are currently only available in Victoria, Nanaimo, Vancouver, Prince George and Surrey.
- Individuals can receive treatment services for their OCD through the Mental Health Clinics in communities throughout the province. These services are not specific to OCD but treat a variety of mental illnesses; however, in some communities specialized OCD groups have been established, for example:
    - The North Shore mental health centre or psychiatrist may offer an anxiety group which will include treatment for various anxiety disorders such as OCD.
    - Specific therapeutic outreach groups are available for OCD in Vancouver – one operating out of the outpatient psychiatry at Vancouver General Hospital and the other in Richmond Mental Health Outpatient Clinic (see attachment #1).

- 'Outreach'-based services are available in some communities to support individuals to live in the community either through the mental health centres or through BC Housing.
- For those individuals whose mental illness is too severe or where adequate community supports are not available, they may require care through tertiary services, which are available in each of the health authorities.
- Finally, a variety of community not for profit organizations provide supports and community programming that may be valuable to individuals with OCD and their families as well as a few private practitioners (information and contacts are readily available on the Internet).

CONCLUSION:

- It is recommended that the writer explore further with the local Director of the Mental Health Centre in the community of concern, which specific options are available and appropriate given the nature of this individual's illness and care needs.

Program ADM/ Division:	Barbara Korabek / Health Authorities Division
Telephone:	250.952.1049
Program Contact:	Monica Flexhaug, MHSU – 250.952.2301
Date:	July 9, 2012
File Name with Path:	Z:\HAD General\Briefing Notes\2012\MHSU\935754 Bullets for MO for MLA MacDiarmid re Mental Health (OCD) - Approved by Teri Collins obo Barbara Korabek July 18.docx

Attachment #1 – OCD Group Program Description

Vancouver General Hospital
Outpatient Psychiatry Team
715 West 12th Avenue, Ground Floor
Vancouver, BC V5N 1N2
Telephone (604) 875-4794
Facsimile (604) 875-5286

OCD Workshop

What is the purpose of the group? The OCD workshop will help you on your journey toward overcoming obsessive compulsive disorder. This group uses a cognitive-behavioral approach to treatment as a means to address your thoughts and actions which contribute to OCD. This CBT treatment model presents methods of modifying your thoughts and actions in order to alleviate symptoms and lead more of an effective life.

Where is the group held? The group is held in a group room at the following location:
Vancouver General Hospital, Outpatient Psychiatry Team
715 West 12th avenue, Health Centre Building, Ground Floor

How will this group help me/ What will I be doing / What will I be learning? The OCD workshop will provide you with a safe, supportive environment in which to learn about OCD and meet others who are struggling with similar difficulties. Through teaching and group discussion, you will learn to identify the ways in which problematic thoughts and behaviors reinforce your experience of OCD. In addition, you will become familiar with Exposure and Response Prevention (ERP) and a variety of cognitive techniques that will help reduce the impact of OCD on your life. In order for these techniques to be effective, it is suggested and encouraged that you engage in both in-group and homework practice assignments.

How often is the OCD Group held? This depends on available clients taken from a waitlist.

How long does the group run for? The group is held once a week for 12 weeks. Each session is 2 hours long. It is important to note the group starts and ends punctually.

Does it cost anything? The group is covered under your Medical Services Plan (MSP).

Group Materials? Handouts are provided and it is suggested that you bring a pencil or pen, writing paper and a binder to hold your handouts and written work together.

Who else is in the group? The group consists of 6-10 participants and two group facilitators.

Is there anything else I can do to prepare for the group? Please keep us informed if you plan to change your phone number as this is the method we use to contact you. After you are waitlisted for this group, we will invite you in for a pre-group meeting to make sure that this group will meet your current needs.

I have another question, who can I ask? You can contact the Outpatient Psychiatry Team at our office number 604-875-4794 and ask to speak with an OCD workshop facilitator.

OCD GROUP

Obsessive Compulsive Disorder

Richmond Mental Health Outpatient Services offers treatment for adults with obsessive-compulsive disorder (OCD).

- A Clinical Psychologist and Occupational Therapist are involved with the group to allow for sufficient individual attention to each client.
- Clients are offered group treatment for 12 weekly, 2-hour sessions.

*The most widely accepted form of psychological treatment for OCD is behaviour therapy based on the principle of **exposure and response prevention.***

This involves developing a fear-hierarchy with each individual client. Obsessions and triggers are listed in terms of the degree of discomfort they cause the client.

Exposure begins with the client confronting each fear beginning with the least anxiety provoking. At the same time the client is being exposed to the obsessive fears, compulsive rituals must be prevented.

*In our program, we follow the approach of Dr. Jeffrey Schwartz, as outlined in his Brain Lock Method. To facilitate response prevention, we encourage clients to **refocus** their attention on a more constructive, positive activity as they attempt to refrain from engaging in their compulsions. We draw on our occupational therapy facility and resources to assist clients in both exposure and refocusing exercises.*

*Please note: RMHOS also offers an **Adolescent** OCD treatment group*
A physician's referral is required.

For further information, **please call 604-244-5534.**

Richmond Mental Health Outpatient Services
The Richmond Hospital
2rd Floor, Westminster Health Centre
7000 Westminster Highway
Richmond, B.C. V6X 1A2

We accept clients from all health regions

Vancouver Coastal Health

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 935881

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR INFORMATION

TITLE: Overall Update on Fraser Health Congestion

PURPOSE: To provide an overview of the current congestion issue at Fraser Health Authority (FHA) and the preparation being made to address the issue (Congestion Action Plan).

BACKGROUND:
Since 2008, FHA has faced significant challenges, reporting unprecedented levels of congestion in its major acute care hospitals. Since 2005/06, Emergency Department visits have increased by 27 percent, patient admissions have increased by 23 percent, and Alternate Levels of Care (ALC) days have increased by 22 percent.

There has also been a lack of improvement in wait time indicators in FHA. Only 51 percent of patients are admitted to inpatient beds within 10 hours of decision to admit. In addition, only 79 percent of hip fracture fixations are completed within 48 hours in FHA, and as few as 51 percent at Surrey Memorial Hospital (SMH) were completed within 48 hours.

Furthermore, FHA has had significant problems with infection control, as outlined in an independent report by Dr. Michael Gardam released in February 2012.

FHA's 350 Challenge, launched in June 2011, seeks to reduce overall length of stay and conserve the equivalent of 348 beds by the end of the fiscal year 2013/14.

In late January 2012, FHA and the Ministry of Health (the Ministry) jointly established a Congestion Review Panel of external experts to identify additional solutions to ease congestion. The review focused on the two largest congested hospitals in FHA, Royal Columbian Hospital (RCH) and SMH. The Panel presented its report in March and recommended that FHA develops an aggressive action plan and that MoH monitors its implementation proactively.

DISCUSSION:
FHA has reported that, through the 350 Challenge, the equivalent of 36 beds was saved in the first two Quarters of fiscal year 2011/12; however, these gains were more than offset by increases in average length of stay of patients transferred between sites. For the full fiscal year, a total of 45 bed equivalents were added.

A directive on improving infection control and congestion in acute care hospitals was issued by the Minister to FHA on June 12th, 2012. In the letter to which the Directive was attached, the Minister instructed that the implementation of all recommendations of the Gardam Report on infection remains unchanged. The Directive outlines priority measures

for the congestion issue and an enhanced role for the Ministry to monitor FHA's performance. The letter, the Directive, and the measures are attached (see Appendices 1, 2, and 3, respectively).

The Directive establishes five key quality measures to be improved and targets to be achieved within 90 and 150 days. FHA will submit a plan by June 26th outlining how visible site leadership at RCH and SMH, with full authority to improve access and flow, will be attained. FHA will also submit a Congestion Action Plan by June 26th, which specifically describes how the targets will be achieved.

The Ministry monitoring team will review FHA's Congestion Action Plan, continuously monitor FHA's performance, and regularly report progress against the targets. The team is ministry-wide and includes members from Financial and Corporate Services, Government Communications and Public Engagement, Health Authorities Division, Medical Services and Health Human Resources Division, and Planning and Innovation Division. Specific timelines and dates for the monitoring process are shown in Appendix 4.

ADVICE:
FHA will develop and implement a Congestion Action Plan and ensure site leadership at RCH and SMH to ease congestion and meet the targets outlined in the Directive issued to FHA. MoH has identified a team to fulfil the enhanced monitoring role as demanded by the Directive. The monitoring team will actively monitor FHA's performance as well as capacity and communications issues. Progress against the specified targets will be assessed and reported regularly.

Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
Telephone:	250-952-1049
Program Contact (for content):	Effie Henry, Executive Director – Hospital and Provincial Services
Drafter:	David Lin
Date:	June 26, 2012
File Name with Path:	Z:\HAD General\Briefing Notes\2012\HPS\935881 Overall Update on Fraser Health Congestion.doc

Appendix 1

BRITISH COLUMBIA

927061

Mr. David W. Mitchell, CA
Board Chair
Fraser Health Authority
Suite 400, Central City Tower
13450 – 102nd Ave
Surrey BC V3T 0H1

Dear Mr. Mitchell:

I acknowledge the effort of the Board of the Fraser Health Authority (FHA) in improving infection control and congestion within the acute care hospitals in FHA.

As you know from our previous discussions, I continue to have significant concerns relating to specific performance indicators within FHA. Due to my concerns about patient safety and quality care, I am directing the Board to take the following priority measures outlined in the attached Directive. Additionally, I have instructed Mr. Graham Whitmarsh, Deputy Minister of Health, to lead active and regular monitoring of the Board's progress in improving congestion and infection control in FHA. In this regard:

- Staff within the Ministry of Health's (the Ministry) Health Authorities Division will step up the frequency and level of their hospital inspection role as outlined in the *Hospital Act*;
- I have enhanced the monitoring role and will be assigning an experienced leader in health care in British Columbia, supported by senior Ministry staff to monitor the congestion issues in FHA including action plans, key indicators, targets and report directly to the Deputy Minister on FHA's progress;
- The monitoring team will participate in FHA executive meetings, and meet regularly with the Chief Executive Officer, key Vice Presidents and executive leads linked to FHA's congestion issues and plans, as deemed necessary;
- In addition, the team will directly assess progress on site at Royal Columbian Hospital and Surrey Memorial Hospital weekly.

Dr. Doug Cochrane will also continue to work with you and FHA staff to monitor infection prevention and control issues at Burnaby Hospital and the implementation of all recommendations of the Gardam Report over the next few months.

...2

Ministry of Health
Office of the Minister
Mailing Address:
PO Box 9050 Stn Prov Govt
Victoria BC V8W 9E2
Location:
Parliament Buildings
Victoria

My goal as Minister of Health is to ensure that every health authority is delivering the highest quality of care to the public, at all times, within the facilities for which they are responsible. Ultimate responsibility for achieving this within each health authority resides with the Board. I am certain that we share the objective of ensuring that the services delivered at hospitals within FHA meet acceptable standards as soon as possible and I am equally confident that we will move forward together with the full cooperation of FHA in achieving the targets and deliverables set out in this letter.

Kindly acknowledge receipt of this letter, in writing, at your earliest convenience.

Yours truly,

Michael de Jong, QC
Minister

Enclosures (2)

pc: Mr. Graham Whitmarsh
Dr. Nigel Murray, President and Chief Executive Officer, Fraser Health Authority
Dr. Doug Cochrane

Appendix 2

BRITISH COLUMBIA

TO: Fraser Health Authority Board

SUBJECT: Directive to Fraser Health Authority

I, Michael de Jong, QC, Minister of Health, direct that:

1. As soon as practical, but in no case more than 14 days from the date of this Directive:
    a) FHA shall ensure visible site leadership at Royal Columbian and Surrey Memorial Hospitals with full authority to improve access and flow.
    b) The Board shall submit for my review and approval, a congestion action plan which specifically describes how FHA will achieve the clinical targets described in Table 1, enclosed.
2. FHA shall achieve the clinical targets described in Table 1 within the specified timelines.
3. The Board shall report progress against these targets to the Deputy Minister of Health monthly beginning in June 2012 and provide any other information as requested by the Ministry of Health.
4. The Board shall instruct the FHA Chief Executive Officer and senior executive: to meet regularly with the Ministry of Health monitoring lead and senior Ministry of Health staff; to grant complete access to FHA facilities, staff and information as deemed required by the monitoring team; and to include them in FHA's weekly executive meetings and other meetings as deemed required to fulfill their monitoring role.
5. In the event that any dispute arises, it will be resolved by Mr. Graham Whitmarsh, Deputy Minister of Health.

Honourable Michael de Jong, QC
Minister of Health

Date

Ministry of Health
Office of the Minister
Mailing Address:
PO Box 9050 Stn Prov Govt
Victoria BC V8W 9E2
Location:
Parliament Buildings
Victoria

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Table 1: Quality Measures and Targets for Fraser Health Authority

Measure	Quality Rationale	Targets			
		Current levels	90 days	150 days and ongoing	Best Practice
1. Number of admitted patients receiving care in locations not designed for clinical care as currently defined in existing congestion reports.[1]	A key overall measure of hospital congestion. Identifies a risk to patient safety and quality of care.	FHA avg. 100 patients per day.	Decrease by30% in each facility; No facility to increase. No one facility with greater than 15.	Decrease by 60% in each facility; No facility to increase. No one facility with greater than 15.	No patients in other locations.
2. Rates of health care related C. difficile cases / 10,000 inpatient days.[2]	A preventable source of significant morbidity and a contributor to long stays.	FHA 10.6 RCH 12.0 SMH 14.5 BH 14.5	Decrease from the previous period and demonstrated downward trend over preceding three months.	Decrease from the previous period and demonstrated downward trend over preceding six months.	BC rate is 8.3.[3]

[1] **Source**: Fraser Health Authority Daily Congestion Reports, Averages for April 2012, Clinical Capacity Office, FHA.
[2] **Source**: CDI Surveillance Report, Quarter 1 and Quarter 2 (Period 1-6) Fiscal 2011/12, Provincial Infection Control Network of BC (PICNet). http://www.picnet.ca/uploads/files/surveillance/CDI%20Surveillance%20Report%20semiannual%202011-2012%20Q1-2.pdf
[3] **Source**: PICNet Clostridium difficile infections (CDI) Surveillance System

Measure	Quality Rationale	Targets			
		Current levels	90 days	150 days and ongoing	Best Practice
3. Average Length of Stay (ALOS).[4]	Reducing the length of stay releases capacity in the system, and improves the patient experience. Optimization requires proactive planning of the whole process of care, as well as active discharge planning.	FHA: Average Total Length of Stay 8.4 days.	8.1 days.	7.9 days.	No benchmarks available. ALOS represents a comparison with other Canadian facilities. Normalized for discharge of long stay patients.
4. Percent of surgical repairs of hip fractures within 48 hours.[5]	Timely hip fracture repairs are associated with reduced morbidity, mortality, pain and length of stay in hospital, as well as improved rehabilitation.[6]	FHA 79% RCH 76% SMH 51% BH 84% ARH 88% PADH 79% Chilliwack GH 80%	87%. No one facility less than 80%. With no increase in waits for other urgent unscheduled surgeries.	90%. No one facility less than 85% . With no increase in waits for other urgent unscheduled surgeries.	Major hospitals that scored 90% or higher: St. Paul's Hospital (VCHA) – 97% Victoria General (VIHA) – 93%

[4] **Source**: Fraser Health Authority Length of Stay Report Quarter 4 (Periods 10-13) Fiscal 2011-12 – Health and Business Analytics, FHA.
[5] **Source**: % Hip Fracture Fixations Completed within 48 hours Quarter 3 (Periods 7-9) Fiscal 2011-12 – Measurement SharePoint, DAD, Management Information Branch, MoH.
[6] Orosz et al. "Association of Timing of Surgeries for Hip Fracture and Patient Outcomes." American Medical Association, 2004.

Measure	Quality Rationale	Targets			
		Current levels	90 days	150 days and ongoing	Best Practice
5. Percent of ED patients admitted within 10 hours of decision to admit.	An overall measure of patient access and flow after being admitted to the hospital via the Emergency Department.	2011/12 FHA 51% RCH 68% SMH 48% ARH 51% BH 69%	FHA 56%; no one facility less than 50%; No decrease in any facility.	FHA 61%; no one facility less than 50%; No decrease in any facility.	Six hours from triage to an inpatient bed is generally accepted as best practice.

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Appendix 4

Table 2: Relevant Dates for FHA Congestion Monitoring Process

Date	Frequency	Delivered to	Reporting Contents
June 12th	One-time	FHA / Public	• Announcement of RCH redevelopment and delivery of the Directive.
Starting June 20th	Weekly	ADM	• Congestion reports • Updates from the on-site monitoring team
June 26th	One-time	Minister (by FHA)	• FHA will submit congestion action plan and plan for site leadership at RCH and SMH to the Minister. • Monitoring team will review plan submitted by FHA.
July 3rd	One-time	DM	• Monitoring team will present analysis of FHA's congestion action plan to DM.
July 6th	Meeting		• MoH senior staff and consultant to meet with FHA senior staff to review materials in anticipation of first data submission for the first monthly report.
July 12th August 10th September 10th (for 90 day measure) October 10th November 13th (for 150 day measure)	Monthly	MoH Monitoring Team (by FHA)	• FHA to submit information on the five measures appended to the Directive.
July 18th August 16th October 16th	Monthly	ADM, DM	• Interim reports – monitoring team will review and analyze information submitted by FHA, from internal MoH sources and gathered through on-site monitoring, and report to ADM and DM.
September 20th	Meeting		• MoH senior staff and consultant to meet with FHA senior staff to review materials in anticipation of 90 day report
September 30th	One-time	ADM, DM, Minister	• 90-day Milestone Report – finalized measure results with analysis and commentary (based on fiscal period end date of September 10th.
November 20th	Meeting		• MoH senior staff and consultant to meet with FHA senior staff to review materials in anticipation of 150 day report
December 5th	One-time	ADM, DM, Minister	• 150-day Milestone Report – finalized measure results with analysis and commentary (based on fiscal period end date of November 5th.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938016

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health – **FOR INFORMATION**

TITLE: Posting of Substantiated Complaints and Inspection Results

PURPOSE: To provide an update on the progress of posting residential care substantiated complaints and inspection results

BACKGROUND:

Government is committed to transparency and accountability with respect to information about residential care services. A commitment was made in the Legislative Assembly on November 1, 2011 to provide information relating to substantiated complaints.

In addition, health authorities are implementing a monitoring and inspection process for extended care hospitals and private hospitals regulated under the *Hospital Act*, and will also post summary information about inspections of these facilities. These projects are included as key deliverables of the Seniors' Action Plan under Action Theme 2: Information.

Health authorities are working with the Ministry to complete this work by September 2012.

DISCUSSION:

Ministry and Health Authority staff are meeting bi-weekly and to date, have achieved consensus in several key areas of the project. These key areas establish a provincial framework for achieving a consistent end result for posting summary information of substantiated complaints and *Hospital Act* residential care inspections. As each health authority have different information systems, this work needs to consider the health authorities' unique challenges in this area, and information may be presented differently on each health authority website.

Key areas where consensus has been reached include:

1. Standardized data definitions and principles (see appendix A)
2. Only substantiated complaints will be posted
3. Complaints will be categorized under 10 areas that are consistent with regulatory requirements (see Appendix B)
4. Complaints information will remain on websites for no more than two years
5. Complaints investigated and substantiated prior to September 2012 will not be posted
6. Complaint websites will go live September 2012

7. Draft concept of health authority complaint website common information (see Appendix C) and frequently asked questions text (see Appendix D).

ADVICE:

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Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
Telephone:	250 952-1049
Program Contact (for content):	Leigh Ann Seller, ED, Home, Community, and Integrated Care
Drafter:	Sue Bedford, Director, Community Care Licensing
Date:	July 18, 2012
File Name with Path:	M:\Z:\Briefing Notes\2012\HCIC\938016 Update on Posting of Confirmed Complaints July 2012 v.2.docx

Appendix A - Standardized Data Definitions and Principles

For the purposes of the Community Care and Assisted Living Act (Licensing) and Hospital Act(Residential Care) substantiated complaint posting project the following definitions and principles have been developed for guidance and agreed to by Health Authority and Ministry of Health representatives.

Definitions:

Service Type

- Long Term Care Facility under the *Community Care and Assisted Living Act*
  - If a facility is licensed to offer mixed care types (i.e. Long Term Care and Acquired injury) they will be included in the posting of substantiated complaints.
- Long Term Care Facility under the *Hospital Act*

Complaint

- A complaint is a concern or dissatisfaction respecting the operation of a Community Care Facility or *Hospital Act* Facility submitted by the general public, person in care, family or staff/volunteer of a facility.
- A complaint made regarding a Community Care Facility or a *Hospital Act* facility is an allegation that the facility may not be operating in a manner that is fully compliant with the applicable Act/Regulations.
- Complaints referred to licensing/residential care from another agency or investigating body (i.e. Patient Care Quality Office [PCQO]) will be considered to be a complaint received from the general public, person in care, family or staff/volunteer of a facility. Each investigating body will carry out their individual mandated processes, timelines and applicable policies and communication strategies.
- Incident reports or self reporting by a facility is not considered to be a complaint.

Complaint investigation

- A complaint investigation is initiated when there is an allegation that a facility may not be ensuring the health and safety of persons in care by operating in a manner that is not fully compliant with the applicable Act/Regulations. The investigation is carried out by the appropriate investigating body which gathers information to determine if there is a contravention or deficiency, and to ensure corrective actions are taken to promote the health and safety of persons in care.

Substantiated complaint

- Means the complaint has been investigated and has been found to be valid as the actions contravene the applicable Act/Regulations (CCALA or Hospital Act).

Type of complaint means a substantiated complaint categorized into one of the broad categories:

- Care and/or supervision may include abuse/neglect or be broken out into additional categories (Care and Supervision Sexual Abuse, Care and Supervision Financial Abuse etc).
- Hygiene and communicable disease control
- Licensing
- Medication
- Nutrition and food services
- Physical facility, equipment and furnishings
- Policies and procedures
- Program
- Records and reporting
- Staffing

Corrective Action

- Corrective action means contraventions or deficiencies have been identified under the applicable Act/Regulations and steps need to be taken by the facility to ensure the health and safety of persons in care.

  *Description (for website)
  The facility has taken steps to correct contraventions or deficiencies substantiated during the complaint investigation, or has submitted a Health and Safety Plan to address contraventions or deficiencies. The facility will be monitored for compliance with that plan to ensure the health and safety of persons in care. Corrections are often implemented voluntarily by the facility, however, if required the Health Authority may implement a system of progressive enforcement to ensure the health and safety of persons in care.

Substantiated findings

- Means that in the course of a complaint investigation the investigator has uncovered facts and/or findings that substantiate the complaint. These substantiated findings are included in the complaint posting.

Other findings

- Means that in the course of a complaint investigation the investigator may uncover issues or concerns that are not related to the complaint, however, highlight contraventions or deficiencies that need to be addressed. "Other findings" will not be posted as part of the complaint posting.

Health and Safety Plan

- A health and safety plan is a written plan of action developed by an operator, at the request of the investigating body, which is put in place to reduce the potential for harm, to prevent similar incidents from occurring, and to ensure the health and safety of persons in care.

Principles:

Governing standards

- *Community Care and Assisted Living Act*, Residential Care Regulation, *Hospital Act*. Through their contractual agreements with the health authority *Hospital Act* Facilities will be aligning with the Residential Care Regulations as the policy standard.

Complaint type

- Only summary information regarding substantiated complaints will be posted.
- Does not include complaints of unlicensed care.

How complaints are counted

- A complaint may be considered as a single complaint when received from a single individual (general public, person in care, family or staff/volunteer of a facility), regardless of the number of issues contained within the complaint.
- A complaint regarding the same facility, with the same issues, submitted by different individuals may be considered as separate complaints. (E.g. three care aides complain about a resident being yelled at and forcefully removed from the dining room.)

Complaint date

- Is the date the licensing/residential care services receives the complaint from the PCQO or the public.

Website refresh

- Minimum of quarterly updates.

Posting date

- No historical complaints will be posted. The web page is to be live for the public in September 2012. Substantiated complaint information will not be considered for posting unless the complaint was received after September 1, 2012. However, until the complaint investigation is completed no information will be posted on the web page.

How long will the summary of complaint information be posted on the website?

- Complaints will be posted on the website for up to two years* from the date the complaint is received. The date the complaint is received is the date the investigating body staff receives it, not the date of when the complaint was submitted (e.g. if sent by letter post the complaint may not be received for several business days or if voice mail message left on 5 pm Friday afternoon it would not be received until Monday.)

* In cases where a substantiated complaint is complex and takes several months to resolve, information may be posted on the website for less than the 2 years (i.e. the investigation lasted 4 months the info posted will only be public for 20 months).

Appendix B - Complaint Category Definitions

Care and/or supervision: Operators are required to ensure adequate care and/or supervision of residents. Operators must maintain and follow individual plans of care for every resident that may include oral care, therapeutic instructions, medication administration and activity planning. Inspectors and staff employed by the health authorities audit care plans to ensure they adequately guide employees in their duties to ensure residents are safe and their care needs are met. As part of care and supervision Operators must ensure that a person in care not subjected to financial abuse, emotional abuse, physical abuse, sexual abuse or neglect

Hygiene and communicable disease control: Operators are required to ensure facilities maintain acceptable levels of hygiene. Inspectors and staff employed by the health authorities inspect for appropriate communicable disease control practices and other practices that would compromise the health and safety of residents.

Licensing: Operators have a continuing duty to inform the Medical Health Officer of any significant changes to the operation of the community care facility. This category contains a number of administrative requirements that inspectors and staff employed by the health authorities assess for compliance.

Medication: Operators are required to store, administer and record the medications of residents according to requirements in the regulations, and established by the medication safety and advisory committee. Inspectors and staff employed by the health authorities examine medication administration records, policies, and storage practices to ensure legislated requirements are met.

Nutrition and food services: Operators are required to store, prepare and deliver foods and fluids safely. Operators must ensure appropriate nutritional content of meals, assistance with eating and texture modifications are made as necessary. Inspectors and staff employed by the health authorities inspect nutrition and food services.

Physical facility, equipment and furnishings: Operators are required to maintain the facility, all equipment and furnishings in sanitary and working condition. Inspectors and staff employed by the health authorities inspect to ensure the facility and equipment is safe, free from hazards, in good repair, and is appropriate for the needs of the residents.

Policies and procedures: Operators are required to have written policies and procedures to guide staff in all matters regarding the care and/or supervision of residents. Inspectors and staff employed by the health authorities inspect to ensure that the facility has policies in place to meet the needs of the residents and that they are adequately communicated and implemented by staff.

Program: Residents must be offered, without charge, an ongoing program of physical, social and recreational activities. Operators must ensure residents are provided with indoor and outdoor recreation areas that are easily accessible and safe. Inspectors and staff employed by the health authorities look for a planned program that is designed to meet the needs of residents.

Records and reporting: Operators are required to keep records on facility matters and matters that guide staff in ensuring the health and safety residents. Inspectors and staff employed by the health authorities inspect record keeping and reporting practices to ensure they are compliant with regulations.

Staffing: Operators are required to ensure a facility has enough staff, who possess adequate training and experience, to meet the care, supervision and activity needs of the residents. Inspectors and staff employed by the health authorities inspect to ensure operators maintain enough staff to meet the needs of residents and that all employees meet basic health and competency standards and are able to carry out their duties effectively.

Appendix C – Licensing/Residential Care Common Information for Public Website

HEALTH AUTHORITY COMMUNITY CARE LICENSING WEBSITE

Long term care facilities are inspected to protect the health, safety and well-being of residents, and to ensure minimum health and safety requirements are being followed. These requirements include facility specific policies, staffing, care, building requirements and others. Inspection reports inform the facility operator and the public of current compliance with requirements and also provide a historical context. In addition to inspections, an investigation is conducted in response to complaints and allegations of abuse. Complaints play an integral part of the ongoing monitoring of long term care facilities.

Long term care facilities may be regulated either under the *Community Care and Assisted Living Act* or *Hospital Act*. A complaint (concern or dissatisfaction) respecting the operation of a long term care facility under the *Community Care and Assisted Living Act* or *Hospital Act* may be submitted by the general public, a person in care, family or staff/volunteer of a facility or another agency. All complaints are investigated, reviewed and followed up.

Complaint information on this website is a summary of a contravention or deficiency that was substantiated during the complaint investigation process. The summary complaint information reflects the date when the complaint was received, the area where the contravention or deficiency was found, and indicates that the facility has taken the necessary corrective actions to ensure the health and safety of the persons in care.

Visitors to this site are cautioned against making conclusions about the quality of a facility based solely on the number or type of complaints. Before making a decision about the quality and suitability of a facility for yourself or loved one, take time to ensure you have enough information on which to base your decision by conducting additional research, gathering information and contacting the facility to make arrangements for a visit.

If you have questions about a particular facility please contact XXX (HA to add applicable contact info/links/ email/ phone numbers).

If you would like to register a complaint about a facility please contact XXX (HA to add applicable contact info/links/ email/ phone numbers/PCQO).

Appendix D - Frequently Asked Questions

What is a Long Term Care Facility?

A long term care facility provides residential care and services for three or more individuals over the age of 19 who are dependent on caregivers for health care, assistance or direction. Long term care facilities are governed by the minimum health and safety requirements of the *Community Care and Assisted Living Act*, Residential Care Regulation and the *Hospital Act.*

Why is complaint information being posted?

The purpose of posting summary information about substantiated complaints is to provide accessible information about long term care facilities to strengthen public accountability and transparency.

What will the complaint information tell me?

Only complaints which were substantiated through the investigation process will be posted on this website. The summary will include information that reflects the date of when the complaint was received, the area where the contravention or deficiency was found, and will indicate whether the facility has taken the necessary corrective actions to ensure the health and safety of the persons in care.

Complaints about a facility which were not substantiated during the investigation process will not appear on this website.

What will the complaint information NOT tell me?

Summary complaint information will NOT:

- Rank or rate facilities against one another;
- Issue a report card that grades facilities;
- Provide personal information about residents;
- Provide specific details of the complaint; or
- Provide information about complaints that were not substantiated upon investigation.

Why is there no information on the facility that I am interested in?

There may not be any substantiated complaints for the specific facility you are looking for as the practice of posting complaints only started in September 2012. It is also possible the facility you are looking for is not regulated as a long term care facility; it may be independent living, supportive housing or a registered Assisted Living Residence.

What can I do to ensure that my loved one is receiving appropriate care?

Regulations are in place to promote the health, safety, and dignity of residents. It is also important to stay involved with you family member's life after they have moved into a facility and to ask questions and observe any changes in their circumstances.
Other ways to be involved are to participate in the resident/family council and to take part in the care planning for your relative. Resources to assist you: (Heath Authorities to add more links, contacts/ PCQO info etc.).

Assisted Living Registrar www.health.gov.bc.ca/assisted/
Alzheimer Society of Canada www.alzheimer.ca
BC Care Providers www.bccare.ca/
BC Seniors Living Association www.bcsla.ca
Canadian Virtual Hospice - www.virtualhospice.ca
Denominational Health Association www.chabc.ca
Parkinson's Foundation of Canada www.parkinson.ca
Senior Care Canada www.seniorcarecanada.ca

Will personal information be posted in the complaint?

No. Personal identifying information regarding the residents, staff or complainants will not be posted on the website. The facility operators name and business contact information will be posted to allow people to contact the facility if they have any additional questions or concerns.

What is the purpose of an investigation under the *Community Care and Assisted Living Act* and *Hospital Act*?

All complaints are investigated in a confidential and timely manner with particular emphasis on the safety of the persons in care and administrative fairness. Complaints are investigated in a fair and transparent manner and, if the complainant requests to be anonymous, every effort is made to protect their identity. However, in circumstances where matters proceed to an appeal, or to court, it may not be possible to protect confidentiality.

Under the *Community Care and Assisted Living Act* and *Hospital Act*, a complaint investigation is to determine if the facility is being operated in a manner that does not comply with the minimum health and safety requirements and to intervene where the quality of care puts residents at risk. Protecting the overall health and safety of residents is the first step of any investigation.

In addition, the Patient Care Quality Office (PCQO) has been established to respond to care quality complaints about your own care, your loved ones care, or care that you or your loved one expected but did not receive. For more information, or to contact the PCQO please visit XXX (HA's to add relevant link and info)

What happens when a complaint is substantiated?

Once a complaint has been investigated and is substantiated, the facility operator is required to identify and implement corrective actions.

Corrective actions are immediate steps that the facility takes to remedy the contravention or deficiency, to prevent harm to persons in care.

There are times when contraventions or deficiencies cannot be immediately corrected, however steps can be taken to ensure safety while an investigation is underway. This is referred to as a Health and Safety Plan. A Health and Safety plan is a written plan of action developed by the facility operator to implement the corrective actions needed to ensure immediate safety. Health and safety plans remain in place until the contravention or deficiency can be corrected, and these plans are monitored for compliance.

Corrective actions and health and safety plans are often voluntarily implemented by the facility, however, if required the Health Authority may also use progressive enforcement to ensure the health and safety of persons in care.

Can I register a complaint through this website? How do I submit a complaint?

Yes/ No (Health Authority to provide relevant info, PCQO contact etc)

How do I access more information about a complaint or investigation process?

Additional information about the investigation process can be found XXX or by calling XXX. You may also submit a request to access more information by XXXX- (link to FOI page of HA or contact info). HA's to add relevant info.

Is the information on this website current?

The information on this website is updated quarterly and may stay on the website for up to two years.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938213 **XREF # 934374**

PREPARED FOR: Honourable Michael de Jong, QC, Minister
- FOR INFORMATION

TITLE: Abbotsford Hospice Society (AHS) construction of Holmberg House hospice residence.

PURPOSE: To provide background information for the Minister.

BACKGROUND:
Construction on Holmberg House hospice residence is scheduled to begin in 2012 and it will be located at the Dave Lede Campus of Care, adjacent to the Abbotsford Regional Hospital and Cancer Centre. The City of Abbotsford contributed land for the campus. The Abbotsford Hospice Society's Light the Way Campaign has been aiming to raise $7.5 million to help cover construction costs of the two-storey, 2,650-square-metre (28,500-square-foot) hospice facility. Approximately $5 million has been raised, according to their website. The name Holmberg House honours the life and legacy of David Holmberg Jr., an Abbotsford resident, whose family made significant financial contributions to hospice, including the campus of care project.

In May 2011, the Ministry provided $3.5 million to support hospice services through the AHS.

DISCUSSION:
A teleconference on July 3, 2012 took place between the Minister, DM, executive from Health Authorities Division (Ms. Barbara Korabek and Ms. Leigh Ann Seller), and FHA end-of-life care executives (Ms. Lynda Foley and Ms. Carolyn Tayler). During the teleconference, FHA was informed that government provided one-time capital funding to AHS to assist with the capital costs of Holmberg House.

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In addition, at the July 5, 2012 meeting, FHA also advised AHS that FHA must approve the blueprints for the hospice and AHS must ensure it meets licensing requirements.

FHA has committed to fund the operating costs for Holmberg House and will work with the Ministry on making the necessary adjustments within their current budgets. FHA is reviewing options to ensure the continuity of end-of-life services at the Mission site.

ADVICE:

S. 13, S. 17

Program ADM/Division:	Barbara Korabek, ADM Health Authorities Division
Telephone:	250 952-1049
Program Contact (for content):	Leigh Ann Seller, ED, Home, Community and Integrated Care
Drafter:	Pauline James, Manager Priority Populations, Home, Community and Integrated Care
Date:	July 20, 2012

File Name with Path: Z:\HAD General\Briefing Notes\2012\HCIC\938213 - REVISED BN Minister meeting with Abbotsford Hospice Society re Holmberg House Hospice - Approved by B Korabek July 25.doc

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 940557 xref 925390

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health –
FOR INFORMATION

TITLE: Provincial Colorectal Cancer Screening Program

PURPOSE: To confirm the final model for a provincial Colorectal Cancer Screening program.

BACKGROUND:
In July 2008, the British Columbia Cancer Agency (BCCA), the Provincial Health Services Authority (PHSA), and the Ministry of Health (the Ministry) initiated Colon Check, a population-based colorectal cancer screening pilot in three sites across BC. In May 2011, PHSA submitted the Colon Check Action Plan (the Plan), which recommended implementing all aspects of the Colon Check pilot design province-wide.

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DISCUSSION:
In January 2012, the Ministry directed PHSA/BCCA to explore alternate options that emphasized the use of existing health system infrastructure and base funding, and incorporated the existing General Practitioners (GPs) role and prevention strategy. The program objectives continued to be increased screening participation and ensuring appropriate access to quality service in a cost-effective model.

In August 2012, the Ministry, PHSA, and BCCA agreed to a Primary Care-centred approach in which GPs will be responsible for referring asymptomatic patients ages 50-74 for a Fecal Immunochemical Test (FIT), or referring patients with a family history to the regional health authority (RHA) for colonoscopy. GPs will then receive and discuss results with patients and refer them to their RHA for follow-up, if necessary. The practice of patients accessing colorectal screening through their GPs is similar to the Alberta and Ontario programs (see Appendix 1 for a comparison of provincial programs/pilots).

The role of PHSA and BCCA will be to enhance public awareness, develop a centralized participant registry, develop systems for data collection and monitoring throughout the pathway, and help to improve processes regarding quality, safety and appropriate access to screening colonoscopies. BCCA will provide overall leadership and provincial oversight of a distributed model.

The most significant change from the current screening practice will be the replacement of the current guaiac fecal occult blood test (gFOBT) with the more costly[1] FIT. FIT is considered a more accurate test with fewer false positives/negatives and easier for patients to administer. At present, FIT is only available (other than through the Colon Check pilot) through private (patient) pay. GPs will provide patients a test requisition form and community labs will procure, supply and process FIT. Labs will send results to both the GP and BCCA. The colon check pilot will move to the new screening model.

Medical Services Division (MSD) will be responsible for implementing the FIT test through the Medical Services Commission approval process. FIT tests are currently used in Saskatchewan, Nova Scotia, New Brunswick, and Newfoundland and Labrador.

The program will also require RHAs to implement colorectal screening coordinators to assist with colonoscopy management, in particular to improve procedure appropriateness.

FINANCIAL IMPLICATIONS:

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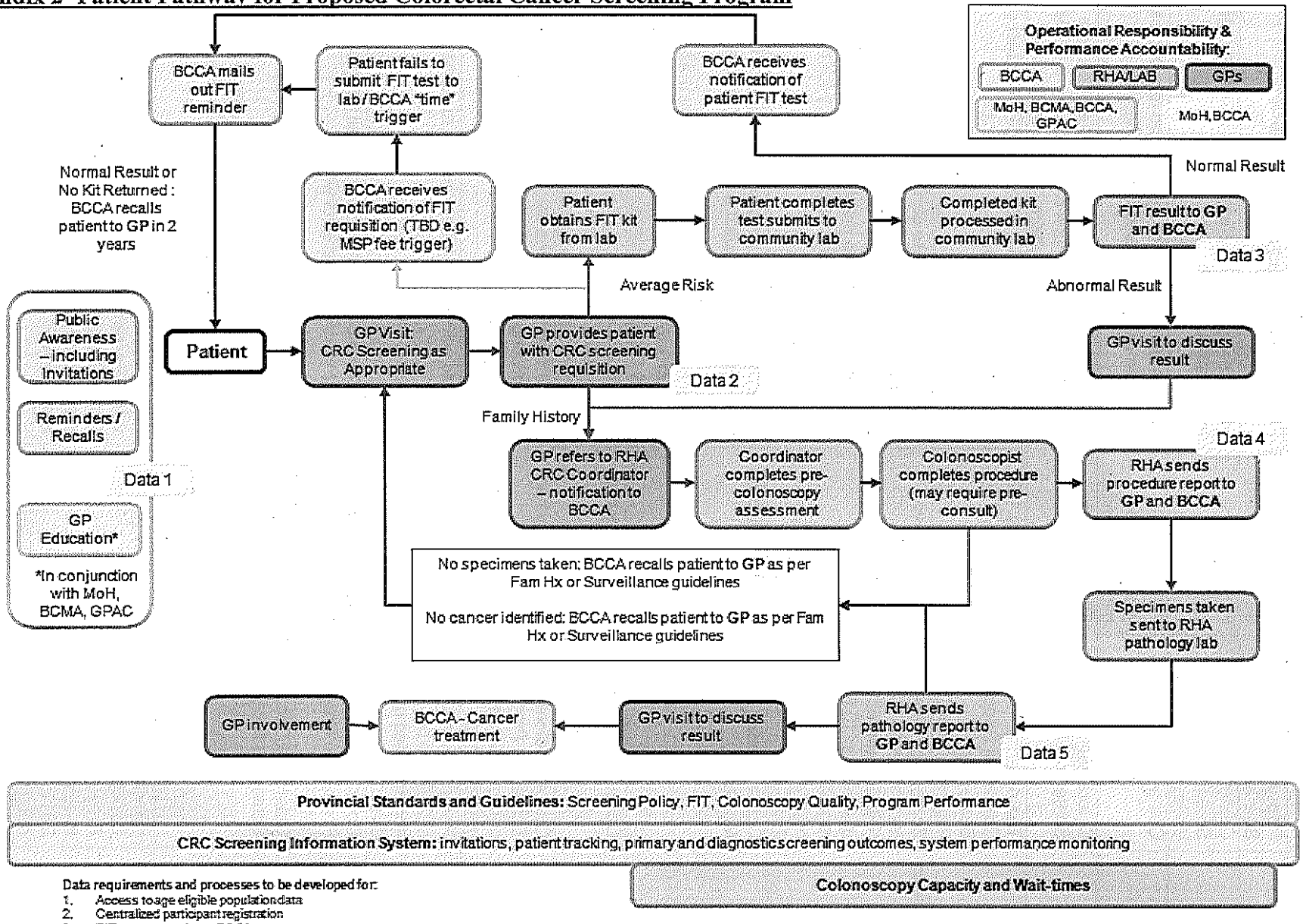
Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
Telephone:	250 952-1049
Program Contact (for content):	Effie Henry, Executive Director
Date:	August 14, 2012
File Name with Path:	S:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\MO BN's\940557 - xref 925390 Colon Check Update BN.docx

[1] gFOBT: guaiac fecal occult blood test @$18.06/kit; FIT: fecal immunochemical test @$30.74/kit through Colon Check; FIT @ $30.00 - $35.00/kit through private lab .

Appendix 1 – Colorectal Cancer Screening Programs in Canada

Province	Population Based Screening Program	Average Risk Screening Test	Patient Recruitment and Pathway
British Columbia- Current	Colorectal Cancer Screening (Prov. Wide)	FOBT every 2 years.	Province wide - GPs refer patients to obtain a gFOBT from community lab.
BC- Pilot	Colon Check (Pilot)	FIT every two years in select pilot communities.	Patients contact Cancer Agency and request a kit. GP's can refer patients to Cancer Agency.
BC- New Proposed Model	Colorectal Cancer Screening Program	FIT every two years.	GP's refer patients to get screened and provide patients with a requisition form to obtain a FIT kit. Screening results are sent to BCCA and GP's.
Alberta	The Alberta Colorectal Cancer Screening Program (ACRCSP)	FOBT every 1-2 years.	Patients receive FOBT from their GP. The test results are then sent to GP's.
Saskatchewan	Screening Program for Colorectal Cancer (Pilot). Currently available in 10 health regions, expected to be province wide in 2012-13.	FIT every two years.	Letters and FIT kits are sent to residents in age group. Reminder letters also sent out. Screening is available in the other health regions through GP's or nurse practitioners. Results sent to GP and cancer agency for monitoring.
Manitoba	Colon Check Manitoba	FOBT every two years.	Patients can request a home test online or by phone. Patients can also request a test through their GP. Patients receive normal test results by mail. Program will phone to follow up for abnormal results. GP's also receive copies of patient's results.
Ontario	Colon Cancer Check	FOBT every two years.	Kits are available through GP's. Individuals without a primary care provider can obtain a kit from a pharmacist or by calling Telehealth Ontario.
Quebec	Québec Colorectal Screening Program currently being implemented.	FOBT every two years.	Once implemented, the target group will receive a letter inviting them to take part in the screening program.
New Brunswick	Program announced in 2009, to be implemented over three years.	FIT every two years.	Patients will receive letters inviting to participate.
Nova Scotia	Colon Cancer Prevention Program (CCPP)	FIT every two years.	Program mails screening tests to all people 50-74. Program contacts patients who
PEI	Colorectal Cancer Screening Program.	FOBT every two years.	Patients request kits from any family health centre or medical clinic. Patients return test to family health centre or local hospital for testing. Results are mailed back directly to patients. Physicians receive results.
Newfoundland & Labrador	Provincial Colorectal Cancer Screening Program. Introduced in select areas in 2011, will be rolled out gradually.	FIT every two years.	FITs are analyzed at a central laboratory within Eastern Health and the results are sent to the Colon Cancer Screening Program. The screening program will then forward the results to patient and their and GP.

Appendix 2- Patient Pathway for Proposed Colorectal Cancer Screening Program



Preliminary Description – Clinical Pathway

1. **Patient visits GP**
   - A GP/patient may raise the possibility of being screened
   - GPs will assess a patient for colorectal cancer screening eligibility (using guidelines from Ministry and/or BCCA guidelines)
   - The GP will determine if the patient is eligible for FIT screening. If so, the GP will provide the patient with a requisition form for obtaining a FIT kit.
   - GP may identify a patient as being "high risk" of having colorectal cancer based on family history. GP will refer such a patient to the RHA colorectal cancer screening navigator (See Step 5).
2. **Low-risk patients obtain and complete FIT kit.**
   - An eligible patient without family history of colorectal cancer will use requisition form to obtain a FIT kit from their community lab.
   - The patient will complete the test and return to lab for processing.
3. **FIT results shared with GP/BCCA**
   - The community lab will share FIT results with the patient's GP and BCCA. The GP will schedule a visit with a patient who has an abnormal FIT result.
4. **Patients with abnormal FIT visit GP**
   - A patient with an abnormal FIT result will meet with their GP to discuss the test result.
   - The GP will refer the patient to the RHA colorectal cancer screening navigator.
5. **Patients visit RHA colorectal cancer screening navigator**
   - A high-risk patient or a low-risk patient with an abnormal FIT result will meet with the colorectal cancer screening coordinators in their RHA.
   - The coordinator will assess the patient to determine whether they are eligible for a colonoscopy based on BCCA guidelines.
   - Eligible patients are referred to a colonoscopist. Patients who are not eligible for a colonoscopy are referred back to their GP.
6. **Patients complete colonoscopy**
   - A colonoscopist will complete the colonoscopy on the eligible patient.
   - The RHA will send a procedure report back to the relevant GP and BCCA.
   - If no cancer is identified, BCCA recalls the patient back to their GP to discuss results.
   - If cancer is identified, RHA notifies BCCA and relevant GP through a pathology report.
7. **Patients discuss colonoscopy results with their GP**
   - If a patient is found to have signs of cancer, they will meet with their GP to discuss the test results and next steps for treatment.
   - The GP will then refer the patient to BCCA for further testing and potential treatment.

Pages 139 through 140 redacted for the following reasons:
- -
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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #: 935750

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
- FOR INFORMATION

TITLE: Ministry of Health Response to Report of Representative of Children and Youth: "Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now"

PURPOSE: Background information for possible briefing week of July 3, 2012

BACKGROUND:

- In March 2012, the Representative for Children and Youth (RCY) submitted the report "Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now" to the Legislative Assembly of British Columbia, detailing her investigation into the deaths of three young children, Kaitlynne, Max, and Cordon Schoenborn, at the hands of their father, Allan Schoenborn, who had a long history of violence and untreated mental health and substance use problems.
- The Government's response to this report is included in the Premier's Family First Agenda for BC in the "Addressing Mental Illness and Addiction" section.
- The report makes eight recommendations across five ministries, the first of which concerns the Ministry of Health working in partnership with the Ministry for Children and Family Development to identify and support families affected by untreated serious mental illness (see Appendix 1: Recommendation 1).
- The Ministry of Health and the Ministry for Children and Family Development have worked collaboratively to develop a draft action plan, which was reviewed at the Deputy Minister's Committee Meeting on June 21st 2012, and will be presented to the RCY as part of a provincial action plan addressing all eight recommendations on July 9th 2012, with a final report to be submitted mid-July to be publically released in September 2012.

DISCUSSION:

The Ministry of Health works with health authorities to provide a range of evidence-based services across the continuum of mental health and substance use problems, including high risk populations. The Ministry of Health and the Ministry of Children and Family Development recognize the need to enhance current practices consistent with the recommendation, particularly in working more closely with each other to support families.

People with serious untreated mental illness who pose a risk to their families represent a small percentage of the population served, and the joint response to the recommendation has been developed with sensitivity to the potential stigma that could result in a poorly thought out response. For example, it is important to be mindful of the risks associated with implying a spurious association between parental mental health and/or substance use and violence towards children per se. Actions need to be carefully monitored to ensure that potential unintended consequences, such as parents' avoidance of medical services for fear of child apprehension, do not result.

The action plan is focused on identifying parents with serious untreated mental illness through appropriate evidence-based screening, and improvements in mental health and substance use service delivery to families through enhanced referral and information sharing processes. The development of tools and staff training will be undertaken through existing knowledge exchange mechanisms in the health system and the Ministry of Children and Family Development. For example, physician protocols could be developed and implemented through existing BC Medical Association/Ministry of Health/Health Authority structures and processes such as the Guidelines and Practice Advisory Committee and the Practice Support Program.

The plan will be implemented in three phases. Firstly, a pilot phase of initiating evidence based best practices in screening, referral and information sharing will be implemented in two rural and two urban communities and include emergency room/hospital, primary care, public health and community mental health and substance use services. This phase will be carefully monitored and include an evaluation. The second phase will expand the pilots to two rural and two urban communities in each of the five regional health authorities (i.e. 20 pilots in total). Full implementation across a range of communities in each health authority will be in place by 2014 (see Appendix 2 for full Action Plan).

Program ADM/Division: Barbara Korabek, ADM, Health Authorities Division
Telephone: 250-952-1049
Program Contact (for content): Ann Marr, Executive Director, Mental Health & Substance Use
Drafter: Elizabeth Hartney, Psychologist, Mental Health and Substance Use
Date: June 25, 2012
File Name with Path: K:\Briefing Notes\2012\Drafts\935750 MoH Response to RCY re Honouring Kaitlynne Max and Cordon- Approved by Barbara Korabek July 3, 2012.docx

Appendix 1: Recommendation #1

That the Ministry of Health, in partnership with the Ministry of Children and Family Development, take immediate steps to ensure that all staff and professionals connected to their systems understand the risk factors relating to children of parents with a serious untreated mental illness, and promote the well-being of children by:

a) Putting in place procedures for the identification at intake in the health care system or child-serving system of the parental role of people with a mental illness, including expectant parents;
b) Developing and implementing policies and procedures to support workers to identify and reduce risk factors for children affected by parental mental illness and domestic violence;
c) Ensuring appropriate information regarding referral to services for families affected by parental mental illness without abdicating the focus on child safety;
d) Developing and implementing policies for early detection of risk factors for families associated with mental illness (e.g. social isolation, frequent moves, emotional and financial instability, violent episodes).

Improvements should include:

a) policies and standards for identifying and managing cases where serious parental mental illness may jeopardize the safety and well-being of children, taking into account concurrent substance abuse;
b) provision for an active outreach and monitoring program across the province, and identifying and monitoring for factors which may increase the risk;
c) ensuring that children who have been traumatized are referred to and engaged with the child and youth mental health system;
d) provision for a consultation service for social workers and other professionals involved with the child so that they can better understand the dynamics in the home;
e) mechanisms to ensure effective links with child protection and child and youth mental health services at the local level;
f) ensuring this report will be used to promote practical learning in the adult mental health system across the province and among policy staff in the ministry.

A plan should be finalized by September 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by December 31, 2012.

Appendix 2: Full Action Plan

Immediate	July 2012 – December 2012 (6 months)	**Phase 1**	Develop
Short Term	January 2013 – December 2013 (6 – 12 months)	**Phase 2**	Implement
Long Term	January 2014 (over 18 months)	**Phase 3**	Evaluation

RECOMMENDATION #1- MoH and MCFD Deliverables									
Deliverable	**Expected Outcome**	**Key Actions**	**Phase**	**Start Date**	**End Date**	**Immediate**	**Short Term**	**Long Term**	**Resources Implications**
Communication/Engagement Strategy: Full engagement of appropriate partners in development and implementation of the Action Plan (linked with overall Communication Strategy)		Consult with senior leaders within MoH/ Health Authorities/MCFD	1	Jul 2012	Dec 2012	✓			
		Develop consultation strategies – (e.g. consistent messaging to HA/MCFD regions and community partners)	1	Jul 2012	Dec 2012	✓			
		Include family representatives with lived experience of mental illness problematic substance use and domestic violence to identify 'family friendly' approaches.	1	Jul 2012	Dec 2012	✓			
		Present to and consult with Key Leadership committees (e.g. HOC, IPCC, GPSC, MCFD Executive Directors of Service)	1	Jul 2012	Dec 2012	✓			
		Work through MHSU Planning Council, Provincial Prevention Director's Planning Council, Child Health BC, IPT, DAA, Child and Youth MHSU CAN, iFNHA, Harm Reduction Strategies and Service (HRSS) Committee, etc.	1	Jul 2012	Dec 2012	✓			
		Identify Roles and Responsibilities	1	Jul 2012	Dec 2012	✓			

RECOMMENDATION #1- MoH and MCFD Deliverables									
Deliverable	**Expected Outcome**	**Key Actions**	**Phase**	**Start Date**	**End Date**	**Immediate**	**Short Term**	**Long Term**	**Resources Implications**
		including champions for prototyping/piloting.							
Conduct Community-based cross system pilots: • Identify parents with a serious mental illness/ problematic substance use • Identify and/or develop evidence informed and 'family friendly' protocols for screening, referral, and information sharing to address safety needs of children • Implement Phase 1 Pilot Sites in a variety of settings • X % of total # of service location sites implemented in Phase 1		Conduct Literature review/environmental scan/ of protocols for identifying, screening and referrals.	1	Jul 2012	Dec 2012	✓			Academic researcher to undertake the Literature Review and Gap Analysis. Project manager to support the development and implementation of the three phases. Evaluation Expert to develop the Evaluation framework and implement the evaluation among the various sites. Impact to CYMH services, Children Who Witness Abuse Programs, and other services for children due to
		Conduct Gap Analysis of existing protocols across service sectors (e.g. ER, community, primary care) and modify consistent with best practice review. This will mean embedding the changes in documents such as the Family Physician Guide and the BC Handbook/Child Abuse and Neglect.	1	Jul 2012	Dec 2012	✓			
		Work with PODV and Ministry of Justice to ensure consistency with their protocols/approaches (e.g. B-Safer Training).	1	Jul 2012	Dec 2012	✓			
		Work with PODV to develop best practices recommendations for curricula and work with professional training institutions, the Ministry of Advanced Education, professional colleges and other stakeholder's organizations to integrate these concepts into professional training and practice.	2	Jan 2013	Dec 2014		✓		

RECOMMENDATION #1- MoH and MCFD Deliverables									
Deliverable	**Expected Outcome**	**Key Actions**	**Phase**	**Start Date**	**End Date**	**Immediate**	**Short Term**	**Long Term**	**Resources Implications**
		Identify relevant available training materials (e.g. U.K., Australia, Ontario) and work through existing HA and MCFD/DAA knowledge exchange mechanisms to develop and implement multi disciplinary training for local community and hospital staff starting with pilot sites. Existing training/education mechanisms include the Physician Practice Support Program, HA Educators, MCFD Learning and Development.	1	Jul 2012	Dec 2012	✓			increase in referrals as a result of identification of parents with Mental Health and or problematic Substance Use issues. Unintended outcome: • Increase waiting lists • Services overwhelmed by referrals and unable to respond to demand Impact to Mental Health and Substance Use programs due to: • Potential increased referrals from service providers
		Integrate harm reduction and early intervention trauma informed approaches. Incorporate domestic violence perspectives into trauma focused cognitive behavioural therapy training and ongoing clinical consultation of CYMH clinicians (train 40 staff per year) – link to Recommendation 4.	2	Jan 2013	Dec 2013		✓		
		Conduct two client care mapping exercises in one urban and one rural setting to inform the implementation of the pilots.	1	Jul 2012	Dec 2012	✓			
		Develop Criteria for choosing pilot sites (i.e. high risk/high impact/high buy-in within existing community capacity such as champions among Divisions of Family Practice and Integrated Primary Care Services Committees)	1	Jul 2012	Dec 2012	✓			
		Identify sites and implement pilots within	2	Jul 2012	Jun 2013	✓	✓		

RECOMMENDATION #1- MoH and MCFD Deliverables									
Deliverable	**Expected Outcome**	**Key Actions**	**Phase**	**Start Date**	**End Date**	**Immediate**	**Short Term**	**Long Term**	**Resources Implications**
		2 urban and 2 rural sites. This will include all relevant service providers and key stakeholders through an integrated approach within the local communities (ER/hospital, primary care and relevant HA/MCFD community services). Protocols, policies, screening tools, risk assessments, information sharing and referral processes will be developed as requred.							recognising risk factors to children
Evaluate the pilots/prototypes to measure outcomes		Develop an evaluation framework in collaboration with key partners and stakeholders aligned with the 5 dimensions of quality	1	Jul 2012	Jun 2013	✓	✓		
		Conduct evaluation on Phase 1 Projects starting with integrated initial feedback for continuous quality improvement.	3	Jan 2013				✓	
		Use findings to strengthen prototypes/pilots to guide phase 2	3	Jul 2013				✓	
Implement Phase 2 Pilot Sites X % of total # of service location sites implemented in Phase 2		Identify and implement additional pilot sites/prototypes for: 2 rural and 2 urban sites integrated across all service sectors in each of the HA/MCFD geographic regions (four in each region, total 20 sites in BC).	2	Jan 2013	Sep 2013			✓	

RECOMMENDATION #1- MoH and MCFD Deliverables									
Deliverable	**Expected Outcome**	**Key Actions**	**Phase**	**Start Date**	**End Date**	**Immediate**	**Short Term**	**Long Term**	**Resources Implications**
Implement the models province wide to support system enhancements • Implement models province wide (phase 3)		Implement the model broadly across all geographic regions to meet needs of local communities. Work with PODV on information enhancement across sectors to support implementation of protocols (PODV takes the lead).	 1	Oct 2013 Jul 2012	Dec 2014	 ✓		✓	
		Enhance existing resources for professionals, for example: • Tools to enhance information sharing consistent with FOIPPA DV amendments • Practice Guidelines (e.g. Trauma Informed Practice Guidelines) • Ulysses Agreements • Community Health and Resource Directory (CHARD)	2	Jan 2013	Dec 2014	✓	✓	✓	

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # S. 13, S. 16

PREPARED FOR: Honourable Michael de Jong, QC, Minister – **FOR INFORMATION**

TITLE:

PURPOSE: S. 13, S. 16

BACKGROUND:

On April 2, 2009, TILMA came into force between the provinces of BC and Alberta. Under it, BC and Alberta agree to mutually recognize or reconcile the rules that impede the free movement of goods, services and people. On April 30, 2010, the New West Partnership Trade Agreement (NWPTA) was entered into by the provinces of BC, Alberta and Saskatchewan, effectively extending TILMA to cover Saskatchewan.

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The Ministry of Jobs, Tourism and Innovation (MJTI) has responsibility for the trade agreements and policy portfolio and is lead for the province of BC. The Ministry of Health (MOH) is responsible for 22 regulatory colleges under the *Health Professions Act* plus the Emergency Medical Assistants Licensing Board.

DISCUSSION:

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S. 13, S. 16 in 2009, when the two provinces agreed to the following Q&A, currently published on the public TILMA website:

What impact will the proposed changes have on public health and safety?
The provinces fully acknowledge that the primary role of regulatory bodies is to ensure public safety and consumer protection. TILMA labour mobility requirements are not intended to undermine this fundamental mandate of regulatory bodies. Each province will continue to set occupational standards as they see fit and as are supported by their governments. If necessary to ensure public health and safety, a government retains the right to impose training and examination requirements on incoming certified workers so long as the additional requirement is necessary to meet a legitimate objective. *[Emphasis added]*

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CONCLUSION:

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Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
Telephone:	250-952-1764
Program Contact (for content):	Corrie Campbell, A/Executive Director, Legislation and Professional Regulation
Drafter:	Robyn White, A/Director, Legislation
Date:	July 25, 2012
File Name with Path:	K:\TRADE AGREEMENTS\LABOUR MOBILITY\TILMA\938798 BN - TILMApanel.docx