

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 955595**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
**- FOR INFORMATION**

**TITLE:** End-of-Life Care in BC - **UPDATED**

**PURPOSE:** Approach for improving end-of-life care in BC including release of the Provincial End-of-Life Care Action Plan

**BACKGROUND:**

- The Ministry of Health (the Ministry) has prioritized improvements to end-of-life care since 2006. Recently, the Seniors Action Plan has reconfirmed that commitment.
- The importance of providing quality end-of-life care will increase in the coming years as the incidence of chronic and life limiting disease rises, due in part to an aging population, and also to a strong desire of most British Columbians to die at home if possible. Patients and families also want to be included as partners in care.
- In May 2006, the Ministry developed the Provincial Framework for end-of-life care that outlined the province's policy on end-of-life care planning, services and approaches for health authorities and stakeholders, and contained more than 130 recommendations. As a result, improvements in end-of-life care services across BC have been implemented through a number of different initiatives (Appendix 1).
- Improved collaboration between physicians and health authorities has led to the introduction of interdisciplinary palliative care consultation and response teams. A significant shift from hospital to planned at home deaths has been supported by the Palliative Care Benefits Program. A revised Joint Protocol for Expected/Planned Home Deaths (2006) has been implemented.
- Palliative protocols through the Guidelines and Protocols Advisory Committee has been developed and a palliative fee code for physicians introduced. A collaborative end-of-life care education module that promotes joint training of physicians and health care professionals is being delivered as part of the Practice Support Program.
- Individuals of all ages at the end-of-life have increased access to a range of home health services to help them stay at home as long as possible, including for death. Services include: home support, case management, community nursing, community rehabilitation, respite care, hospice care and innovative uses of technology that provides 24/7 support and information.
- Every region has increased availability and access to publicly-funded hospice care services. BC has a total of 266 publicly-subsidized hospice palliative care beds<sup>1</sup> distributed across the province.

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<sup>1</sup> Facilities Bed Count, September 2012. VIHA: 14 beds; NHA: 23 beds; FHA: 108 beds; VCHA: 50 beds; IHA: 71 beds

- The Provincial Health Services Authority (PHSA) also provides a range of end-of-life care services in several of its agencies and organizations. See Appendix 1 for health authority end-of-life initiatives.
- Hospice Societies also provide many services that enhance the publicly-subsidized care system and support improvements in patient and family care experience.
- A key initiative over the past year has been the implementation of advance care planning across the province to ensure capable adults have options for making their wishes and instructions known for future health care treatment and personal planning.

## **DISCUSSION:**

- To increase individual, community and health care services' capacity and support people at the end-of-life to remain at home and in their communities to the greatest extent possible an End-of-life Action Plan (Appendix 2) has been completed together with stakeholders and focuses on three fundamental areas:
  1. Redesigning health services to deliver timely coordinated end-of-life care together with physicians that includes improvements to existing services, and development of new services including expansion of telehealth and telemonitoring and development of stronger working relationships with specialized services delivered through the Provincial Health Services Authority including BC Cancer Agency and BC Renal Agency.
  2. Providing individuals, caregivers and health care providers with increased palliative care information, education, tools and resources, that includes a strategy for improving awareness of the palliative approach and the development of a provincial Centre of Excellence for End-of-life Care that serves all health authorities and health care professionals in BC.
  3. Strengthening health system accountability and efficiency through improved access to information and services, and reporting out on effectiveness of the continuum of end-of-life services and observance of advance care plans.

## **ADVICE:**

Strengthen the delivery of quality end-of-life care throughout the province by:

- releasing the Provincial End-of-life Care Action Plan for British Columbia;
- establishing a provincial advisory committee that includes physicians, health authority staff and key stakeholders to oversee and provide advice on the implementation of the End-of-Life Action Plan;

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## APPENDIX 1

### PROVINCIAL END-OF-LIFE CARE INITIATIVES

#### BC Palliative Care Benefits Program

This program provides palliative patients who receive care at home with access to comparable drug benefits, medical supplies and equipment from their health authority as those patients receiving care in hospital.

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Over 66,000 clients have received benefits

since the program started in 2001.

#### Physicians and End-of-Life Care in British Columbia

The *Provincial Framework for End-of-Life Care* provides guidance to the General Practice Services Committee (GPSC), a joint committee of the Ministry of Health, the B.C. Medical Association, and the Society of General Practitioners of B.C. In recent years, the GPSC has undertaken the following key initiatives:

- In 2009 the Palliative Care Incentive Fee Code for general practitioners was implemented; inclusion of specialists occurred in 2012.
- An End-of-Life Care Practice Support Module was developed in 2010/2011 to assist family physicians and specialists provide interdisciplinary, shared end-of-life care with other physicians and allied health professionals, including Home and Community Care. The module has been updated to include use of the new provincial advance care planning materials. As of fall 2012 over 800 physicians have taken the training.<sup>2</sup>

The Guidelines and Protocols Advisory Committee has developed a suite of End-of-Life Care and palliative care guidelines in partnership with the Family Practice Oncology Network. Part 1 was released in 2010 and Parts 2 and 3 followed in 2011.

Physicians and other primary health care providers are seen as key in supporting individuals and their families as death approaches, and are key in managing pain and symptoms with appropriate specialist support<sup>3</sup>. End-of-life care recommendations have been included in the service frameworks for dementia, chronic obstructive pulmonary disease, arthritis and osteoporosis.

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<sup>1</sup> Ministry of Health, Pharmanet data, summer 2012

<sup>2</sup> Practice Support Program data (provided by Primary Health Care Branch), Ministry of Health, Fall, 2012

<sup>3</sup> Primary Health Care, Ministry of Health Services. Primary Health Care Charter. 2007

## FRASER HEALTH CENTRE FOR EXCELLENCE IN END OF LIFE CARE

The Fraser Health Centre for Excellence in End of Life Care will accelerate innovation and best practice in the field of quality care for people with life limiting conditions.

In collaboration with its partners, the centre will generate leading edge knowledge and tools and share them with professionals and the interested public across BC, Canada and worldwide.

Building on Fraser Health's track record of award-winning programs and services, the centre will focus on research, education, information management, and policy & clinical care.



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### PARTNERS

BC Ministry of Health--University of Victoria -- Trinity Western University -- CARENET Canadian Researchers at End of Life -- Canadian Hospice Palliative Care Association -- CIHR -- MSHRF -- Canadian Partnerships Against Cancer -- Technology Evaluation in the Elderly -- Network Centres of Excellence (TECH VALUE NET) BC Hospice Palliative Care Association Learning Center for Palliative Care -- HealthLink BC

### PROJECT HIGHLIGHTS

- My Voice materials – award-winning and adapted or referenced by twenty Canadian Health care organizations as well as health organizations in USA, New Zealand and the UK
- Hospice Residence Reference and Symptom Management Guidelines – adopted by many Canadian organizations
- After Hours Palliative Telenursing to enable home stays – award-winning and published model, adopted provincially April 2012
- Initiative for a Palliative Approach in Nursing Education and Leadership – iPANEL (underway)
- A mixed methods knowledge synthesis to a Palliative Approach (underway)
- Advance Care Planning projects: ACP Evaluation in Hospitalized Elderly patients (underway), “JUST ASK” campaign



## END-OF-LIFE CARE INITIATIVES<sup>4</sup> BY REGIONAL AUTHORITY

### **Vancouver Island Health Authority**

The Vancouver Island Health Authority's (VIHA) end-of-life care priorities were identified through an end-of-life care program review conducted in 2011 involving extensive stakeholder consultation. The priorities align with provincial direction to support high quality, appropriate and accessible end-of-life care to Vancouver Island residents. Implementation is ongoing and achievements include:

- Leadership and infrastructure for coordinated end-of-life care services:
  - Implementation of a Manager of End-of-Life Care Services
  - Establishment of an End-of-Life Care Quality Council
  - Establishment of an End-of –Life Care Coordinating Council
  - Ongoing communication/planning with Vancouver Island Federation of Hospices;
- Planning and implementation by Home and Community Care and local Divisions of Family Practice to develop Geographic Palliative Consultation Teams, to support clients with complex symptoms or psychosocial needs at the end of life regardless of location - in their homes, acute care, residential care and assisted living;
- An in-progress review on the South Island of the Palliative Response Team services through Victoria Hospice, and palliative care services provided by the Home and Community Care Program;
- Development of an end-of-life care service continuum to provide a range of services for the right care in the right place at the right time.

### **Vancouver Coastal Health Authority**

Vancouver Coastal Health Authority (VCHA) priority initiatives focus on palliative care education, building community capacity, standardization of clinical practice and establishing a regional approach to advance care planning. Initiatives include:

- Building community capacity to provide palliative care in the home with initiatives including: on-going caregiver education offered in partnership with community-based organizations; implementation of palliative care medication kits to improve access to medications in the home; and the development and distribution of Regional Community Hospice Palliative Care Clinical Practice Guidelines.
- With the exception of Vancouver Community which has its own after-hours palliative service, VCHA has partnered with Fraser Health to provide an after-hours palliative nursing service for palliative patients;
- Provided pilot sessional funding to support rural outreach modules in Sechelt/Gibsons and Squamish for enhanced skilled family physicians to provide community expertise to home care nurses;
- Identification of acute in-patient populations with non-cancerous conditions including the frail elderly with under-recognized palliative care needs, who could benefit from a palliative approach to care and linking them to services they require;
- Expansion of hospice palliative care in residential care with initiatives including: education sessions for all staff, access to specialized hospice palliative care consultation for residential clients, research, and integration of end-of-life care issues into the care-planning process;

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<sup>4</sup> All health authority information is self-reported and is current to November 29, 2012

- Creation of Regional Hospice Standards; and
- Initiation of an End-of-Life Care Community Reference Committee, consisting of 15 community members to receive public input into the planning, implementation and evaluation of their program;

### **Interior Health Authority**

For the past year Interior Health Authority (IHA) has achieved many milestones including:

- Establishment of the After-Hours Palliative Nursing Service (AHPNS) in collaboration with all regional health authorities, HealthLink BC and the Ministry of Health. The AHPNS is available for clients across IHA, with the exception of Kelowna, where the recently expanded Palliative Response Team provides after-hours response for all community clients.
- Divisions of Family Practice have been established across Interior Health and many have identified palliative care specifically as one of their priorities. For example,
  - Salmon Arm completed a community wide Palliative Care service survey during summer 2012. The survey results were shared at a public forum on November 14<sup>th</sup>.
- Interior Health staff (RNs, LPNs, Care Aids, and Community Health Workers) participated in the iPANEL research survey (initiative for a palliative approach in nursing- evidence and leadership) that explored nurses' confidence in providing a palliative approach to patients.

### **Fraser Health Authority**

End-of-Life Care is a high-level priority program within Fraser Health Authority (FHA) and is supported by medical and administrative co-leadership.

In addition to the work being done towards the development of a Centre of Excellence in End-of-Life Care, recent Fraser Health Authority achievements include:

- In April of 2012 FHA in partnership with Health Link BC and the other regional health authorities commenced the expanded After-Hours Palliative Nursing Service, which provides telephone support to palliative care clients and their families living at home.
- Medical Orders for Scope of Treatment (MOST) was implemented in October 2012 across FHA, including in residential care. MOST is a physician order related to the patient's goals of care in the event that a patient is unable to direct his/her own care, and is based on advance care planning conversations.
- In November 2012, the End of Life Program in partnership with the Home Health Program in Tri-Cities began a prototype to transition a home care generalist nursing model to a population based model to support palliative clients.
- Through Integrated Primary and Community Care funding, enhanced resources will be available to support an increased number of clients who wish and are able to die at home, or to delay admission to acute care or a hospice residence for as long as possible. As part of this project, FHA will trial hand held tablets to support Patient/Family Reported Outcomes.
- The Abbotsford Hospice Society is planning to build a 10 bed hospice residence on the site of a campus of care adjacent to Abbotsford Regional Hospital and Cancer Centre.
- Numerous funded research projects are underway relating to end-of-life care including a revision of an FH Quality of Death Tool study, Canadian Partnership Against Cancer Surveillance Study (just completed); and Dexmedetomidine drug trial at the Abbotsford Cancer Centre (currently at the subject recruitment stage).

### **Northern Health Authority**

In Northern Health Authority (NHA) a regional hospice palliative care program provides a standardized palliative framework for all palliative services across all care settings. The framework supports a rural/remote service delivery model based on best practices, and a specialized Hospice Palliative Care Consultation team provides support for all clinicians working in all care settings.

The following have been implemented with ongoing evaluation/quality improvement activities:

- Designated hospice palliative care beds in specific residential care settings have been added across Northern Health to provide other options for dying people and their families;
- Palliative care-specific drug kits for the management of pain and symptoms are available in patients' homes;
- Best practice palliative clinical practice guidelines have been developed;
- A website (internal and external to Northern Health) has been developed to provide access to assessment tools and best practice guidelines to increase accessibility of resources; and
- A formal partnership was developed between NHA, HealthLink BC and Fraser Health to provide an After-Hours Palliative Nursing Service for end-of-life care clients and their families living in the north.

### **Provincial Health Services Authority**

The Provincial Health Services Authority (PHSA) is responsible for managing the following province-wide health-care programs and services related to end-of-life care.

#### **B.C. Cancer Agency: Symptom Management and Palliative Care**

Each of the B.C. Cancer Agency's sites has an interdisciplinary symptom management and palliative care team to assist patients and their families to manage their pain and other distressing symptoms, or deal with the knowledge that their cancer may be incurable. Teams consist of doctors, nurses, counselors, clinical pharmacists and nutritionists who use their specialized knowledge while working together to help individual patients. Each centre serves part of B.C.:

Each centre is closely networked with palliative care providers within each regional health authority to enable patients and families to be managed seamlessly between their cancer-curative experience and their ongoing palliative and primary care teams. The BC Cancer Agency is also integrating Advance Care Planning and piloting goals of care in each Centre.

#### **BC Renal Agency**

A PHSA level end-of-life care working group ensures that the BC Renal Agency's end-of-life recommendations and guidelines are aligned with provincial policy and are complementary and integrated within the health authorities' palliative care programs. In 2010, a renal end-of-life strategy was released to guide future planning. Throughout 2011- 2012, a number of the strategic milestones have been achieved and collaborative work continues across all health authority renal programs.

*B.C. Women's Hospital and Health Centre: End-of-life Care in the Newborn Care Program*

The Neonatal Intensive Care Unit offers end-of-life care for infants with a variety of life-limiting conditions. Care is individualized to honour the traditions of culturally diverse populations.

*B.C. Children's Hospital - Pediatric Oncology Program, hospice palliative care*

This program addresses the needs of children with cancer for whom cure is no longer possible. The aim is to provide optimal comfort and quality of life, and sustain hope and family connection despite the likelihood of death. Care is planned and delivered collaboratively by an interdisciplinary team, and is based on a family-centered approach with shared decision-making and sensitivity to the family's cultural and spiritual values, beliefs and practices.

*British Columbia Children's Hospital: Advanced Symptom and Palliative Care Service*

This service supports children and families living with progressive, life-threatening diseases, and also the health professionals caring for them. Services include:

- In-patient and telephone consultation, and out-patient follow-up care at Madison Clinic;
- Assessment and management of symptoms associated with life-limiting diseases;
- Education and support for parents and/or health care providers;
- Information about symptoms, trajectory, and advance directives; and,
- Coordination with providers at B.C. Children's Hospital, Canuck Place and other programs.

*Canuck Place Children's Hospice (CPCH)*

Canuck Place is open to all children in BC up to and including the age of 19 living with progressive, life-threatening illnesses. Over 250 children/teens are on the program annually as well as approximately 150 bereaved families. In-hospice 24 hour care is provided for up to nine children and four families. Children are admitted for respite/family support, symptom management, and/or end of life care.

Canuck Place provides a pediatric palliative care consult team at B.C. Children's and Women's Hospital as well as consultation through videoconferencing to distant communities and offers home visits by advanced practice nurses in the lower mainland. A 24 hour 1-800 number answered by CPCH nurses with physician backup is provided to families, nurses, doctors and other care professionals throughout B.C.

Canuck Place Children's Hospice is building a second facility housed within the "Dave Lede Campus of Care," located on a two-acre property located in Abbotsford. With 10 beds and 5 family suites, the new 30,000 square foot hospice will double the current capacity of Canuck Place Children's Hospice to better meet the growing need for pediatric palliative care services across the province.



# Provincial End-of-Life Care Action Plan for British Columbia

*Priorities and actions for health system and service redesign*

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Ministry of Health  
February 2013



## EMBARGOED DRAFT COPY

Not to be published or shared in any form before the time of publication.

### Acknowledgements

The *Provincial End-of-Life Care Action Plan for British Columbia* was developed with input from clinical experts, community stakeholders, policy leaders and service providers from across the province under the leadership of the provincial end-of-life care working group. All are thanked for their insight, expertise and time in the development of the action plan.

Thanks also go to the Canadian Institute for Health Information, Victoria office, for organizing two end-of-life care knowledge transfer workshops that provided important information to confirm and refine the priorities and actions identified in the action plan.

CONFIDENTIAL DRAFT

## Definitions

### Palliative Care

Palliative care is specialized medical care for people with serious illness. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family and is provided in a variety of locations including people's homes and community settings, hospices, residential care settings and hospitals. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with any beneficial treatment.<sup>1</sup>

### End-of-Life Care

End-of-life care is associated with advanced illnesses, and focuses on comfort, quality of life, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns.

### Life-Limiting Illness

Life-limiting illness is used to describe illnesses that can be reasonably expected to cause the death of the individual within a foreseeable future. This definition is inclusive of both malignant and non-malignant illnesses that are expected to shorten an individual's life. .

### Population Needs-Based Approach to Palliative Care

A population needs-based approach recognizes that individuals facing a life-limiting illness have different needs, based on their unique health conditions, stage of disease and complexity of symptoms.<sup>2</sup> Health care services and supports should therefore vary in type and intensity to most effectively meet the needs of the individual.

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<sup>1</sup> Centre to Advance Palliative Care, <http://www.getpalliativecare.org/whatis/>

<sup>2</sup> Palliative Care Australia, *A Guide to Palliative Care Service Development: A population based approach* (February 2005), p. 11.

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## Executive Summary

The *Provincial End-of-Life Care Action Plan for British Columbia* is a key component of the province's health innovation and change agenda to achieve better health outcomes and experiences for British Columbians through a more efficient, sustainable health care system. The plan outlines key priorities and achievable actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.

This action plan is intended to guide health authorities, physicians, health care providers, and community organizations in planning integrated primary and community care services. It supports quality hospice, palliative and end-of-life care services across British Columbia with a focus on supporting individuals with life-limiting conditions to remain at home in their community, reducing the need for hospital or emergency department visits, and improving coordination of care across all settings.

Based on leading practices for managing chronic and life-limiting conditions, the action plan incorporates a population needs-based approach to palliative care, which recognizes that the health care needs of individuals vary over the course of a life-limiting illness. With this in mind, end-of-life care is most effective in meeting the needs of a patient with complex needs through an integrated team approach that includes the patient, patient's family, family physician, specialists, nurse practitioners, community health teams and others.

A key element of this approach is the early identification of individuals who would benefit from a care approach that focuses on the individual's quality of life to ensure the patient's symptoms and goals of care are identified and addressed appropriately. This care approach takes into account the individual's beliefs, values, and wishes and represents a significant shift from an eligibility based model that provides access to specific service bundles. Incorporating the individual's journey, including the final stages of life, into discussions and planning for care, requires a shift for patients, families and health care providers who deliver their care.

Through the priorities in this action plan, the ministry has outlined areas that research evidence and expert stakeholders agree are of high importance in providing quality end-of-life care. Implementing this plan will ensure the diverse health care needs of those requiring hospice palliative and end-of-life care services are met through:

- Appropriate clinical approaches and ranges of services required to meet end-of-life care needs, including a focus on partnerships and technical innovation;
- Improved skill mix, expertise and qualifications of health care providers involved in the provision of hospice palliative and end-of-life care services; and
- Monitoring frameworks to evaluate the access, efficiency, integration and effectiveness of end-of-life care services available across the province.

As hospital staff identify people with palliative and end-of-life care needs more readily, and referrals to appropriate community based services are made, more individuals will receive quality end-of-life care at home. This will support improved quality of life, patient and family engagement in the community, and help to maintain the capacity of hospital resources to respond to those who require hospital care.

This action plan is foundational to the planning and delivery, by ministries, health authorities, physicians, nurse practitioners and other health care providers, of quality compassionate care for persons at the end of life and their families. The plan is one part of the Ministry of Health's larger collaborative effort with health authorities and all health care providers to support the shift towards a stronger, more effective and integrated health care system, particularly in the community sector.

## Introduction

The *Provincial End-of-Life Care Action Plan for British Columbia* is a key component of the province's health innovation and change agenda to improve health outcomes for British Columbians, and provides an integrated, proactive approach to community health care services. The action plan outlines important shifts in the way the needs of people with life-limiting health conditions are addressed. It identifies priority actions that build on work in B.C. and other jurisdictions to improve health care outcomes and quality of life for individuals coping with the end of life, and for their families and caregivers.

Access to palliative and end-of-life care services is becoming increasingly important. As people age, the likelihood they will have at least one chronic disease rises dramatically, resulting in more people with complex care needs. With B.C.'s growing and aging population, it is projected that the prevalence of chronic conditions may increase by 58 per cent over the next 25 years.<sup>3</sup>

BC Stats estimates that the percentage of seniors aged 80+ in B.C. will grow from 4.4 per cent of the population in 2012 to 7.4 per cent of the population by 2036.<sup>4</sup> This statistic has significant implications for health service use in British Columbia and access to end-of-life care services in the community.

## Health Care Use at the End of Life in British Columbia<sup>5</sup>

In 2008, the Canadian Institute for Health Information (CIHI) undertook a study of the usage patterns of health care services in the two years prior to death for the 29,456 persons of all ages who died in British Columbia between April 2003 and March 2004. The CIHI study noted that the majority of deaths were attributed to chronic diseases and cancer and that 79 per cent of those who died were aged 65 and over.

CIHI's study of health care use in the last two years of life also revealed two other important factors that have significance in planning for quality end-of-life care in British Columbia. The report notes that despite the fact the majority of deaths were from diseases that are known to be life-limiting, only about 15 per cent of the study group had received palliative care. Identification and receipt of palliative care services tended to be most closely linked to cancer patients, rather than those who died from other diseases such as congestive heart failure, kidney disease or dementia.

Another finding in CIHI's study was in the pattern of health care use over the last two years of life. While it is often assumed that the use of health care services increases steadily over the final

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<sup>3</sup> Ministry of Health, Medical Services Division, *Chronic Disease Projection Analysis* (March 2007).

<sup>4</sup> BC Stats, *British Columbia Population Projections 2012 – 2036* (September 2012), p. 9.

<sup>5</sup> Canadian Institute for Health Information, *Health Care Use at the End of Life in British Columbia* (September 2008).

one to two years of life, the data suggested that for many users, health service use peaked in the final three to six months of life. The findings also showed that many people with chronic illness and co-morbid conditions, in addition to people with cancer, had increased need for and received complex bundles of services in the period of time well before the last three to six months of life.

These results suggest a number of important factors to consider in developing priority actions for end-of-life care. First, there is a need to improve the identification of individuals with non-cancerous conditions who may benefit from a palliative approach to care. Second, if, as the CIHI data suggests, the majority of those with life-limiting illnesses manage their health condition for most of its duration with the support of a primary health care team, family and friends, it is important to ensure that end-of-life care strategies strengthen individual capacity for self-management, as well as the connection between the family physician and other members of the health care team.

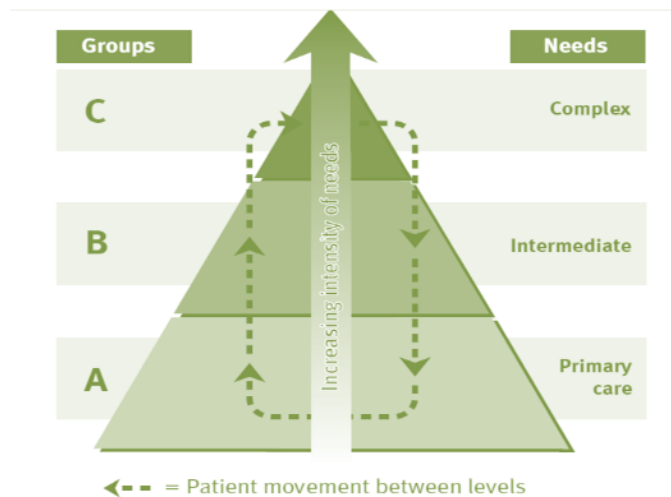
### **Population Needs-Based Planning and Quality End-of-Life Care**

Individuals with life-limiting conditions can have a wide range of different needs. A population needs-based approach to health care services planning recognizes that as the needs of individuals vary, the health care services they require will vary as well – from working solely with the individual's primary health care provider through to an interdisciplinary care team that works with the patient and their family physician to help assess and manage complex needs.

Australia led the way for many jurisdictions in incorporating a population needs-based approach into end-of-life care using a model they called the palliative approach. This model is based on the principle that palliative care services must be effective, efficient and ethically delivered at the medically appropriate time. It also recognizes the needs of family members and the importance of volunteers and community.

The model (Figure 1) includes all individuals with life-limiting illnesses: those whose needs can be managed with support from their primary care physician or health care provider (Group A), those with complex needs who may occasionally need shared care services (Group B), and those who frequently require specialized services and facilities with highly specialized palliative care physicians and staff (Group C). The model also recognizes that individual needs change over time, and consequently an individual may move both upwards in complexity, as well as down, as their disease progresses.





**Figure 1: Palliative Approach Population Needs Based Model of care.**<sup>6</sup>

Australia's experience with this approach confirmed that the majority of clients can manage their illness in the community, with support from their primary care provider and integrated health services as needed. A smaller number of clients require periodic shared physician care and only a small number need frequent specialized services.

In practice, the population needs-based model promotes the development of networks between primary health care providers and specialist hospice palliative care services in the delivery of hospice palliative care to all individuals with life-limiting illness.

### **Implementing a Population Needs-Based Approach to End-of-Life Care Services**

An important element of implementing a population needs-based approach includes identifying individuals with life-limiting illness earlier, including patients with cancer and non-cancerous conditions, and initiating important discussions regarding advance care planning based on the person's beliefs, values, and wishes. This includes important conversations with family, friends and family physicians or other health care providers regarding possible future health care treatments and decisions about which treatments the patient wishes to accept or refuse. In planning ahead, it is also important that care providers understand those things that give the individual's life meaning, and contribute most to their quality of life. A population needs-based approach to end-of-life care services must also include support for the family up to and including bereavement.

<sup>6</sup> Palliative Care Australia, *A Guide to Palliative Care Service Development: A population based approach* (February 2005), p. 13.

Health care providers require resources, skills and support to provide both the clinical care that is needed and the skills to effectively support the individual and their family in managing their own journey. It is also important to publicly report on how end-of-life care services are meeting the needs of British Columbians in terms of quality, safety and accessibility.

## **The Provincial Framework for End-of-Life Care in British Columbia<sup>7</sup>**

In 2006, British Columbia released the *Provincial Framework for End-of-Life Care in British Columbia*. The framework outlines the province's policy on end-of-life care planning, services and approaches for health authorities and stakeholders, developed in consultation with clinical experts, service organizations, patients and families.

The framework describes an integrated approach to providing hospice palliative and end-of-life care services across sectors, consistent with established leading practice models for chronic disease management. The framework's vision sets out that end of life is a critical phase that must feature high quality services that are competent, compassionate and respectful of all people who are dying and their families.

Many successes and milestones have been achieved since the provincial framework was released.

- The Ministry of Health and British Columbia Medical Association have strengthened access to quality end-of-life care by general practitioners and specialists, including collaborative palliative care education with community health teams provincewide.
- Health authorities are actively engaged in planning and implementing new services, and the number of publicly-subsidized hospice beds has increased.
- All health authorities have introduced interdisciplinary palliative care consultation teams, and there has been a significant shift away from hospital deaths to planned, expected natural deaths at home. To support this shift, the B.C. Palliative Care Benefits Program, which provides access to the same drugs and palliative supplies and equipment at home as if the person were in hospital, has served increasing numbers of clients in the last six months of life.

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<sup>7</sup> Ministry of Health, *A Provincial Framework for End-of-Life Care* (British Columbia, May 2006).

## Integrated Primary and Community Care in British Columbia

Addressing many of the overall challenges posed by the growth and aging of its population has led government to commit to other innovative approaches to how services are organized and delivered. Through integrated primary and community care initiatives, the Ministry of Health and health authorities are working with physicians and other health care providers, community organizations and researchers to redesign and realign services in partnership with patients. An integrated system of primary and community care offers improved patient experience of care in community based settings with timely access to quality hospital services when needed.

Integrated primary and community care initiatives specifically targeted to support improved end-of-life care include:

- End-of-life care training is offered as part of the Practice Support program, delivered in partnership between the Ministry of Health and the British Columbia Medical Association. The End of Life module is training physicians and their office staff together with health authority staff to improve their knowledge and skills in delivering end-of-life medical care and aims to improve collaborative care for patients and support for families.
- A palliative care planning fee code was introduced in 2009 to provide general practice physicians with an incentive to do more comprehensive, individualized palliative care planning with their clients. In 2012, a similar fee code was introduced for specialist physicians to work with general practice physicians.
- The Michael Smith Foundation for Health Research provided \$800,000 to the University of Victoria and Fraser Health to support the initiative for a palliative approach in nursing: evidence and leadership<sup>8</sup> (iPANEL).
- Provincial legislation for advance care planning updated and supporting resources for the public and health care providers developed to enable individuals' wishes for end-of-life care to be known, respected and followed.
- After-hours palliative nursing services implemented provincewide through an innovative partnership between the home and community care program, health authorities, and HealthLink BC.
- Stronger working relationships with Provincial Health Services Authority's staff and physicians developed to promote advance care planning and the adoption of the palliative approach to care within their specialized services including BC Cancer Agency and BC Renal Agency.

These initiatives provide a foundation of meaningful support for the significant shift in clinical practice and service planning required to implement a proactive, integrated approach to end-of-life care.

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<sup>8</sup> K. Stajduhar and C. Tayler, *Initiative for a Palliative Approach in Nursing: Evidence and Leadership*, British Columbia Hospice Palliative Care Association Conference (May 2012).

## **Need for System-Wide Innovation and Support for End-of-Life Care**

Building on this foundation, further improvements in end-of-life care services across B.C. are needed to improve patient and family experience, while reducing the need for emergency department or hospital care and admissions. The goal of this action plan is to increase individual, community and health care services' capacity and support people at end of life to remain at home and in their communities to the greatest extent possible.

## **Action Plan Priorities for End-of-Life-Care in British Columbia**

Three key priorities were identified in consultation with clinical experts, health authorities, researchers, community organizations and patient representatives to reflect the principles of the provincial end-of-life framework and the shift to integrated health services.

### **Priority #1 – Redesign Health Services to Deliver Timely Coordinated End-of-Life-Care**

**Goal:** Improved access to a range of quality end-of-life care services delivered in collaboration with physician care, responsive to the needs of individual patients, their families and caregivers and with a focus on supporting end-of-life care in the community.

- **Action: Implement a population needs-based approach to planning quality end-of-life care services** that identifies individuals earlier, including those with cancer and non-cancerous conditions, who would benefit from a palliative approach and who would receive quality care in the most appropriate settings based on their beliefs, values, and wishes.
- **Action: Integrate quality end-of-life care into service planning for all life-limiting chronic diseases** that includes information and planning for the end of life as a component of the patient's journey.
- **Action: Leverage opportunities to expand telehealth and telemonitoring technologies** to improve the ability of individuals and care providers to effectively manage health conditions at a distance, including pain and other symptoms.
- **Action: Improve the capacity to provide quality end-of-life care in residential care facilities and other housing and care settings**, focusing on an individual's quality of life and access to appropriate supportive care and services for their complex needs.

## **Priority #2 – Provide Individuals, Caregivers and Health Care Providers with Palliative Care Information, Education, Tools and Resources**

**Goal:** Individuals and families are provided with information and resources to effectively manage their own care journey, and health care providers are supported to provide quality, integrated care that is respectful and responsive to the expressed wishes of patients coping with the end of life.

- **Action: Increase public knowledge and awareness of palliative care, as an approach to care that improves the quality of life for both the patient and the family at any stage in a serious illness.**
- **Action: Provide information and resources to support advance care planning,** including an understanding of the available options for ensuring values, wishes and instructions for health care treatments and choices for end-of-life care are respected by health care providers.
- **Action: Provide awareness and education on the unique end-of-life care needs of specialized populations,** including Aboriginal peoples, children, and individuals with dementia, kidney disease, or chronic mental health and substance use issues who may require special consideration for planning and care delivery to improve health outcomes.
- **Action: Promote excellence in end-of-life care and quality, consistent end-of-life care practice,** including promotion of innovation and best practices in end-of-life care, and support for end-of-life care education for family physicians, specialists and health care professionals.

## **Priority #3 – Strengthen Health System Accountability and Efficiency**

**Goal:** End-of-life care services reflect evidence based, clinically appropriate practices, and the public has timely information on the accessibility and outcomes achieved through publicly subsidized care.

- **Action: Develop and report on provincial end-of-life care service information and performance measures,** including the ability to report publicly on service delivery, **observance of advance care plans,** and death statistics for children, youth, adults and Aboriginal peoples.
- **Action: Implement provincial end-of-life care clinical guidelines, protocols and standards** with a focus on clinical transitions and interdisciplinary care, and with a clear priority of improving pain and symptom management.
- **Action: Provide equitable access to the B.C. Palliative Care Benefits program and promote its' sustainability,** ensuring residents of residential care facilities have access to

the same medications they would have if in hospital, in a hospice or being cared for at home.

- **Action: Streamline policies and administrative processes used to access services** to improve access to services and supplies in a timely manner.

## Summary and Conclusions

Creating a high quality, sustainable system for end-of-life care provincewide is increasingly important as B.C.'s population grows and ages, and as more individuals live with long-term illnesses.

Although much progress has been achieved in recent years, opportunities for improvement remain. This provincial end-of-life care action plan will help enable innovative advancements in the end-of-life care British Columbians receive. By strengthening and integrating our health care system, particularly in the community sector, we hope to realize our vision of high quality, compassionate, respectful and competent care for all people who are dying and their families.

This plan will foster the spread of a population needs-based palliative approach to end-of-life care throughout the system. With its emphasis on primary and community care services that meet patients' varying needs, this approach will ensure the province's palliative care services are effective, efficient and delivered at the medically appropriate time.

This action plan will help to improve access to quality end-of-life care for patients and families, while fostering the sustainability of B.C.'s publicly funded health care system, through service redesign and enhanced planning of services, provision of information, tools and resources, and strengthened health system accountability and efficiency.

Achievement of the actions in this plan will help physicians and health care providers, community partners, and the health care system itself, to honour and respect the beliefs, values, wishes, and needs of dying patients, to assist them to remain at home and in their communities to the greatest extent possible, and to care for them and their families at one of the most important times in their lives.

## **MINISTRY OF HEALTH INFORMATION BRIEFING NOTE**

**Cliff # 959931**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health -  
**FOR INFORMATION**

**TITLE:** Summerland Seniors Village

**PURPOSE:** To provide report on outcome of investigation of Assisted Living Units at Summerland Seniors Village.

### **BACKGROUND:**

- The investigation at Summerland Seniors Village was initiated on December 3, 2012 after a complaint regarding the care of Sect 22 was received by the assisted living registry from the Sect 22 of an individual who was a resident at Summerland Seniors Village. She believed that Sect 22 was receiving assisted living services. The Sect 22 suggested that the lack of appropriate monitoring resulted in Sect 22
- At Summerland Seniors Village, assisted living services are part of a Campus of Care that includes independent living services, assisted living and licensed residential care. The investigation subsequently determined that the individual subject to the complaint was receiving independent living services, not assisted living, and therefore the complaint was not within the jurisdiction of the Assisted Living Registrar. However, the investigator did confirm that the Sect 22
- On December 10, 2012 the BC Coroners Service confirmed it is investigating this death and information obtained during the investigation was shared with the Coroner. This review is ongoing.
- This complaint initiated a review of the assisted living units at the site as the investigator had reason to believe that the manner in which assisted living services were being provided could jeopardize the health and safety of residents residing in assisted living units (see appendix A Summerland Seniors Village Report for details).

### **DISCUSSION:**

- Retirement Concepts collaborated with the assisted living investigator, and Interior Health Authority (IHA), as soon as they were advised of identified health and safety concerns at Summerland Seniors Village.
- In response to draft report findings, Retirement Concepts began developing an action plan to address the identified concerns (see Appendix B for details).
- In addition, Retirement Concepts also independently completed an internal review of all of their sites that offer assisted living services and has invited Assisted Living Registrar staff to review a number of sites to confirm that the sites are meeting or exceeding the health and safety standards for assisted living.
- The Assisted Living Registry and Retirement Concepts will continue to collaborate on improvements to policies and supporting materials and a monitoring approach that includes reviewing and updating the action plan on a regular basis, regular reporting by the operator and site visits to ensure that the operator is in full compliance with the assisted living health and safety standards.

- This investigation also identified that there is a general lack of clarity about the level of personal assistance and monitoring individuals receive when residing in an assisted living unit versus independent living setting.

**ADVICE:**

- The first monitoring meeting is set for Tuesday January 8, 2012. Assisted living Registry, IHA and Retirement Concepts staff will review and revise the action plan and set up an ongoing monitoring schedule.
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Sect 13

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**Program ADM/Division:** Barbara Korabek, ADM Health Authorities Division  
**Telephone:** 250 952-1297  
**Program Contact:** Leigh Ann Seller, Executive Director, Home, Community & Integrated Care  
**Drafter:** Robin McMillan, Home, Community & Integrated Care  
**Date:** January 7, 2013  
**File Name with Path:** Y:\MCU\DOCS PROCESSING\Briefing Documents\2013\Approved\HAD\959931 - Summerland Seniors Village.docx



## **Appendix A: Report on Summerland Seniors Village**



959931 Site  
Inspection Rpt Summ

## **Appendix B: Action Plan – Summerland Seniors Village Assisted Living**



SSV Action Plan Dec  
28, 2012.docx

Initiation Date: December 28, 2012

FACILITY PLAN: SUMMERLAND SENIORS VILLAGE						
#	Objectives	Outcomes (specific, measurable, etc.)	Person Responsible	Target Date	Action Plan Notes (resources, specific steps, etc.)	Audits/Sustainability
1	1.3.1 Registrants must provide building security that protects residents from harm	Policy in place All staff aware of and follow policy	P&P committee Julia to submit Sue Ball to complete a draft	Jan, 31, 2013	Develop policy for Breach of Security for staff to follow.	Policy to be reviewed yearly at Policy committee and with A/L Staff
2	1.3.2 Registrants must maintain the privacy of residents	Staff aware and familiar with policy	Julia GM	Dec 21, 2102 Dec 21, 2012	Confidentiality policy sent to Robin Pledge of Confidentiality form sent to Robin	Review policy with staff on a yearly basis Review policy with new staff on hire.
3	1.3.3.Registrants must respect resident privacy	Policy in place reflective of access to suites	P&P committee Julia to submit Sue Ball to complete in draft form	Jan 31, 2013	Develop policy for Access to Residents suites	Review yearly and on orientation
4	1.4.2 Registrants must ensure that staff is trained to respond appropriately to emergencies	Evidence of table top exercises quarterly And yearly mock evacuations involving all staff of A/L	GM	Feb 28, 2013	A/L to be included in table top exercises and mock evacuations.	Quarterly tabletop exercises and yearly mock evacuation

**FACILITY PLAN: SUMMERLAND SENIORS VILLAGE**

5	1.5.1.Registrants must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths	Meal Absenteeism forms generated and followed up	GM	Dec 21, 2012	Previous Missing tenant policy sent to Robin Missing tenant policy revised , reviewed with staff and fully implemented Exploring other systems that may provide another level of surveillance	Policy to be reviewed yearly and at orientation GM to review Meal Absenteeism forms weekly
6	1.6.1 Registrants must have a plan in place to prevent, contain and report infectious outbreaks	Staff familiar with toolkit	Julia	Dec 24, 2012  Dec 28, 2012	Send outbreak policy to Robin as it refers to the FHA infection control and prevention toolkit for A/L as this has been our policy since Sept 2010 Place copy in A/L Office	Review polices yearly and during orientation Review toolkit with A/L staff yearly
7	1.7.1 Registrants must protect residents from abuse or neglect and respond promptly and effectively to allegations of abuse and neglect	HA, PGT and funding agency reflected in the policy	Julia	Jan 15, 2013	Add HA, PGT or funding agency t to policy Policy is reviewed yearly and part of orientation	Continue to review yearly and on orientation Develop education component to accompany policy review
8	2.4.1.Registrants must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population	Policy to reflect response time	Julia	Jan 15, 2013	Add "immediately" to emergency response policy	Review with staff on a yearly basis
9	3.1.1 Registrants must ensure site management is effective and appropriate for the resident population	Weekly schedule reflective of an LPN 7.5 hours per day x 5 days per week	Julia / Sue	Dec 31, 2013	Oversight was to be provided by the GM who is an RN, but failed to comply	LPN clinical oversight to be added 7.5 hours per day x 5 days
10	3.2.1 Registrants must ensure staffing levels are sufficient to meet the hospitality service needs	Schedule reflective of HSW on nights Added HSW hours for PP services equate	Julia/Sue	Feb 1, 2013 (Date dependant on union )	Staffing levels have been appropriate however we will be changing the night janitor to a HSW Private Pay hours are added as services are added	Monitor private pay hours on a monthly basis add hours as needed

# **FACILITY PLAN: SUMMERLAND SENIORS VILLAGE**

	of the resident and deliver personal assistant services offered					
11	3.3.1 Registrants must ensure staff has qualifications consistent with their job	All staff to have a CA/HSW certificate on file from a recognized school	Julia / Melanie	January 31, 2013	The Sect 22 in question we will be call the college where Sect 22 took course to look at comparison to Care aide program See if see can challenge exam, or maybe take partial course if necessary	Only hire staff with Care aides certificate or HSW certificate for a recognized school
12	3.3.2 Registrants must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff	Education calendar and tracking tool in place	January 31 2013	BJ/Julia /A/L Staff	Develop education plan for A/L staff	Yearly education plan developed in December.
13	3.4.1. Registrants must ensure appropriate delegation of professional tasks	All HSW will have certificate for medication admin. Yearly testing results on A/L staff personnel files	BJ and Sue	Dec 19, 2012	Policy in place Facility not following HSW received education for medication course	Yearly Testing GM to audit DOTs
14	4.1.1.Registrants must fully inform prospective residents about hospitality and personal assistance services offered	Optional Services form signed on admission to facility whether receiving services or not	Shelley Grenier Marketing manager	Jan 15, 2013	Standardize process used in Kamloops for admission documents across all sites. This is to include the optional services form	Review process with all marketers and GMs yearly. Audit files (4) for compliance on a quarterly basis.
15	4.2.1.Registrants must develop an exit plan in consultation with residents, their physician, support network and HA if appropriate.	Policy to reflect consultation with tenant, physician , HA and support network	P&P committee Julia to submit	Jan 15, 2013	Review exit plan policy and clarify HSW role	Review of exit planning policy yearly with all A/L staff
17	5.1.1.In conjunction with each resident, the registrant must develop a PSP	All staff to be aware of PSP policy All tenants have PSP	Julia Julia	Dec 12, 2012 Feb 15, 2013	Policy in place Sent to Robin Review policy with A/L Staff	Review with staff yearly

## FACILITY PLAN

FACILITY PLAN: SUMMERLAND SENIORS VILLAGE						
		reviewed and updated in accordance with the policy				
18	6.1.1.Registrants must deliver ADL in such a way as to promote the safety and independence of residents	Performance reviews on file for all A/L Staff	P&P committee Julia to submit  GM / input from LPN	March 1, 2013	Develop policy for evaluation (spot checks) of HSW in relation to ADLs. Complete performance reviews as per RC policy  LPN to provide the clinical oversight	LPN to provide spot checks for HSW ADL delivery
19	6.2.1 Registrants must deliver medication services in accordance with the PAG and the Registrars Medication services and standards of practice guidelines	HSW fluent with the medication policies  PRN medications only given by HSW if resident is self directing. HSW not making an assessment for PRN medication.  Any resident unable to self direct will have an exit plan developed. Within the exit plan it states PRN meds will be removed and the HSW will no longer assist with PRN meds.	Julia	Jan 8, 2013	Review medication policy with HSW Review PRN medication policy with HSW Review all residents currently receiving PRN medications Determine who is responsible for giving PRN medications if necessary to do so	Review all policies yearly with all HSWs
20	7.1.1 Registrants must have internal complaint policy that is communicated to residents	Policy in place in regard to the complaint box. All A/L staff understand lines of communication and where to go with a concern.	Julia	Mar 1, 2013	Complaints box is site specific. Will look at developing a policy in relation to the box.	Review with A/L staff yearly

# **Report on Summerland Seniors Village Assisted Living Units**

**January 7, 2013**



## OVERVIEW AND PURPOSE OF REPORT

The purpose of the investigation was to determine whether the residence and operator is in compliance with the *Community Care and Assisted Living Act* (CCALA) in meeting the provincial Assisted Living Registrar's health and safety standards for residents receiving assisted living services at Summerland Seniors Village.

Assisted Living Registrant Information		Site Visit Information	
Residence Name	Summerland Seniors Village	Date:	December 3 to 5, 2012
Address	12803 Atkinson Road Summerland B.C. V0H 1Z4 250 404-4400	Time:	Varying times during the days December 3 to 5, 2012
Site Manager	Bernadette McRae – Director of Care (available December 3 and 4 , 2012) Julia Glover – Regional Manager (available December 5, 2012) Anne-Sophie Boutin – General Manager (away at the time of the site visit)	<b>Site Review Team:</b> <ul style="list-style-type: none"><li>• Primary investigator – Robin McMillan, Ministry of Health, Director, Assisted Living Services</li><li>• Kathy Chouinor – Program Director, Community Care, IHA</li><li>• Lana Mathers – Practice Leader Home Health, IHA</li><li>• Tami Dunstan-Adams – CIHS Manager, SOK Community Care, IHA</li></ul>	
Owner Information	Azim Jamal, President & CEO Tony Baena, Vice President of Operations 1160-1090 West Georgia Street Vancouver, BC V6E 3V7 <a href="http://www.retirementconcepts.com">www.retirementconcepts.com</a>		
Staff Interviews Summerland Seniors Village	DeeDee Kolodychuk – Support Services Manager Sharon Lusch – Marketing Coordinator Bernadette McRae – Director of Care Jan Morasse – Care Aide Julia Glover – Regional Manager Sue Ball – Regional Manager		

This investigation report covers both the publicly subsidized and private registered assisted living units at Summerland Seniors Village that are regulated under the CCALA. At Summerland Seniors Village, assisted living services are part of a Campus of Care that includes assisted living services (18 publicly subsidized and 18 private units) and licensed residential care services (75 publicly subsidized beds and 5 private beds). In addition, this site also has approximately 70 independent living units where seniors reside on a private pay basis and receive hospitality services only. Residents in the independent living and the assisted living section both sign a Standard Resident Agreement – Independent Living Services. Residents who receive assisted living services also sign an Assisted Living Service Costs form.

Residents in the assisted living units receive hospitality services (housekeeping, laundry, meals, 24-hour emergency response and social activities) and up to two personal assistance services (regular assistance with activities of daily living, such as bathing toileting or mobility assistance, and medication assistance) referred to as prescribed services. Services must be provided to residents in a way that does not jeopardize their health or safety and must meet or exceed the Assisted Living Registrar's health and safety standards.

This investigation was initiated as a result of a complaint received by the Assisted Living Registry from the Sect 22 of an individual who was a resident at Summerland Seniors Village. She believed that Sect 22 was receiving assisted living services. The assisted living investigator determined that the individual subject to the complaint was receiving independent living services and therefore the complaint was not within the jurisdiction of the Assisted Living Registrar. However, this complaint initiated the review of the assisted living units at the site because the investigator had reason to believe that the manner in which assisted living services were being provided could jeopardize the health and safety of residents in assisted living.

To complete the investigation of the assisted living services at this site in a timely manner, it was decided to conduct a joint investigation with Ministry of Health (the Ministry), Assisted Living Registry staff and Interior Health Authority (IHA) staff. Interviews and review of information pertaining to assisted living services were shared between the Director, Assisted Living Services and IHA community care staff. IHA is completing a separate assisted living operational review report on the 18 publicly subsidized beds.

In the course of this investigation Sect 22 contacted IHA to express concerns about the supports and services that their Sect 22 received while residing in Summerland Seniors Village in the IL/AL section. The information provided by the families identified similar concerns to those identified in the case that initiated this review. The Assisted Living Registry investigators will investigate these two complaints independently.

On December 6, 2012, IHA put in clinical and care aide staff to oversee and deliver personal assistance and medication management assistance. This was done with the agreement of the operator. These supports were implemented to ensure immediate safety of residents, but do not replace the operator's responsibilities in addressing the recommendations of this review or the requirement to ensure ongoing compliance to the standards for assisted living services. To date these supports remain in place. In addition, Retirement Concepts agreed to stop all admissions to the site until the urgent actions are fully achieved. Retirement Concepts fully collaborated with the assisted living investigator and, as soon as they became aware of the health and safety concerns at Summerland Seniors Village, started to develop an action plan to address the identified concerns.

At the time of this investigation, IHA Licensing was completing a residential care licensing inspection report and an IHA team of nine interdisciplinary members was completing a Quality Review of the licensed residential care section of the Campus of Care. Results of these reviews will be reported out by IHA.

**Scope of Review** – included review of physical plant, policies and procedures, and operations of the assisted living residence section of the Campus of Care.

**Review Methodology** – included the following:

- Introductory meeting between the site review team and Summerland Seniors Village, Director of Care, Bernadette McRae
- Tour of residence
- Review and photocopy of policies, procedures and other documents
- Review of client records
- Interviews of site manager and staff
- Family interviews
- Meeting to debrief findings with the Regional Manager, Julia Glover
- Further requests for policies and procedures



## SUMMARY OF FINDINGS RELATED TO REQUIRED STANDARDS (See Appendix 1 for details)

All findings are assigned a determination based on the following definitions:

- **In compliance:** meets the requirements of the Assisted Living Registrar's provincial health and safety standards and policies
- **Not fully compliant:** missing required elements for full compliance
- **Not in compliance:** no evidence of meeting the standards and policies

The investigation occurred over a three day period of time on site with subsequent requests for information from the site management, and included a review of seven assisted living health and safety standards. The investigation has shown that the operator of Summerland Seniors Village is not fully compliant with the seven health and safety standards and policies.

### 1. Registrants must provide a safe, secure and sanitary environment for residents. – Not fully compliant

#### *In compliance with the following policies:*

- Environment (1.1.1, 1.1.2, 1.1.3)
- Building maintenance (1.2.1)
- Emergency preparedness and fire safety (1.4.1, 1.4.2, 1.4.3)
- Abuse, neglect and self-neglect (1.7.2)

#### *Not fully compliant with the following policies:*

- Security (1.3.1, 1.3.3)
- Abuse, neglect and self-neglect (1.7.1)

#### *Not in compliance with the following policies:*

- Security (1.3.2)
- Accidents, deaths and medical emergencies (1.5.1)
- Infectious outbreaks (1.6.1)

### 2. Registrants must ensure hospitality services do not place the health or safety of residents at risk. – Not fully compliant

#### *In compliance with the following policies:*

- Laundry (2.1.2, 2.1.3, 2.1.4)
- Housekeeping (2.2.1, 2.3.1, 2.3.2, 2.3.3, 2.3.4, 2.3.5)
- Social and recreational activities (2.5.1, 2.5.2)

#### *Not fully compliant with the following policies:*

- 24-hour emergency response (2.4.1)

3. Registrants must ensure sufficient staff is available to meet the service needs of residents, and that staff has the knowledge and ability to perform their assigned tasks. – Not fully compliant

***In compliance with the following policies:***

- Workforce disruptions (3.2.2)
- Safe transportation to and from social and recreational outings (3.5.1)

***Not fully compliant with the following policies:***

- Staff qualifications and training (3.2.1, 3.3.1, 3.3.2)

***Not in compliance with the following policies:***

- Management (3.1.1, 3.2.2)
- Delegated tasks (3.4.1)

4. Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services. – Not fully compliant

***In compliance with the following policies:***

- Entry screening (4.1.2)
- Exit plans (4.2.2)

***Not fully compliant with the following policies:***

- Exit plans (4.2.1)

***Not in compliance with the following policies:***

- Information for prospective residents (4.1.1)

5. Registrants must develop and maintain personal services plans that reflect each resident's needs, risks, service requests and service plan. – Not fully compliant

***In compliance with the following policies:***

- Personal service plans (5.1.2)

***Not fully compliant with the following policies:***

- Personal service plans (5.1.1)

6. Registrants must ensure prescribed services are provided in a manner that does not place the health or safety of residents at risk. – Not in Compliance

***Not in compliance with the following policies:***

- Activities of daily living (6.1.1)
- Medication management (6.2.1)

7. Residents are provided with information on complaint processes. – Not fully compliant

***Not fully compliant with the following policies:***

- Complaints (7.1.1)

## **REQUIRED ACTIONS TO ENSURE COMPLIANCE WITH ASSISTED LIVING STANDARDS AND POLICIES**

The following are required actions that Retirement Concepts must complete to ensure compliance with assisted living health and safety standards and maintain current registration as Assisted Living. These actions have been organized by:

### **Corporate and Site Leadership**

1. Ongoing and accessible clinical leadership, increased support, training and supervision for staff providing prescribed services within the assisted living section, and immediate compliance with the provincial Personal Assistance Guidelines need to be implemented to ensure safety of the residents and increase the competency of personal assistance staff.
2. Policies, procedures and staff training about privacy legislation need to be implemented and monitored for compliance by the operator to protect the confidentiality and privacy of resident personal information.
3. Policies and procedures related to review of care aide competencies and personal assistant procedures, must be implemented to ensure prescribed services are provided in a safe manner.
4. Policies and procedures about medication management, delegated and assigned tasks for care aides, must be revised and implemented to ensure compliance with the provincial Personal Assistance Guidelines.
5. Policies, procedures and staff training related to the prevention of and response to accidents and medical emergencies need to be implemented and regularly monitored by the operator to ensure the health and safety of all residents.

### **Clinical**

6. Educational plans for the direct care staff need to be implemented including medication administration, direct care, infection control, occupational health and safety, violence in the workplace and communication skills to support the safe provision of services.
7. Policies and procedures related to resident exit planning must be implemented to ensure safe transitioning between different types of service.
8. Policies and procedures regarding the development and updating of personal support plans, and communication between internal and external caregivers and families must be implemented to ensure up-to-date and appropriate personal support plans for residents.

### **Quality Improvement and Risk Management**

9. Policies and procedure related to how staff manage breaches in building security need to be implemented to ensure residents are protected from harm.
10. Policies and procedures related to prompt effective reporting of abuse or neglect allegations need to be developed and/or revised, and staff training needs to be implemented to ensure the safety of residents.
11. Clear and accurate information about assisted living including the future care costs of Summerland Seniors Village needs to be developed to effectively assist the public, residents and families about the requirements, and to plan for their future care and support if required.

## **Corporate/Organization Support**

12. Supportive processes for staff to voice complaints or concerns without fear of repercussion must be developed and implemented to support the provision of safe service for residents.
13. Corporate policies and procedures need to be implemented in a consistent manner and compliance monitored to ensure the safety of residents, families, and staff.

## **Communication**

14. Policies and process regarding clear and consistent communication with residents, families, and staff to be implemented to ensure the health and safety of residents.

The Ministry must be assured that all assisted living residents living at Summerland Seniors Village are safe and that they are receiving appropriate services that are consistent with the required health and safety standards. The operator must establish and sustain appropriate clinical oversight, and report any changes in this arrangement to the Assisted Living Registry. For the immediate term, this has been achieved through the addition of clinical leadership at the site by IHA to provide daily clinical oversight. IHA has confirmed that they will continue to provide this essential clinical oversight until the Assisted Living Registrar is satisfied that this clinical oversight is no longer required. Any changes in clinical oversight at Summerland Seniors Village will require immediate review and approval by the Assisted Living Registrar.

The Assisted Living Registry and Retirement Concepts will continue to collaborate on improvements to policies and supporting materials, and the monitoring approach that includes reviewing and updating the action plan on a regular basis, reporting by the operator and site visits to ensure that the operator is in full compliance with the assisted living health and safety standards. This diligence is required due to the nature of the population residing in this residence and the potential risks associated with not completing the required actions identified in the investigation. In addition, the agreement to halt admissions will remain in place until agreement is reached with the Assisted Living Registrar, Retirement Concepts and IHA that the operator has achieved compliance with required clinical oversight and health and safety policies.

Retirement Concepts has engaged in a proactive review process and, based on feedback provided by Assisted Living Registry, independently completed an internal review of all of their sites that offer assisted living services utilizing the standards and policy statement tool that the Ministry used for the review of Summerland Seniors Village. They have invited the Assisted Living Registrar staff to review a number of sites to confirm that the sites are meeting or exceeding the health and safety standards for assisted living.

Possible sites to review include:

- The Terraces on 7th: 1570 West 7th Avenue Vancouver, BC V6J 5M1
- Maple Ridge Seniors Village: 22141 - 119th Avenue Maple Ridge, BC V2X 2Y2
- Rosemary Heights Seniors Village: 15240 34th Avenue Surrey, BC V3S 0L3
- Waverly Seniors Village: 8445 Young Road Chilliwack, BC V2P 7Y7
- Langley Seniors Village: 20363 - 65th Avenue Langley, BC V2Y 2Y7
- Williams Lake Seniors Village: 1455 Western Avenue Williams Lake, BC V2G 5N1
- Kamloops Seniors Village: 1220 Hugh Allan Drive Kamloops, BC V1S 2B3
- Comox Seniors Village: 4640 Headquarters Road Courtenay, BC V9N 7J3
- Nanaimo Seniors Village: 6085 Uplands Drive Nanaimo, BC V9V 1T8
- The Gardens: 650 Berwick Road North Qualicum Beach, BC V9K 2T8
- The Wellesley: 2800 Blanshard Street Victoria, BC V8T 5B5

The Ministry would like to acknowledge the efforts of Retirement Concepts to support this review. Staff at Summerland Seniors Village fully cooperated with the reviewers by providing information for the report both during and following the site visit. We anticipate that this cooperation and responsiveness will continue in addressing the recommendations and further reviews that will be undertaken.

We would like to further acknowledge your cooperation with IHA to address a number of the issues identified in the review that required an immediate and urgent response.

Inspection report completed by Robin McMillan, Director, Assisted Living Services, Ministry of Health

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Signature

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Date

Barbara Korabek, Assisted Living Registrar,

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Signature

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Date

## Appendix 1

HEALTH & SAFETY STANDARD		FINDINGS/OBSERVATIONS
<b>Standard # 1 – Registrants must provide a safe, secure and sanitary environment for residents.</b>		
<b>1.1 Environment</b>		
1.1.1	Registrants must ensure that building design, construction and occupancy comply with the requirements of applicable legislation, regulations, bylaws and codes.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Assisted Living Registration is for 18 publicly subsidized and 18 private units</li> <li>All permits current and posted by front desk</li> </ul>
1.1.2	Registrants ensure the design of common areas and resident units accommodates the special needs of their resident population.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Common areas and resident areas separate, and appropriate design</li> </ul>
1.1.3	Registrants must provide adequate and appropriate social and recreational space for residents.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Building includes country kitchen, large TV room, hairdressing salon, exercise gym, library, and social event room with a bar, open cafe area and outside space including the resident garden</li> </ul>
<b>1.2 Building maintenance</b>		
1.2.1	Registrants must maintain buildings and grounds in a good state of repair and a safe and sanitary condition, and in compliance with the requirements of applicable legislation, regulations, bylaws and codes.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Records show all permits current</li> <li>Buildings and grounds appear in good condition</li> <li>Ongoing flood restoration work has the necessary permits</li> </ul>
<b>1.3 Security</b>		
1.3.1	Registrants must provide building security that protects residents from harm.	<b>Not fully compliant</b> <ul style="list-style-type: none"> <li>Coded door installed, residents and family know the code and can exit the building whenever they wish.</li> <li>Front door is locked at 4:40 PM. Intercom and bell at front door for others to use to gain admission to residence. Security cameras at the front door</li> <li>Two other outside doors to the Assisted Living section are coded, but have no bell – visitors must come to the front door</li> <li>No policies in place related to breach of security process for staff to follow</li> </ul>

HEALTH & SAFETY STANDARD		FINDINGS/OBSERVATIONS
1.3.2	Registrants must maintain the privacy of residents' personal information in accordance with applicable legislation, using it only as required in the delivery of services.	<b>Not in compliance</b> <ul style="list-style-type: none"> <li>Resident personal information kept in room with a lockable door, but other SSV staff have access as well</li> <li>Privacy breach related to disposal of blister packs in domestic garbage</li> <li>Policy regarding access to tenant record is not comprehensive – deals with requests to general manager, does not speak to how staff protect the privacy and confidentiality of residents</li> </ul>
1.3.3	Registrants must respect resident privacy, provide lockable doors to resident units and a lockable cabinet within each resident unit for valuables.	<b>Not fully compliant</b> <ul style="list-style-type: none"> <li>Units have a lockable door and a lockable cabinet</li> <li>No evidence of policies regarding resident privacy or access to a resident's unit</li> <li>No evidence of staff orientation or training regarding privacy and confidentiality</li> </ul>
<b>1.4 Emergency preparedness and fire safety</b>		
1.4.1	Registrants must provide services and/or facilities that enable residents to self-preserve in the event of fires or other emergencies.	<b>In Compliance</b> <ul style="list-style-type: none"> <li>Documentation confirmed fire drill held fall 2012</li> <li>September Tenant Council minutes indicate that a fire drill was held and that fire procedures were discussed. November Tenant Council minutes indicate that a new fire plan is being developed with the fire department (draft fire processes provided), and that there is an evacuation plan</li> <li>Evidence that staff and residents receive fire protocol and the ERS system training when they first move into the residence</li> <li>Evacuation instructions posted in resident units</li> </ul>
1.4.2	Registrants must ensure that staff is trained to respond appropriately to emergencies.	<b>Not fully compliant</b> <ul style="list-style-type: none"> <li>Emergency response and weapons/dangerous goods policy in place</li> </ul>

HEALTH & SAFETY STANDARD		FINDINGS/OBSERVATIONS
		<ul style="list-style-type: none"> <li>Care staff have first aid certificates and carry a cell phone on all shifts</li> <li>No evidence of staff training related to how to respond to an emergency other than a fire</li> </ul>
1.4.3	Registrants must ensure the fire safety requirements of the local fire authority are met.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Confirmation that the annual fire department inspection is satisfactory</li> </ul>
<b>1.5 Accidents, deaths and medical emergencies</b>		
1.5.1	Registrants must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.	<b>Not in compliance</b> <ul style="list-style-type: none"> <li>Unexpected death policy in place</li> <li>Evidence confirmed care aides have first aid certificates</li> <li>Emergency response policy requires additional information to ensure staff understanding of the appropriate steps to take in emergencies. Incident reports are completed by care aides and sent to GM. Care aide reported that they all do not follow the policy in a consistent manner</li> <li>Missing resident policy in place. Policy was recently revised to include documentation of resident absences from meals. Policy was not followed consistently by staff</li> <li>No evidence of staff training related to processes to follow in the event of accidents, deaths and medical emergencies</li> <li>Lack of ongoing communication of and review of policies by management with staff</li> </ul>
<b>1.6 Infectious outbreaks</b>		
1.6.1	Registrants must have a plan in place to prevent, contain and report infectious outbreaks.	<b>Not in compliance</b> <ul style="list-style-type: none"> <li>Policies on hand hygiene, outbreak management and influenza prevention in place</li> <li>Corporate policy on infection control available, but specific procedures not available and staff unaware of them</li> </ul>



HEALTH & SAFETY STANDARD		FINDINGS/OBSERVATIONS
<b>1.7 Resident abuse, neglect and self-neglect</b>		
1.7.1	Registrants must protect residents from abuse or neglect and respond promptly and effectively to allegations of abuse or neglect.	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• Written complaint and abuse policy in place</li> <li>• Care aides have criminal record reviews on file</li> <li>• Residents are given Assisted Living Registry complaint brochure at move in and brochures are available on site. Current brochures have incorrect Assisted Living Registry contact information (brochures with correct contact information mailed to residence December 7)</li> <li>• Tenant abuse policy does not address communication with the health authority (local designated agency), PGT or funding agency</li> <li>• Abuse policy reviewed with staff at orientation. No additional education related to abuse and neglect for staff</li> </ul>
1.7.2	Registrants must maintain a record of incidents that occur within the residence and report serious incidents to the Assisted Living Registrar.	<p><b>In compliance</b></p> <ul style="list-style-type: none"> <li>• Evidence of written incident reports</li> <li>• Incident policy in place</li> <li>• Serious incident reporting policy in place</li> </ul>

**Standard # 2 – Registrants must ensure hospitality services do not place the health or safety of residents at risk.**

**2.1 Laundry**

2.1.2	Registrants must store clean laundry in a manner that prevents contamination.	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Soiled laundry collected 3 times per day</li> <li>• Processes in place to prevent cross contamination</li> </ul>
2.1.3	Registrants must change linens at time intervals necessary to avoid health issues.	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Bed linens and towels cleaned weekly</li> </ul>
2.1.4	Registrants must provide residents with access to safe and sanitary personal laundry equipment (or provide a personal laundry service).	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Washers and dryers on each floor where residents can do personal laundry</li> </ul>

**2.2 Housekeeping**

2.2.1	Registrants must provide housekeeping in resident units that maintain a safe, clean and sanitary environment.	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Light housecleaning policy that resident must sign-off in place</li> <li>• Written job routines processes in place</li> <li>• Suites are cleaned weekly. Extra cleaning is available for an additional cost</li> <li>• Standard is that repairs are generally completed within 24-hours</li> <li>• Residence has a new computer maintenance management system that tracks requests for maintenance work and how long this work takes</li> </ul>
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**2.3 Meals**

2.3.1	Registrants must offer meals that provide balanced and adequate nutrition for residents.	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Policies, Four-week menu rotation and November 14, 2012 client food audit provided</li> <li>• Two options per meal offered</li> </ul>
2.3.2	Registrants must establish an individual dietary plan with residents who require a special or therapeutic diet, have food allergies or intolerances, and/or have special needs associated with chewing or swallowing.	<b>In compliance</b> <ul style="list-style-type: none"> <li>• Confirmed that residence provides celiac, diabetic and may cut up some foods if required</li> <li>• Snacks are provided and fruit is provided with each meal</li> </ul>

2.3.3	Registrants must ensure that residents can access meals.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Hallways are wide and there is an elevator to the lower level to accommodate walkers and wheelchairs</li> <li>Meal reminder and room service available if requested for an extra cost</li> </ul>
2.3.4	Registrants must obtain appropriate professional advice (dietitian or food service supervisor/diet technician) to plan menu rotations, special or therapeutic diets, and food preparation to accommodate chewing and swallowing abilities.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Menus approved by dietitian employed by Retirement Concepts</li> <li>Residence has recently hired an executive chef</li> </ul>
2.3.5	Registrants must adopt safe practices for the preparation and delivery of meals.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Confirmed that all staff have a FoodSafe certificate</li> </ul>
<b>2.4 24-hour Emergency Response</b>		
2.4.1	Registrants must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.	<b>Not fully compliant</b> <ul style="list-style-type: none"> <li>Electronic emergency response system (ERS) in place in suites and additional pendant available</li> <li>Policy on emergency response requires revision including an immediate response time protocol and the type of response to be provided. Investigator observed that staff responded to a call within a minute</li> <li>Staff carry a telephone, but do not have a way to request assistance if required</li> </ul>
<b>2.5 Social and Recreational Opportunities</b>		
2.5.1	Registrants must ensure safe transportation to and from social and recreational outings.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Residence has their own bus for recreational outings</li> <li>Safety checks are done on the bus before each trip</li> </ul>
2.5.2	Registrants must offer social and recreational programs that promote the mental wellbeing of residents.	<b>In compliance</b> <ul style="list-style-type: none"> <li>Social and recreational calendar was posted (showed programming) and calendars are provided to residents</li> <li>Client satisfaction surveys provided to review team</li> </ul>

**Standard # 3 – Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.**

### 3.1 Management

3.1.1	Registrants must ensure site management is effective and appropriate for the resident population.	<p><b>Not in compliance</b></p> <ul style="list-style-type: none"> <li>• Current management team consists of (maintenance, marketing, recreation, support services, administration and general manager, who is a registered nurse). Job descriptions of care aide and general manager reviewed</li> <li>• Clinical oversight for assisted living section to ensure compliance with delegation of duties required for prescribed services and support for staff providing direct care not effectively provided by general manager</li> </ul>
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### 3.2 Staffing levels

3.2.1	Registrants must ensure staffing levels are sufficient to meet the hospitality service needs of residents and deliver the personal assistance services offered.	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• RN or LPN on-call and available to assisted living care aides for personal service assistance consultation after hours</li> <li>• No evidence of consistent nursing oversight for assisted living</li> <li>• All staff have first aid training</li> <li>• Staff on site 24/7, support service worker available on night shift</li> </ul>
3.2.2	Registrants must have plans in place to address situations where there is a disruption to the residence's regular work force.	<p><b>In compliance</b></p> <ul style="list-style-type: none"> <li>• Evidence that there are processes in place to manage staffing when there is a disruption such as sick calls or inclement weather</li> </ul>

### 3.3 Staff qualifications and ongoing training

3.3.1	Registrants must ensure that staff has qualifications consistent with their job responsibilities. Staff providing personal assistance services must have home support/care aide	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• One of the six care aides has a Special Needs Worker certificate</li> <li>• Five of the six care aides do not have a</li> </ul>
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	certification from an accredited educational institution, or an equivalent combination of education and experience.	<p>medication management certificate</p> <ul style="list-style-type: none"> <li>• All care aides are registered with the BC Care Aide and Community Health Worker Registry except the Special Needs Worker</li> </ul>
3.3.2	Registrants must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff.	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• Orientation for care aides confirmed</li> <li>• Recent training related to use of safety belts and use of restraints</li> <li>• No evidence of educational plans for direct care staff specific to the provision of direct care</li> </ul>
<b>3.4 Delegated tasks</b>		
3.4.1	Registrants must ensure appropriate delegation of professional tasks to nonprofessional staff, consistent with the Ministry of Health Services <u>Personal Assistance Guidelines</u> .	<p><b>Not in compliance</b></p> <ul style="list-style-type: none"> <li>• No RN sign off on delegated tasks</li> <li>• Care aide stated that she uses the pharmacist for education and direction</li> <li>• Written delegation and assignment of task policies, but implementation not consistent with policy</li> <li>• Policy allowing care aides to give PRN medications to be clarified so as to be compliant with Personal Assistance Guidelines</li> <li>• Lack of procedures for documenting medication use</li> <li>• One blister pack had several empty med slots with no signatures in the client's file in the med drawer</li> </ul>

**Standard # 4 – Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services.**

#### **4.1 Entry**

4.1.1	Registrants must fully inform prospective residents about the hospitality and personal assistance services offered in the residence.	<p><b>Not in compliance</b></p> <ul style="list-style-type: none"> <li>• Marketing and web site language indicate that the site offers independent living and assisted living services, but does not differentiate between the two. Confirmed through discussions with the Marketing Coordinator and care aide. This is consistent across the province</li> <li>• Lack of an Assisted Living Tenancy Agreement (Independent Living Tenancy Agreement is used for both independent living and assisted living)</li> <li>• Marketing materials are not clear about how a resident transitions from independent living to assisted living, except that a resident can ask for “additional care services”</li> <li>• Information provided to residents is not clear about differences in levels of service</li> </ul>
4.1.2	Registrants must screen residents for suitability in relation to building design features, personal assistance services offered, and ability to make decisions on their own behalf.	<p><b>In compliance</b></p> <ul style="list-style-type: none"> <li>• Entry Criteria policy in place.</li> <li>• Discussion with Marketing Coordinator confirmed that prospective residents are interviewed and screened before entering the residence</li> <li>• Marketing Coordinator stated that the General Manager (who is an RN) also interviews and assesses prospective residents</li> </ul>

#### **4.2 Exit plans**

4.2.1	Registrants must develop an exit plan in consultation with the resident, their physician, support network and health authority if appropriate where a resident’s needs exceed the service delivery capacity of the residence or the resident becomes unable to make decisions on their own behalf.	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• Exit Planning policy available, lack of clarity in role of care aide in implementing policy</li> </ul>
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4.2.2	Registrants must ensure that exit plans include strategies for providing increased services to minimize risk and meet the higher care needs of residents awaiting a move out of the residence.	<p><b>In compliance</b></p> <ul style="list-style-type: none"> <li>• Residents are able to hire extra private assistance if they need additional care.</li> <li>• Residents with IHA care management receive added care hours if they are no longer suitable for AL</li> </ul>
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***Standard # 5 – Registrants must develop and maintain personal services plans that reflect each resident's needs, risks, service requests and service plan.***

**5.1 Personal Service Plans**

5.1.1	In conjunction with each resident, the registrant must develop a personal services plan upon their entry to the residence. The plan must be reviewed on a regular basis and updated as the resident's needs change.	<p><b>Not fully compliant</b></p> <ul style="list-style-type: none"> <li>• Tenant Service Delivery policy contains the personal service plan process</li> <li>• All residents have a personal service plan that is developed by the General Manager at time resident move into the residence.</li> <li>• Caregivers meet regularly with IHA case managers</li> <li>• PSPs updated by care staff October 18, 2012</li> <li>• No policies and processes regarding communication between external caregivers and internal caregivers</li> <li>• Care staff call family directly with concerns</li> </ul>
5.1.2	Registrants must respect the personal decisions of residents and accommodate a resident's right to take risks, as long as the risks do not place other residents or staff in jeopardy.	<p><b>In compliance</b></p> <ul style="list-style-type: none"> <li>• Site uses "negotiated risk agreements" when appropriate and updates them as needed</li> <li>• No residents had risk agreements in place at the time of the site visit</li> </ul>



**Standard # 6 – Registrants must ensure prescribed services are provided in a manner that does not place the health or safety of residents at risk.**

**6.1 Activities of Daily Living (ADL)**

6.1.1	Registrants must deliver ADL in such a way as to promote the safety and independence of residents.	<p><b>Not in compliance</b></p> <ul style="list-style-type: none"> <li>• No evidence of routine evaluation of care aides competency in performing activities of daily living</li> <li>• No consistent clinical oversight for personal assistance tasks</li> <li>• No personal assistance procedures provided</li> </ul>
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**6.2 Central storage of medication, distribution of medication, administering medication or monitoring the taking of medication**

6.2.1	Registrants must deliver medication services in accordance with provincial <u>Personal Assistance Guidelines</u> and the Assisted Living Registrar's <u>Medication Services and Standards of Practice Guidelines</u> in order to promote the safety and independence of residents.	<p><b>Not in compliance</b></p> <ul style="list-style-type: none"> <li>• No evidence of consistent nursing oversight of delegated or assigned clinical tasks</li> <li>• Medication management policy to be revised</li> <li>• No evidence of routine evaluation of care aides competency in performing assigned tasks</li> <li>• Care aides review blister packed meds for errors without clinical supervision</li> </ul>
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**Standard #7 – Complaints Residents are provided with information on complaint processes.**

7.1.1

Registrants must have internal complaint policy that is communicated to residents and you must not prevent or intimidate anyone from initiating a complaint.

**Not fully compliant**

- Internal complaint policy provided as part of the move-in package that residents receive
- Assisted Living Registry Complaint policy contained in resident information package
- Internal “complaints box” for residents to anonymously provide feedback at the residence
- No written procedures regarding who is responsible for the “complaints box” – general manager responsible to manage
- Evidence of complaints and safety issues being addressed at the monthly tenant council meetings
- Staff stated that they were afraid of repercussions by management should they put forth complaints and said they felt unsupported because the union aligned themselves with management

**MINISTRY OF HEALTH  
INFORMATION BRIEFING DOCUMENT**

**928561**

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

**TITLE:** Release of Vancouver Coastal Health Authority (VCHA) Internal Review of Transgender Health Program (THP) to its Advisory Group.

**PURPOSE:** To provide a summary of VCHA's internal report and advise the Minister of its impending release.

**BACKGROUND:**

Services for the transgendered population in British Columbia are currently concentrated in Vancouver within VCHA. This population has higher than normal suicide and suicide attempt rates, and is more likely to be living in poverty (see Appendix One).

THP is not a clinical program but rather provides support and assistance to anyone with a transgender health question (transgender people, youth, loved ones, health care providers, etc.) by offering information, resources and short term support. The annual budget for THP is \$160,000.

In September 2011, an internal review of the THP was commissioned by VCHA. The aim of the review was to gather information about the strengths and challenges of the THP, as well as to identify opportunities for strategic planning and implementation over the next five years. This report presents 15 high-level recommendations arising from the review process (Appendix Two contains the recommendations; Appendix Three is the full report).

**DISCUSSION:**

The surgical program for Gender Reassignment Surgery is not part of the review and is not expected to be relocated from VCHA.

Findings from the report include the need for a more structured approach to the THP to ensure that services are fully coordinated. The report notes that both the program and the community should reach out to diverse partners who share some common interests to leverage existing programs and services. It also acknowledges the contribution of those working in the area to moving the overall program of support to the transgendered community forward.

The THP advisory group, which includes transgendered members as well as family members of transgendered people from NCHA area and other health authorities, was consulted extensively during the review process and has expressed concern that the report has not yet been released to them.

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Other health authorities are aware that there may be minor funding implications as a result of the recommendations, mostly in the mental health/community sector in future years. However, as this population is already accessing services, more knowledge of the needs of this community may result in better care and potentially less expenditures as needs are better addressed.

Other health authorities support the release of the report to the advisory group. A draft was presented to the Health Operations Committee on May 11, 2012, and there were no major concerns expressed.

### **FINANCIAL IMPLICATIONS:**

There are no direct financial implications of releasing the report to the advisory group.

VCHA is making short-term changes to improve the program within the current budget and working to secure additional funding (e.g. developing a business case and exploring new partnerships) to implement longer-term recommendations.

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### **ADVICE:**

It is recommended that VCHA release the report to its advisory group.

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<b>Program ADM/Division:</b>	Effie Henry, A/ADM, Health Authorities Division
<b>Telephone:</b>	250-952-1049
<b>Program Contact (for content):</b>	Kirk Eaton, A/Executive Director – Hospital and Provincial Services
<b>Drafter:</b>	Nancy South
<b>Date:</b>	May 17, 2012
<b>File Name with Path:</b>	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\928561 - THP review release to AdvisoryGroup.docx

## Appendix One:

### Transgendered Health Program – Quick Facts from VCH Literature Review

#### 1. Estimated size of trans population

- Currently, there are no reliable epidemiological studies on the incidence/prevalence of transgendered people.
- Estimates in Western adult populations vary significantly based on definitions and study methodology; for the sake of discussion here, it is assumed that 0.1 % to 1.0 % of the adult population is transgendered.
- All numbers show an **increasing trend**.

#### British Columbia Estimates of Trans Population Size

Health authority	Estimated population in 2010	Estimated # of trans* people (at 0.1% prevalence)	Estimated # of trans* people (at 1% prevalence)	Estimated # of people who will transition (at 0.2% prevalence)
Interior	73,4587	735	7,346	1,469
Fraser	1,608,913	1,609	16,089	3,218
Northern	228,569	229	2,286	457
Vancouver Coastal	1,140,892	1,141	11,409	2,282
Vancouver Island	757,999	758	7,580	1,516
<b>Province total</b>	<b>4,470,960</b>	<b>4,371</b>	<b>43,710</b>	<b>894 to 8,942</b>

Source: BC Stats for Population estimates.

#### 2. Suicidal ideation and attempts – Canadian estimates

- **Past year suicide ideation rates** are 10 times higher in the transgendered population than in the rest of the Canadian population.
- **Past year suicide attempts** are 10 to 20 times higher in the transgendered population.
- **Youth** – 47 % have suicidal ideation and 19% attempted suicide in past year.
- These rates are higher than other high-risk populations, including the Aboriginal population.

Note: After transgendered people complete transition, suicide rates return to the Canadian average.

#### 3. Poverty Rates for the Transgendered Population (study in Ontario)

- 50% had personal annual income less than \$15,000
- 21% incomes under \$30,000
- Discrimination by employers is major issue

Because many forms of care needed by transgendered people are only available privately, many cannot access the services they need. Families may be financially stressed in supporting transgendered youth by paying for private care needs.

#### **4. High rates of violence and stigma**

- Transgendered people are more prone to violent physical and sexual assaults.
- Transgendered victims of violence have a four-times higher rate of suicide attempts than other transgendered people.

## Appendix Two:

### *Internal Review of the Vancouver Coastal Health Transgender Health Program; Recommendations for five year strategic plan*

1. Clarify the scope, function and responsibility of the Transgender Health Program, specifically:
  - Differentiate THP versus the VCH Transgender Health Primary Care Consultation Service
  - Consider a name change to support identifying the scope
  - Determine the best location for management of the THP (within VCH) – Mental Health and Addiction, Primary Care, Population Health.
  - Review and update statements of THP Vision, Goals, and Aims to reflect clarity of scope and function.
2. Establish outreach processes in collaboration with cultural communities and other organizations in order to strengthen the THP's capacity to account for the gaps in trans health care across culturally diverse populations.
  - Ensure every effort is made to include diverse populations in all program areas of the Transgender Health Program
  - Access, utilize, and partner with cultural resources.
3. Support a process for the Advisory Group to establish clear terms of reference including, but not limited to: purpose, rights and responsibilities, conduct (with clear expectations such as a written "job description" and appropriate training or support to allow them to function effectively), composition of membership, size.
  - Educate trans communities (including the THP Advisory Group) with regard to broad institutional procedures and processes involved in bringing about change, "*How it works (on the inside) to get appropriate service.*" (Health Administrator)
4. Advocate in support of creating a formal clinical transgender health youth service at BC Children's Hospital. (E.g. this would require a solid business plan and a well facilitated presentation involving THP Medical Director).
5. Create an up-to-date and improved website and print material using accessible language designed to empower trans individuals to participate in their own care management, and to build capacity
  - Publish information related to trans health and medical transitioning for health care providers and trans people
6. Develop communication strategies in order to seek stakeholder input and to share information regularly with stakeholders. e.g. Hold "Town Hall" meetings with strong facilitation; launch comprehensive media campaign

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7. Increase core budget, to expand staffing arrangements to meet improved service:
  - Employ a minimum of three qualified and experienced people to provide health navigation, education, group facilitation, building resource for\with trans and queer youth and their families, grant writing, etc.
    - i. Coordinator\Administrator: (full-time) qualification: Masters level from a health profession, community development or equivalent, with proven leadership abilities
    - ii. Create a minimum of two full time other positions (one targeting youth); positions will require demonstrated focus and experience in the area of trans health and community engagement
  - Provide for the succession planning to minimize disruption and loss of knowledge when experienced staff leave
  - Arrange for qualified staff to participate with BC trans-care group.
8. Arrange for qualified staff affiliated with the THP to participate in the BC Trans Clinical Care Group and other provincial tables of relevance.
9. Work with Ministry of Health to promote trans competent services that are responsive to community needs across the province.
  - Develop core competencies
  - Develop a specific advocacy plan in collaboration with the six health authorities focused on finding new ways to provide timely access to trans health services by appropriate providers across the regions.
  - Advocate for a systematic monitoring of wait list \ wait time for endocrinological and surgical procedures through MSP
10. Create strategic plan (including business case) to support an increased focus on trans youth mental health.
  - Designate partial or full responsibility of a proposed new staff position - to function as a Youth Support Worker
  - Engage youth and families in the planning process
  - Collaborate with relevant partners such as MCFD and the Vancouver Board of Education to move forward the youth strategy (e.g. develop TQ2S inclusive anti-discrimination policies and strategies to implement them)
  - Collaborate with partners to assist in fostering the development of TQ2S and gender variant youth specific 'safe spaces' (or groups) to be available across the province..

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11. Continue to lead in the development and implementation of a province wide comprehensive education strategy to promote trans-positive primary health care, including supportive and crisis counselling, to health care professionals, including first responders, who have demonstrated interest in trans health care,
  - Include assessment and treatment protocols for hormones and clear referral pathways for further Endocrinological and Surgical health care.
  - Foster a Therapeutic Community-of-Practice Network with a mandatory supervision component.-accessing various modalities such as videoconferencing to support and sustain as required.
  - Integrate THP educational approach which reflects the shift taken in WPATH SOCv7 - a de-psychopathologizing, de-medicalizing position. (Psychiatry and other Mental Health Professionals have been experienced as “gatekeepers” by many trans and gender non-conforming people in the past.)
12. Identify and build intentional partnerships with community agencies and services to collaboratively develop and deliver a comprehensive set of groups for trans communities across all health authorities of BC.
  - Collaborate across agencies, across the province, across modalities in the development and implementation of identified groups.
  - Ensure qualified and skilled facilitators
  - Develop groups with a view to multi-modal delivery; e.g. in addition to face-to-face groups, the use of technology – through social media i.e. Skype, etc.
13. Develop a strategy to bring transgender health related knowledge and skill to the Health Professions curriculums at Universities and colleges, and Continuing Professional Development
14. Develop a strategy to provide counselling or therapy for people across the province who apply and meet identified criteria. For example: a program whereby a successful applicant would be eligible for up to \$2000.00 for counselling / psychotherapy with a qualified trans-competent mental health provider across BC. (Secondary gain for THP would be identifying and building capacity with counsellors / therapist across BC who would require the necessary trans-health competencies in order to accept referrals
15. Explore programs which currently support successful volunteer services – their screening and training, etc. – with a view to best approaches for establishing and maintaining a volunteer and mentoring program as part of THP services.
  - Determine how, when, where to best use volunteers - with attention to competencies required, safety, etc.

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## **MEETING MATERIAL**

**Cliff # 962410**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health

**TITLE:** Meeting between Minister of Health and Denominational Health Association

### **MEETING REQUEST/ISSUE:**

Denominational Health Association President, Derland Orsted, requested a meeting with the Minister to discuss the role of the providers included in the Association, and challenges these providers are facing.

**SHOULD MINISTRY STAFF ATTEND THIS MEETING:** No, not required.

### **BACKGROUND:**

The Denominational Health Association (DHA) is an organization of faith-based agencies which deliver acute care and residential care. When regionalization began in British Columbia in 1994, faith-based health care providers opposed amalgamation with health authorities (HAs). The DHA was formed in 1995 to negotiate an alternative to amalgamation for these providers. Appendix A contains a list of organizations and facilities included in the DHA.

In 1995, the DHA and the province negotiated a Master Agreement that established the general terms of the relationship between the faith-based facilities and HAs. The Agreement clarified that HAs are accountable for planning and managing health care services within the region. HAs are to develop affiliation agreements with denominational facilities who will provide services on behalf of the HA, but the religious groups retain ownership and control of their facilities. To date affiliation agreements are in place for most, but not all, denominational facilities.

The Master Agreement was intended to be an interim measure to maintain stability for denominational facilities for a minimum of three years, or until affiliation agreements were signed between the parties. Accordingly, in 1998 the decision was made that no new denominational organizations would be added to the Master Agreement, in preparation for phasing out the Agreement; in 2008 the Ministry declined the request of the DHA to expand the Master Agreement to include assisted living facilities.

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**APPENDIX A**  
**DENOMINATIONAL ORGANIZATIONS AND FACILITIES**

<b>Member</b>	<b>Facility</b>
Evergreen Baptist Society	Evergreen Baptist Home 1550 Oxford Street White Rock BC V4B 3R5
Fair Haven United Church Homes	The Fair Haven United Church Home 4341 Rumble Street Burnaby BC V5J 2A2
Governing Council of the Salvation Army	Buchanan Memorial Sunset Lodge 409 Blair Avenue New Westminster BC V3L 4A4
Hope Reformed Church Society	Westminster House 1653 – 140 <sup>th</sup> Street Surrey BC V4A 4H1
Lutheran Senior Citizens' Housing Society	Zion Park Manor 5939 – 180 <sup>th</sup> Street Surrey BC V3S 4L2
Mennonite Benevolent Society	Menno Home 32910 Brundige Avenue Abbotsford BC V2S 1N2  Menno Hospital 32945 Marshall Road Abbotsford BC V2S 1K1
St. Michael's Society	St. Michael's Centre 7451 Sussex Avenue Burnaby BC V5J 5C2
Tabor Home Society	Tabor Home 31944 Sunrise Crescent Clearbrook BC V2T 1N5
The Good Samaritan Society (not yet a member of DHA)	New Westminster Site "M" Woodlands McBride Boulevard New Westminster BC
United Church of Canada	Hazleton-Wrinch Memorial Hospital 2510 Highway 62 PO Bag 999 Hazelton BC V0J 1Y0
Broadway Pentecostal Care Society	Broadway Pentecostal Lodge 1377 Lamey's Mill Road Vancouver BC V6H 3S9
Columbus Long-Term Care Society	Columbus Residence 704 West 69 <sup>th</sup> Avenue Vancouver BC V6P 2W3
Fair Haven United Church Homes	The Fair Haven United Church Home

	2720 East 48 <sup>th</sup> Avenue Vancouver BC V5S 1G7
Jewish Home for the Aged in British Columbia	Louis Brier Home and Hospital 1055 West 41 <sup>st</sup> Avenue Vancouver BC V6M 1W9
Kopernik (Nicolaus Copernicus) Foundation	The Kopernik Lodge 3150 Rosemont Drive Vancouver BC V5S 2C9
Mennonite Intermediate Care Home Society of Richmond	Pinegrove Place 11331 Mellis Drive Richmond BC V6X 1L8
Providence Health Care	Brock Farhni Pavilion 4650 Oak Street, Vancouver BC V6H 4J4  Holy Family Hospital 7801 Argyle Street, Vancouver, BC V5P 3L6  Honorio Conway at St. Vincent's Heather 4875 Heather Street, Vancouver BC V5Z 0A7 (to open Spring 2008)  Marion Hospice 900 – 900 West 12 <sup>th</sup> Avenue, Vancouver, BC V5Z 1N3  Mount Saint Joseph Hospital 3080 Prince Edward Street, Vancouver BC V5T 3N4  Saint Paul's Hospital 1081 Burrard Street, Vancouver BC V6Z 1Y6  Saint Vincent's Hospital – Langara 255 West 62 <sup>nd</sup> Avenue, Vancouver BC V5X 4V4  Saint Vincent's, Heather Site 4855 Heather St., Vancouver BC  Youville Residence 4950 Heather Street, Vancouver BC V5Z 3L9
Saint Jude's Anglican Home Society	Saint Jude's Anglican Home 810 West 27 <sup>th</sup> Avenue Vancouver BC V5Z 2G7
Southview Heights (contracted, not affiliated with VCH)	7252 Kerr Street, Vancouver BC V5S 3V2

United Church of Canada	Bella Coola General Hospital PO Box 200 Bella Coola BC V0T 1C0
	R.W. Large Memorial Hospital PO Box 778 88 Waglisla Street Bella Bella BC V0T 1Z0
The Calling Foundation	Blenheim Lodge 3263 Blenheim Street Vancouver BC V6L 2X7
The Good Samaritan Society (not yet a member of DHA)	Christenson Village 585 Shaw Road Gibsons BC V0N 1V8
Adventist Health Care Home Society	Rest Haven Lodge 2281 Mills Road Sidney BC V8L 2C3
Baptist Housing Society of BC	Central Care Home 844 Johnson Street Victoria BC V8W 1N3
	Mount Edwards Court 1002 Vancouver Street Victoria BC V8V 3V8
Bishop of Victoria (Sole Corporations)	Saint Joseph's General Hospital 2173 Comox Avenue Comox BC V9M 1P2
Governing Council of the Salvation Army	Sunset Lodge 952 Arm Street Victoria BC V9A 4G7
Luther Court Society	Luther Court 1525 Cedar Hill Cross Road Victoria BC V8P 5M1
Marie Esther Society	Mount Saint Mary Hospital 999 Burdett Avenue Victoria BC V8V 3G7
The Good Samaritan Society (not yet a member of DHA)	Hillside Village 2891 – 15 Avenue NE Salmon Arm BC V1E 1G9
	Mountainview Village #100 - 1540 KLO Road Kelowna BC V1W 3P6
	Pioneer Lodge 1051-6 <sup>th</sup> Avenue NE Salmon Arm BC V1E 4S1
	Vernon Phase 1 & 2

	4900 – 20 <sup>th</sup> Street Vernon BC V1T 4E8  Village by the Station 270 Hastings Avenue Penticton BC V2A 2V5
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## Denominational Health Association

September 21, 2012

MINISTER'S OFFICE HEALTH	
# 945136	
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<input type="checkbox"/> SA	<input type="checkbox"/> DM

Hon. Dr. Margaret MacDiarmid  
Minister of Health  
Room 337 Parliament Buildings  
Victoria, BC V8V 1X4

Dear Dr. MacDiarmid,

On behalf of the Board of Directors of the *Denominational Health Association*, I send sincere congratulations to you on your recent appointment to the position of Minister of Health for British Columbia.

You may recall that representatives from our Association met with you in May of 2011 when you were the Parliamentary Secretary for Seniors. At that time we had the opportunity to introduce our Association and our members to you and to talk about some of the challenges our members were experiencing as care providers.

We would now welcome an opportunity to meet with you again to give you an update on our work over the past year and to hear from you what your expectations are for the future of health care in our province. We appreciate the significant task you have taken on as Minister. It is *DHA's* philosophy and our practice to work cooperatively and collaboratively with the Health Ministry and health authorities to ensure that the best care possible is given to those we serve.

In the eighteen years since *DHA* was established, we are pleased to be able to say that we have met with each successive Health Minister. We look forward to hearing back from you as to when we might have an opportunity to meet at a place and time that is convenient for you.

Yours truly,

Derland Orsted  
President

*DHA*  
was established  
in 1995  
to strengthen  
understanding  
and cooperation  
between  
denominational  
health care  
facilities and  
the government  
and to ensure  
that the  
multicultural  
and spiritual  
needs of our  
health care  
clientele  
are met.

*DHA* members  
are the  
twenty-three  
owners of  
more than sixty  
health care  
facilities in BC.

Our members  
employ 15,000  
individuals and  
care for patients  
and residents  
in more than  
6,000 beds in  
our facilities  
throughout the  
province.

*DHA*  
is a registered  
non-profit  
association.



## **MINISTRY OF HEALTH BRIEFING DOCUMENT**

**Cliff # 966245**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
– **FOR INFORMATION**

**TITLE:** Child and Youth Mental Health and Substance Use (CYMHSU)

**PURPOSE:** Provide an overview of the work in British Columbia to support children and youth with mental health and substance use needs and transitions of care

### **BACKGROUND:**

According to prevalence data, about 130,000 children and youth (C&Y) experience mental health (MH) challenges at any given time in BC. The majority of these C&Y will experience mild to moderate MH challenges, including anxiety and depression, while a small portion will experience more severe disorders such as schizophrenia. The majority of C&Y with mental illness receive services from General Practitioners (GPs), sometimes with community supports.

Services for C&Y mental illness are provided by multiple organizations, including schools, non-profits, community agencies, Ministry of Children and Family Development (MCFD), health authorities (HAs), GPs, and psychiatrists. MCFD has the mandate for C&Y MH in the community including The Maples Adolescent Treatment Centre, youth forensic psychiatric services and substance use (SU) services in the youth justice system. MCFD spends approximately \$94 million annually, employs 500 practitioners in about 100 MH centres and serves more than 20,000 C&Y annually. HAs provide some C&Y community services, hospital and tertiary MH services. In the 2010/11 fiscal year the health care system served 71,984 unique clients 0 to 19 years old in the community for MH problems.<sup>1</sup> Additionally, 2,369 unique clients 0 to 19 years old receive hospital services, resulting in 41,365 hospital stay days.<sup>2</sup>

Those with moderate to severe MH problems receive community services in combination with GPs, psychiatrists and family and youth support workers with the aim of providing comprehensive wrap-around services. To serve C&Y with complex MH challenges and/or concurrent disorders, MCFD works with HAs to provide a range of services and supports, such as the early psychosis intervention program, intensive out-patient counselling including psychotherapy, medication therapy management, youth concurrent disorder therapists, adolescent outreach/assertive outreach services, Kelty Resource Centre, and specialized programs (e.g., eating disorders and concurrent disorders). HAs have 78 acute and tertiary youth psychiatric beds,<sup>3</sup> a range of residential facilities (e.g., Portage) and a number of community services that compliment MCFD services and MHSU services provided by other organizations.

### **DISCUSSION:**

As noted in the background section, CYMHSU services are provided by multiple organizations and in a variety of settings. In order to provide the best care possible attention must be paid to how C&Y are transitioned between different services and from one setting to another.

Children and youth ‘transitions’ can include:

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<sup>1</sup> Planning and Innovation Division, CERTS 2012\_0222

<sup>2</sup> Planning and Innovation Division, CERTS 2013\_0223

<sup>3</sup> Planning and Innovation Division, CERTS 2012\_0428 includes 14 eating disorder beds at BCCH

1. **Transitions between acute/inpatient care and community care.** Discharge planning is a key element of continuity of services from inpatient to community care and occurs in a variety of ways depending on the C&Y needs and severity. Tools that assist in supporting smooth transitions include: protocols between HAs and MCFD regions, joint service partnership models such as early psychosis intervention programs, protocols between hospitals and CYMH, joint health and MCFD committees and professional relationships

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Sect 13

2. **Transitioning from adolescence to adulthood** may result in both developmental and service challenges for youth. The Cross-Ministry Transition Planning Protocol for Youth Special Needs<sup>4</sup> outlines planning activities and provider roles for youth starting at age 14 who fall under the Child and Youth Special with Needs Framework<sup>5</sup>. MCFD regional and health authority level protocols were developed in 2002 to support the transition of youth with a mental illness to the adult system of care for those who require it.
3. **Transitions for concurrent disorders.** As youth SU services are primarily provided by HAs and the majority of MH services for youth are provided by MCFD, procedures are in place to facilitate smooth transitions for youth with concurrent disorders.

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## CONCLUSION:

Strengthening the CYMHSU system continues to be a priority.

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Sect 13 HAs and MCFD are increasing their use of tele-mental health to increase their capacity to serve clients in rural and remote locations. Through the Guidelines and Protocols Advisory Committee and the Practice Support Program, GP guideline and training for C&Y MH are being implemented

Sect 13

Sect 13

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: Joanne MacMillan, Mental Health & Substance Use  
Date: March 12, 2013  
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2013\Approved\HAD\966245 - Child and Youth Mental Health and Substance Use.docx

<sup>4</sup> [http://www.mcf.gov.bc.ca/spec\\_needs/pdf/transition\\_planning\\_protocol.pdf](http://www.mcf.gov.bc.ca/spec_needs/pdf/transition_planning_protocol.pdf)

<sup>5</sup> [http://www.mcf.gov.bc.ca/spec\\_needs/pdf/CYSN\\_FrameWorkForAction\\_Combo\\_LR.pdf](http://www.mcf.gov.bc.ca/spec_needs/pdf/CYSN_FrameWorkForAction_Combo_LR.pdf)

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 967826**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
- **FOR INFORMATION**

**TITLE:** Proposed Utilization of the Portage Program for Drug Dependencies (Portage)

**PURPOSE**

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**BACKGROUND:**

The Crossing at Keremeos (the Crossing) opened in January 2009 and is operated by Portage under contract with Vancouver Coastal Health Authority (VCHA) and Fraser Health Authority (FHA). It is a 42-bed, long term, tier 4 residential treatment centre for youth aged 14 – 18 years experiencing substance use problems.

In March 2008, the Ministry of Health (the Ministry) provided a \$2 million grant to the Central City Foundation to support construction and renovation of existing buildings and amenities on the site. In 2011/12, VCHA, FHA, and Interior Health Authority (IHA) provided a combined total of \$2.3 million in operational funding to the Crossing.

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With regard to governance, given the need for tier 4 beds is provincial, and Provincial Health Service Authority (PHSA) has current accountabilities with other provincial mental health/substance use facilities (e.g., Heartwood; Woodstone; Burnaby Centre), PHSA is well positioned to provide oversight and coordinate funding for the Crossing.

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Sect 13, Sect 17

Sect 13, Sect 17

## ADVICE:

Sect 13

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<b>Program ADM/Division:</b>	Barbara Korabek, ADM, Health Authorities Division
<b>Telephone:</b>	250-952-1049
<b>Program Contact:</b>	Ann Marr, Executive Director, Mental Health and Substance Use
<b>Drafter:</b>	Emily Arthur, Manager, Mental Health and Substance Use
<b>Date:</b>	March 8, 2013
<b>File Name with Path:</b>	Y:\MCU\DOCS PROCESSING\Briefing Documents\2013\Approved\HAD\967826 - Proposed
<b>Utilization of Portage Program for Drug Dependencies - Min Bfing Mar 12.docx</b>	

## MINISTRY OF HEALTH INFORMATION BRIEFING NOTE

Cliff # 971436

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health -  
**FOR INFORMATION**

**TITLE:** Update on Advocacy for Adults with Eating Disorders

**PURPOSE:** To provide an overview of the collaboration with representatives of the Provincial Advocacy Group for Eating Disorders.

### **BACKGROUND:**

The Provincial Advocacy Group for Eating Disorders (PAGED) is an organization of approximately 90 people with personal histories of eating disorders who raise awareness about eating disorders and advocate for enhancements to the system of care. PAGED's members maintain a website (<http://advocacyforadultsedinbc.webs.com>), participate in radio and television interviews, publish newspaper articles and consult with representatives of health authorities and the Ministry of Health (the Ministry).

In 2008, representatives of PAGED met with the Minister of Health and identified the need for improvements to the continuum of eating disorders services in BC. In response, in April 2009, the Ministry held a forum with a broad range of stakeholders including representatives of PAGED and, in collaboration with health authorities and the Ministry of Children and Family Development (MCFD), followed up in 2010 with the *Action Plan for Provincial Services for People with Eating Disorders* (the Plan). The actions in the Plan include the development of a provincial plan for secondary and tertiary eating disorders services including the redesign of the adult tertiary model of care at St. Paul's.

### **DISCUSSION:**

Since 2010, representatives of the Ministry, the Provincial Health Services Authority (PHSA), Vancouver Coastal Health Authority (VCH) and Providence Health Care (PHC) have consulted with representatives of PAGED through provincial forums and individual sessions around a number of key issues such a

Sect 13, Sect 17

These consultations with representatives of PAGED and other key stakeholders have resulted in a more streamlined out-of-province assessment and approval process and an improved, more client-centred approach to dealing with patients concerns at St. Paul's.

In 2012, PHSA and Ministry staff met with representatives of PAGED on numerous occasions to obtain input into the development of a service delivery model for adult tertiary care services. The development of the draft service delivery model has been developed through an evidenced-based process involving provincial, national and international experts; representatives from health authorities, MCFD and Ministry staff and then as indicated validated with patients, families and representatives of PAGED.

On February 15, 2013, PHSA staff oriented representatives of PAGED to the latest draft of the model and received positive feedback. Specifically, representatives of PAGED were supportive of the client-centered and integrated care approach, the inclusion of trauma-informed care, access to substance use services and Dialectical of Behaviour Therapy, and transition support to reintegrate patients back into the community.

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To obtain input from individuals with eating disorders in the regional planning process of secondary eating disorders services, health authorities are forming regional advisory committees – with representation from individuals, families, service providers and clinicians – that will provide input into these plans. Representatives of PAGED have been approached to recommend members for these committees.

Overall, representatives of PAGED are pleased with the opportunities they have had to provide input on the various initiatives. Their input has been well received by staff of the Ministry, PHSA, health authorities, PHC and MCFD and has resulted in enhancements to the system of care.

For more information on the status of the redesign of the provincial adults tertiary care eating disorders services, please see Briefing note Cliff # 969714.

**ADVICE:**

Continue the collaborative approach established between the representatives of PAGED and staff of the Ministry, PHSA, health authorities, PHC and MCFD to support enhancements to the system of care for people with eating disorders.

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Program ADM/Division:	Barbara Korabek
Telephone:	250 952-1049
Program Contact (for content):	Gerrit van der Leer, Acting Executive Director, Mental Health and Substance Use
Drafter:	Gerrit van der Leer, Director, Mental Health and Substance Use
Date:	March 18, 2013
File Name with Path:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2013\Approved\HAD\971436 Update on Advocacy for Adults with Eating Disorders Services.docx

## Cliff# 965813 – Minister’s Meeting

Sect 22

### Background

- The Minister’s Office has requested information on health issues relating to the landslide

The issues are:

Sect 22

- Health Care

Sect 14, Sect 22

- 

Sect 14, Sect 22

### Recommended Response

Sect 22

- Regarding ongoing mental health issues, the Disaster Psychosocial (DPS) Program run by the Provincial Health Services Authority (PHSA) is responsible for the development and provision of psychosocial strategies involving a *continuum* of supportive services, targeting those people, both public and responders alike, who are affected by an emergency or disaster. The DPS was activated on July 12 immediately following the disaster.
- DPS protocols include assessment of the mental health status of affected individuals as well as determining local community capacity for mental health services and coordination and provision of these and additional services as required.
- Oversight and coordination of these activities occurs until the DPS team determines that the local communities (i.e., health authorities) are able to continue to provide all necessary mental health services on their own.

# BACKGROUND

FOR IMMEDIATE RELEASE

October 4, 2012

## FACT SHEET: DELTA VIEW HABILITATION LTD. CONTRACT TERMINATION NOTICE

- In April 2012 Delta View Habilitation Ltd. (DVH) gave Fraser Health 365-days notice to terminate its contract to provide 71 tertiary level residential care beds for older adults with mental health and substance use problems effective March 31, 2013. Delta View subsequently granted Fraser Health a one month contract termination extension to April 30, 2013.
- Delta View Habilitation Ltd. (DVH) first entered into a residential service contract with Fraser Health in 2004 for 19 beds and added 52 beds in August 2007 as part of the Riverview redevelopment project.
- In 2010, a review of financial reporting by the Fraser Health contracts department identified that funding for “support costs” provided to DVH are significantly higher than those paid to other residential care service providers in Fraser Health.
- Support costs include laundry, gardening, food service, office, non-clinical supplies, upkeep of property and salaries that administrators pay themselves and their management team. Support costs do not include any costs associated with direct care for residents.
- Fraser Health had been negotiating with DVH to reduce the amount of funding for support costs to align with other residential care providers. Property costs were also reduced to reflect actual costs reported in Delta View financial statements; however, DVH said they could not longer operate a viable business with the requested funding reductions to support and property costs and gave Fraser Health 365 day termination notice on their Mental Health Residential Care service agreement.
- As a publicly-funded agency, Fraser Health has a responsibility to ensure that contracts are monitored and managed according to accepted standards.
- DVH has publicly stated that Fraser Health reduced the per diem paid to DVH for each resident from \$344 in 2007 to \$286 in 2012 forcing Delta View to provide care at below cost. This is not accurate. The amount of per diem DVH receives has remained the same; the only thing that has changed is who is paying it.
- In 2007, 64 patients from Riverview transferred to DVH as part of the Riverview redevelopment project. At that time, Ministry of Health policy required that Fraser Health pay the per diem costs on behalf of the Riverview clients. Per diems, which cover “room and board” expenses, are normally paid by residents. Over time, the number of former Riverview residents has decreased at DVH, and other clients have taken their place. There are now only nine Riverview clients remaining at Delta View.
- The new Delta View clients pay the per diem directly to Delta View. These funds have replaced the funds previously paid by Fraser Health on behalf of Riverview clients. As a result, Fraser Health reduced the per diems it has provided Delta View accordingly. Fraser Health continues to pay the per diem for the nine former Riverview residents remaining at Delta View. If Fraser Health continued to pay the per diem for all Delta View clients, DVH would be receiving the same payment twice.

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## BACKGROUND

- To address the previously noted funding discrepancies, Fraser Health proposed a <sup>Sect 17</sup> budget reduction, which would see Delta View continue to receive more than <sup>Sect 17</sup> in annual funding from Fraser Health in addition to the per diems collected from residents.
- The <sup>Sect 17</sup> budget reduction is comprised of a <sup>Sect 17</sup> reduction in property funding to reflect the actual costs reported by DVH and a <sup>Sect 17</sup> reduction in support funding to align with the standard maximum support per diem funded by Fraser Health residential care.
- DVH did not agree to the reduction and gave Fraser Health a 365-day contract termination notice.
- Fraser Health asked Delta View to extend its contract termination to three years to allow time for the development of a new, state-of-the-art owned and operated facility; however, Delta View declined this offer as it did not meet its business plans. This decision made it necessary for Fraser Health to move immediately to ensure that the ongoing care needs of these residents are met by securing temporary mental health residential care beds in existing facilities.
- Delta View Habilitation Ltd. is the only "for profit" provider of tertiary mental health services in Fraser Health's Mental Health and Substance Use portfolio and remains one of the highest funded contracted residential sites across the Fraser Health tertiary services continuum.
- Fraser Health also funds Delta View for 150 publicly funded residential care beds at Delta View Life Enrichment Centre. These beds and this contract are not affected.

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For media inquiries, please contact:  
Fraser Health Media Pager: 604-450-7881  
[media@fraserhealth.ca](mailto:media@fraserhealth.ca)

Visit [www.fraserhealth.ca](http://www.fraserhealth.ca) for more health news and information.  
Follow us: <http://twitter.com/Fraserhealth>



## CONFIDENTIAL BRIEFING NOTE

Oct. 3, 2012 – **Delta View Habilitation transition plan**

Fraser Health is opening 79 tertiary level mental health residential care beds for older adults with complex psychiatric and mental health care needs at Clayton Heights in Surrey and Highland Lodge in Langley to offset the loss of tertiary mental health beds resulting from Delta View Habilitation Ltd's decision to terminate its contract with Fraser Health.

### **Update: November 27, 2012**

- From November 27-29, FH MHSU will be mailing out letters informing neighbours of Highland Lodge that a specialized care program will be moving into the formerly housed Highland Lodge, now called Arbutus Place.
- This letter is sent as a form of community consultation which is required by MOH to designate Arbutus Place as a mental health facility.
- Arbutus Place is being requested to be designated as a "Provincial Mental Health facility" under the Mental Health act as it will be providing care to persons who have serious and persistent mental illness with age related disorders. Persons may need to be certified and detained under the mental health act at Arbutus place for treatment.
- The community consultation is a requirement as part of the process for designation as a provincial mental health facility.

### **Background:**

- In April 2012 Delta View Habilitation Ltd. (DVH) gave Fraser Health 365-days notice to terminate its contract to provide 71 tertiary level residential care beds for older adult mental health and substance use clients effective March 31, 2013. Delta View subsequently granted Fraser Health a one-month contract termination extension to April 30, 2013.
- Delta View Habilitation Ltd. (DVH) first entered into a residential service contract with Fraser Health in 2004 for 19 beds and added 52 beds in August 2007 as part of the Riverview redevelopment project for a total of 71 beds.
- In 2010, a review of financial reporting by the Fraser Health contracts department identified that funding for "support costs" provided to DVH are significantly higher than those paid to other residential care service providers in Fraser Health.
- Support costs include laundry, gardening, food service, office, non-clinical supplies, upkeep of property and salaries that administrators pay themselves and their management team. Support costs do not include any costs associated with direct care for residents.
- For the past 18 months, Fraser Health has been negotiating with DVH to reduce the amount of funding for support and property costs to align with other residential care providers and reflect actual costs reported in Delta View financial statements.
- To address these funding inequities, Fraser Health proposed a budget reduction of Sect 17 his was following negotiations with Delta View where concessions were made by Fraser Health to address concerns about sufficient funding for professional staffing wages and model of care Sect 17

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- The new proposed budget for 2012 / 2013 was to be <sup>Sect 17</sup> budget reduction. This new budget also includes nine additional Residential Care beds being transferred to MHSU that reside in the Delta View Habilitation building. The <sup>Sect 17</sup> reduction is broken down as follows <sup>Sect 17</sup> for support costs and <sup>Sect 17</sup> or property costs.
- Delta View remains one of the highest funded contracted sites across the Fraser Health network.
- Delta View is the only "for profit" provider of Tertiary Mental Health Services in Fraser Health's Mental Health and Substance Use portfolio.
- Delta View advised Fraser Health that it is not willing to accept this funding reduction and gave 365 days notice to terminate the contract effective March 31, 2013. Delta View subsequently granted Fraser Health a one-month contract termination extension to April 30, 2013. This notice period is within the terms of the contracts and is compliance with all contractual and regulatory requirements.
- Fraser Health asked Delta View to extend its contract termination to three years to allow time for the development of a new, state-of-the-art owned and operated facility; however, Delta View declined this offer as it did not meet its business plans. This decision made it necessary for Fraser Health to move immediately to ensure that the ongoing care needs of these residents are met by securing temporary mental health residential care beds in existing facilities.
- Fraser Health will proceed with plans to develop an owned and operated facility; details and timelines for that project will be announced at a later date.
- Delta View agreed to work with Fraser Health to coordinate the transfer of services to another location in order to cause as little disruption as possible for residents.
- Fraser Health transition team has had several meetings with DVH staff and residents/families and on Sept. 28, 2012 a letter was sent to DVH residents and families informing them that Fraser Health is opening 79 tertiary level mental health residential care beds for older adults with complex psychiatric and mental health care needs at Clayton Heights in Surrey and Highland Lodge in Langley to offset the loss of tertiary mental health beds resulting from Delta View Habilitation Ltd's decision to terminate its contract with Fraser Health.
- Physicians and a multidisciplinary transition team will work with Delta View staff, residents and family members to determine the best placement to meet the clinical needs of each resident displaced by the Delta View contract termination notice.
- Transfers will begin in November 2012 following individual meetings with residents and family members and will be completed by the end of April 2013.
- Clayton Heights is a new, purpose-built facility that also has a contract with Fraser Health to provide 166 complex residential care beds as well as a 15-space residence for young adults with acquired brain injuries. In addition to these services, Clayton Heights will provide a 29-bed tertiary behavioural stabilization program for older adults.
- Highland Lodge is an older facility that will undergo \$500,000 in renovations before residents move in next spring. Highland Lodge will be funded to provide a 50-bed tertiary behavioural stabilization program for a total of 79 tertiary mental health residential care beds between the two sites.
- Further details about Highland Lodge renovations will be available after Facilities staff complete detailed plans for the renovations, which is now ongoing.
- Both facilities will provide specialized mental health care for older adults with all staff trained in Person-Centered Care, a similar model of care to what is currently provided at Delta View. As well, the staff will benefit from opportunities to connect and collaborate

with the care team at Fraser Health's nationally-recognized Czorny Alzheimer Centre in Surrey.

- Residents will receive the same high-quality care as is currently provided at Delta View and the current physician group will continue to provide care in the new locations.
- Fraser Health also funds Delta View for 150 publicly funded residential care beds at Delta View Life Enrichment Centre. These beds and this contract are not affected.
- Delta View will also continue to operate private pay residential care beds at both Delta View Habilitation Centre and Delta View Life Enrichment Centre.

### **Per Diem Funding**

- In 2007, 64 patients from Riverview transferred to DVH as part of the Riverview redevelopment project. At that time, Ministry of Health policy required that Fraser Health pay the per diem costs on behalf of the Riverview clients. Per diems, which cover "room and board" expenses, are normally paid by residents. Over time, the number of former Riverview residents has decreased at DVH, and other clients have taken their place. There are now only nine Riverview clients remaining at Delta View.
- The new Delta View clients pay the per diem directly to Delta View. These funds have replaced the funds previously paid by Fraser Health on behalf of Riverview clients. As a result, Fraser Health reduced the per diems it has provided Delta View accordingly. Fraser Health continues to pay the per diem for the nine former Riverview residents remaining at Delta View. If Fraser Health continued to pay the per diem for all Delta View clients, DVH would be receiving the same payment twice.

### **Key Messages:**

- After many months of negotiations, Delta View Habilitation Ltd. made a business decision to terminate its contract with Fraser Health.
- Once we received contract termination notice, our focus shifted from contract negotiations to planning for the ongoing care needs of these residents. We cannot allow an operator to use contract termination notice as a bargaining tactic as this creates uncertainty and instability for vulnerable residents.
- There will be **no** reduction in the level of service or the number of mental health beds.
- Fraser Health had been negotiating with Delta View to reduce support costs to bring funding for support costs in line with other service providers. Support costs include laundry, gardening, food service, office, non-clinical supplies, upkeep of property and salaries that administrators pay themselves and their management team. Support costs **do not** include any costs associated with direct care for residents.
- Fraser Health made significant concessions during negotiations,

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- Fraser Health is opening 79 tertiary level mental health residential care beds for older adults with complex psychiatric and mental health care needs at Clayton Heights in Surrey and Highland Lodge in Langley to offset the loss of tertiary mental health beds resulting from Delta View Habilitation Ltd's decision to terminate its contract with Fraser Health.
- Clayton Heights and Highland Lodge will provide specialized mental health care for older adults with all staff trained in Person-Centered Care, a similar model of care to what is currently provided at Delta View.

- Transitions teams will now work with Delta View staff, residents and family members to determine the best placement to meet the clinical needs of each resident displaced by the Delta View contract termination notice. Transfers will begin in November 2012 following individual meetings with residents and family members and will be completed by the end of April 2013.
- We recognize that moving to a new location, even if the level of service being provided remains the same, can be difficult and we are committed to working one-on-one with residents throughout the transition process and we are hopeful that the end result will be better care for these residents. Individual transition plans will be developed for each resident.

Contact information			
Contact	Name	Title	Phone
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Communications	Roy Thorpe-Dorward	Senior Consultant, Public Affairs	604-587-4612

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 955969**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
**- FOR INFORMATION**

**TITLE:** Amending Letter of Intent with Canadian Blood Services

**PURPOSE:** Canadian Blood Services and the Provinces and Territories have agreed to amend certain terms of their Letter of Intent with regard to funding contributions for Organ and Tissue Donation and Transplantation.

**BACKGROUND:**

In April of 2008, the Federal, Provincial and Territorial Ministries of Health gave Canadian Blood Services (CBS) a five-year mandate for organ and tissue donation and transplantation. This mandate included the following four areas:

1. System design;
2. Supporting leading practices/public awareness and education;
3. System performance; and
4. Patient registries.

Funding for CBS's role has been provided by the Federal Government through Health Canada (Contribution Agreement) and the Provincial and Territorial (PT) Ministries (Letter of Intent) through annual matching contributions of \$3.58 million (total \$7.16 million annually) for the fiscal years 2008/09 to 2012/13.

During this time, CBS has been a partner in advancing Organ and Tissue Donation and Transplantation (OTDT) in Canada and has facilitated over 126 living paired transplants as a result of the Living Donor Paired Exchange Registry. In 2012/13, the last year of the current mandate, CBS has implemented the National Organ Waitlist and will implement the Highly Sensitized Patient registry, further improving Canadian patient access to donations.

**DISCUSSION:**

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**ADVICE:**

Sect 13, Sect 16

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<b>Program ADM/Division:</b>	Nichola Manning, ADM, Medical Service and Health Human Resource Division
<b>Telephone:</b>	(250) 952-3465
<b>Program Contact (for content):</b>	Jane Crickmore, Executive Director, LDBS Branch
<b>Drafter:</b>	Janet Carter, Manager, Blood Services
<b>Date:</b>	December 24, 2012.
<b>File Name with Path:</b>	Z:\LDBSB\Briefing Notes\Blood\2012\955969 I-BN Amended Letter of Intent.docx

Pages 80 through 83 redacted for the following reasons:

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Sect 13, Sect 16



**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 962475**

**PREPARED FOR:** Dr. Margaret MacDiarmid, Minister of Health  
- **FOR INFORMATION**

**TITLE:** Emergency Room Coverage and Physician Recruitment,  
Princeton General Hospital

**PURPOSE:** Provide the Minister with background information in preparation for the teleconference with His Worship Frank Armitage, Mayor of Princeton.

**BACKGROUND:**

As a community, Princeton would benefit from a team of four physicians who would share the responsibilities for providing on call support for hospital emergency department services, support for hospital inpatient services as well as providing primary care services in the community.

The challenge for Princeton has been the recruitment and retention of permanent physicians in the community.

Currently there are three physicians practicing in Princeton; however, only two are willing to provide hospital ED services. Four physicians are likely required to provide stable, 24 hour public access to hospital ED coverage.

**DISCUSSION:**

- A number of changes to rural programs have recently been made that are specifically targeted to helping communities like Princeton:
  - Effective September 1, 2010, health authorities (HAs) may now apply for locum support for vacant positions in their Physician Supply Plan when it is causing serious health care service access problems and/or an unreasonable workload on existing physician(s) in a rural community. These enhancements have further strengthened medical coverage for BC's more isolated and vulnerable communities.
  - Under the Recruitment Incentive Program, increased incentives were introduced effective April 1, 2010, to incent physicians to relocate to more rural and vulnerable communities like Princeton. Physicians recruited to a vacancy identified in the Physician Supply Plan receive different incentive amounts depending on the degree of isolation of the community (A communities = \$20,000; B communities = \$15,000; C communities = \$10,000; D communities = \$5,000). Princeton is designated as an "A" community.
  - Under the Rural General Practitioner Locum Program, effective October 1, 2008, physicians offering locum services are now compensated at different rates depending on the degree of isolation of the community and on the additional skills they provide in rural hospitals.

- The Rural Emergency Enhancement Fund (REEF) – was developed and announced by the Joint Standing Committee on Rural Issues (JSC) on July 18, 2011, to encourage physicians to provide stable public access to hospital emergency services in communities like Princeton. The REEF program will provide up to \$200,000/annum to groups of rural physicians who collectively commit to maintain 24 hour per day public access to local, hospital ED.
- In 2012/13, sufficient physician commitment could only be found to provide 24 hour public access to Princeton hospital ED services from May 1, 2012, to March 31, 2013, from Saturday to Monday (inc. STATS). From Tuesday to Friday public access to ED services had to be limited – from 8:00 a.m. to midnight. The REEF program provided \$164,923 to support the more limited public access to ED services that physicians were willing to commit to.
- In addition to the incentives available through BC's provincial, rural, physician programs, the Ministry has been funding, additional, supplemental physician locum support to help stabilize Princeton's primary care and ER services. In 2009/10 the Ministry provided 243 days of additional locum support at a cost of approximately \$110,000. In 2010/11, the Ministry provided 189 days of additional locum support at a cost of approximately \$96,259. In 2011/12, the Ministry provided 63 days of additional locum support at a cost of approximately \$44,138.
- Currently Health Match BC has two permanent family practitioner vacancies and one temporary physician locum opportunity posted on their website for Princeton.
- Interior Health Authority (IHA) is continuing to work very closely with the community to support Princeton's health services. A joint steering committee that includes members from IHA as well as the Town Council and the Regional District and a community representative has been established. At the most recent meeting the committee discussed the following:
  - A new physician has signed a contract to begin work in Princeton in August 2013.
  - IHA is in discussions with a few other physicians who might be interested in relocating to Princeton.
  - With a goal to expand beyond a focus only on physicians to other health care providers, there was an announcement of the recruitment of a new physiotherapist to the community – filling a position that has been vacant for 3 years.
  - IHA has informed this joint steering committee of its plans for some new capital expenditures for the Princeton General Hospital to demonstrate its commitment to ongoing running of the hospital in the community.
  - The community has been very involved with supporting locums and potential new physician recruits in several ways (i.e. by providing some accommodation, developing an introduction package to the community).
- See Attachment for Recent Events.

## ADVICE:

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Program ADM/Division: Nichola Manning, ED, Medical Services and Health Human Resources  
 Telephone: 250-952-3166  
 Program Contact (for content): Rod Frechette, ED, Physician Human Resource Management  
 Drafter: John English, Director, Physician Compensation  
 Date: January 30, 2013 File Name with Path: z:\phrm arc\adminin 100-499\executive 280\20 bn's\2013\962475 - emergency room coverage and physician recruitment at princeton general hospital.doc

**RECENT EVENTS:**

On January 23, 2013, the Interior Health Authority

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physician in the community, Sect 22

an interim plan was quickly put in place to move the ER to Life and Limb Threatened Organ until other measures could be enacted.

The physicians on the Rural Emergency Enhancement Fund contingency planning list were called at

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Meanwhile site administration and medical administration worked hard at finalizing privileges

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December 20, 2012

949550

His Worship Frank Armitage  
Mayor of the Town of Princeton  
PO Box 670  
Princeton BC V0X 1W0

Dear Mayor Armitage:

It was a pleasure meeting with you during the Union of British Columbia Municipalities convention in Victoria, and having the opportunity to discuss issues of importance to the people of Princeton.

I appreciate the challenges of attracting and retaining physicians in smaller communities like Princeton. The Government of British Columbia, in collaboration with the British Columbia Medical Association, has developed a comprehensive set of programs to encourage physicians to live and practice in rural BC communities like Princeton. A summary of these programs can be found at <http://www.health.gov.bc.ca/pcb/rural.html>.

Interior Health Authority (IHA) and other health authorities are working with communities to develop comprehensive approaches to physician recruitment. Physician recruiters work with Health Match BC to provide coordination and support to local communities. As physicians trained in rural areas are more likely to return to practice in their training community after graduation, the government has also set up the Southern Medical Program as a key component of the expansion of the University of British Columbia's medical school.

As you are aware, IHA continues to work closely with the town, local physicians and the area's elected officials to examine all the options available so that, together, a strategy can be developed. The goal is to recruit and retain physicians to the community and establish a long term plan in order to resume 24/7 coverage to Princeton General Hospital's emergency department. It is expected that the interim plan may need to be in place for approximately one year while longer term solutions are sought.

I encourage you to continue to work with IHA as part of your physician recruitment efforts, and in addressing issues with respect to emergency room coverage.

Yours truly,

**ORIGINAL SIGNED BY:**

Margaret MacDiarmid  
Minister

## MEETING MATERIAL

**Cliff #:** 966644

**PREPARED FOR:** The Honourable Dr. Margaret MacDiarmid, Minister of Health, for a meeting with her constituent, Kent Chan-Kent and Marie Little, Chair of the Trans Alliance Society (TAS), on March 15, 2013.

**TITLE:** Minister MacDiarmid is meeting with Kent Chan-Kent and Marie Little to discuss transgender rights.

**MEETING REQUEST/ISSUE:** This meeting was requested by Kent Chan-Kent to discuss transgender rights and funding for transgender people outside of the Vancouver area. Mr. Chan-Kent has also requested that Mary Little also attend the meeting.

**SHOULD MINISTRY STAFF ATTEND THIS MEETING:** No

### BACKGROUND:

The Minister's Office has requested information on the TAS and the role of the Trans Health Collective.

- TAS is a province-wide coalition, bringing individuals and groups together to inform and work on transgender issues. Work of the coalition includes:
  - forums and resources to assist in the personal development, growth, and contact of its members within the transgendered community;
  - promoting knowledge and understanding of the transgender culture;
  - building a sense of community through contact with other organizations or individuals sharing similar objectives; and
  - working towards removing all forms of barriers that negatively impact the transgendered community.
- Staff in the Health Authorities Division (HAD) have had discussions with Marie Little to address questions and concerns regarding the Transgender Health Program (THP) operated and funded through the Vancouver Coastal Health Authority (VCHA). HAD has also prepared an Information Briefing Document regarding the release of the VCHA internal review of the THP to its advisory group. Copies of the briefing document, internal review and related correspondence are enclosed for reference
- The THP provides the following services and supports:
  - a resource hub that provides information to anyone in BC with a transgender health question;
  - provides health care professionals who specialize part of their practice in transgender health care to build capacity in the local communities;

- provides primary care access for transgendered persons living in the Vancouver Coastal Health (VCH) Region (Vancouver, Richmond, North Shore, and Coastal/Rural) requiring diagnosis, hormone readiness assessment, and related health care services;
  - these services are provided to those living in the VCH Region out of three sites: Three Bridges Clinic, Raven Song, and Pender Clinic; and,
  - youth (under the age of 25), refugee claimants, those with complex mental health diagnoses, and individuals with post-operative complications, who *live outside the VCH Region* are given special consideration regarding access on a case by case basis. This may include referral to another health care provider or organization.
- The Medical Services Plan (MSP) insures and pays for physician services for BC residents. This includes services related to sex reassignment surgery (SRS) such as psychiatric assessments, family physician visits, specialist visits (e.g. endocrinologists), surgeon's fees, surgical assistant fees, anesthetic fees, and physician-requisitioned laboratory services.
  - Currently MSP insures the following SRS services, on a pre-approval basis: female to male services include bilateral subcutaneous mastectomy (with contouring), hysterectomy, oophorectomy, and phalloplasty/metaioplasty. Male to female services include vaginoplasty (penectomy, orchidectomy) and breast augmentation (under specific conditions).
  - SRS is a highly specialized field, with a very small number of qualified specialists who perform these complex procedures.
  - The Ministry of Health (the Ministry) is currently working to increase access to qualified assessors for patients and clients requesting SRS in BC
- Sect 13
- Sect 13
- Currently the Ministry has no outstanding issues or working relationship with the Trans Health Collective.

**Program ED/Branch/Division:** Stephanie Power, ED, Medical Services Branch, MSHHRD

**Date:** March 7, 2013

**File Name with Path:** K:\CRU - MSP\2013\Green Folder\Meeting Material 2 - Transgender Health 966644.docx



967301

Dear Honourable Minister MacDiarmid,

As a follow-up to our meeting on Friday, February 8, 2013, regarding the BC Care Aide and Community Health Worker Registry review, the attached materials are being provided to support our upcoming discussion on the recommended response to the report:

- The original meeting materials (the review report and briefing materials for recommended response to the report);
- More detailed background on the Registry's genesis and the intent to review;
- The Ministry of Health's proposed action plan in response to the final recommendations.

Sincerely,

Sandra Carroll  
Associate Deputy Minister  
& Chief Operating Officer

*XREF 965606 966065*

## MINISTRY OF HEALTH INFORMATION BRIEFING NOTE

Cliff # 965606

**PREPARED FOR:** Honourable Dr Margaret MacDiarmid, Minister of Health  
– FOR INFORMATION

**TITLE:** Recommendations from the Review of the BC Care Aide Registry

**PURPOSE:** To provide information regarding the recommendations in the final report from the external review of the BC Care Aide Registry (the Registry) and next steps.

### **BACKGROUND:**

The Registry was first established in January 2010, as a response to elder abuse incidents that received widespread public attention. It was developed very quickly, with a mandate to protect vulnerable patients as well as to develop minimum standards of education and skill among health care assistants (HCAs). Implementation has been a phased approach. The primary area of development for 2012/13 includes the education recognition process, as well as essential database and web portal upgrades.

The intent to review the Registry's operations was publicly announced by the Honourable Minister de Jong in June 2012. The announcement was primarily a response to 2012 BC Care Providers' Association (BCCPA) AGM resolutions that questioned the effectiveness of the Registry and called for a review, as well as findings in the Ombudsperson's Report on Seniors from earlier in the spring. Additionally, pressure came from media attention on a Registry-investigated case of alleged abuse in which a family member demanded (and was denied) a copy of the confidential Registry investigation report.

The final report was received on February 1, 2013 (see Appendix A). Recommendations in the report are guided by the comments and concerns raised by interviewees, focusing largely on gaps in the Registry's mandate to prevent elder abuse, the cost of investigations, and uncertainty regarding the legitimacy and extent of the Registry's authority. The final recommendations are:

**Recommendation 1:** The Ministry of Health (the Ministry) should review the suitability of the enabling framework under which the Registry exists/operates (i.e., the Letter of Understanding and 'Appendix A') with particular attention to mandate clarity/focus, the implications for the Registry's scope (e.g., inclusion of private sector employers/employees) and ability to ensure the participation of employers and HCAs.

### **Advice:**

- Agree - enabling framework will be strengthened, private sector will be included.
  - The Registry framework should consider organizations that operate in both unionized and non-unionized environments.
- Continue with full implementation in the publically funded sector while developing mechanisms to mandate private employer/employee participation (possible avenues to include requirements to demonstrate Registry compliance as a condition of licensure, and revisions to clinical oversight requirements in the *Community Care and Assisted Living Act*)



**Recommendation 2:** The Ministry should ensure an appropriate governance structure exists for the Registry and that, within the context of the Registry's enabling framework, it is vested with the necessary authority to pursue the Registry's objectives and to establish a management structure charged with implementing strategic direction, developing operating policy/procedure, etc.

**Advice:**

- Agree - governance/management structure will be clarified and improved
- There is no legal authority to create a Board at this time. In the interim, the Registry Advisory Committee should be engaged and a Ministry representative added to the council

**Recommendation 3:** The Ministry should take steps to redress current gaps in the Registry's protection mandate. Minimally, this would include: addressing the exclusion of private sector HCAs; establishing an oversight role related to abuse accusations handled outside the Registry's investigation process; eliminating loopholes (e.g., resignation of an accused HCA) that frustrate the Registry's ability to investigate; broadcasting Registry suspensions to employers; and compelling HCA registration as a condition of employment and employer participation in Registry investigations, etc.

**Advice:**

- Agree - however a strengthened protection mandate will require union discussions as well as clarity and improvement on registry's ability to deal with potential offenses, investigations and employer notification
- Privacy concerns will need to be identified and addressed pertaining to broadcasting cases of alleged abuse, broadcasting suspensions to employers and requiring HCAs to identify past suspensions, terminations or disciplinary action at the time of registering.
- The Registry should move forward to implement criminal records checks as part of the Registry's application process

**Recommendation 4:** The Ministry should review the Registry's funding model with a view to ensuring a sustainable funding base as well as an equitable allocation of expenses. Given that the Registry's intent parallels, in some dimensions, the function of a regulatory college, and given that the Registry's creation is in part a response to failed human resource processes, charges to registrants and employers cannot be precluded. Existing inequities related to investigation costs (e.g., higher costs for facilities geographically distant from investigators and no costs for non-union facilities) should also be addressed.

**Advice:**

- Agree - however, funding sources for registry will need to be found.
- Establishing a user fee will raise concerns for both registrants and employers.

**DISCUSSION:**

The Registry represents an important contribution to the Seniors Action Plan and Elder Abuse Prevention Strategy, and its abuse prevention mandate will not be fulfilled until all employers are participating fully in the investigative process. The mandate to include private employers, however, will be a longer-term process given the size and complexities involved. Mechanisms that may be utilized include requirements to demonstrate Registry compliance as a condition of licensure, and revisions to clinical oversight requirements in the *Community Care and Assisted Living Act*.

Recommendations involving gaps in the Registry's operations and need for equitable funding are expected to draw heavy criticism from unions. Union members on the Registry Advisory Committee – representing the Health Employers Union and the BC Government Employees' Union – are of the opinion that the Registry is operating as intended and is not in need of any changes. The agreement between the unions and the Health Employers Association of BC (HEABC) will need to be renegotiated, and matters pertaining to the type of registrant information the Registry may collect and share – as well as its ability to collect fees – will be at issue.

**ADVICE:**

The issues raised in the report constitute concerns as to the Registry's ability to fulfil its mandate of abuse prevention – a message that was also expressed in the Ombudsperson's Report on Seniors' Care, released earlier in 2012. Given the public attention the Registry has gained over the past year, combined with the Ministry's work on the Seniors Action Plan and Elder Abuse Prevention Strategy, going ahead with the four proposed recommendations for the Registry is advised.

The report is currently available for public release. The Ministry will commit to developing an action plan to address its response to the four recommendations. In the interim, work will continue on completing the implementation of HCAs in the publicly funded health care system.

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**Program ADM/Division:** Nichola Manning, ADM, Medical Services & Health human Resources Division  
**Program Contact:** Sharon Stewart, ED, Health Human Resources Planning  
(Nursing & Allied Health Professions)  
**Telephone:** 250-952-3656  
**Drafter:** Katelyn Ranger  
**Date:** February 7, 2013  
**File Name with Path:** Y:\MCU\DOCS PROCESSING\Briefing Documents\2013\Pending\965606 - Recommendations from the Review of the BC Care Aide Registry.docx

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

Cliff # 966065

**PREPARED FOR:** Honourable Dr Margaret MacDiarmid, Minister of Health  
– **FOR INFORMATION**

**TITLE:** Background on the BC Care Aide Registry

**PURPOSE:** Detailed Background on the BC Care Aide & Community Health Worker Registry and the Registry Review

**OVERVIEW:**

The BC Care Aide and Community Health Worker Registry (the Registry) mandate is to protect vulnerable adults from abuse by caregivers while receiving care in a variety of settings in BC, and to ensure high quality service and standards of care among the care aide and community health worker occupations. The Registry is offered to all care aides and community health workers who are employed or wish to be employed in BC by a publicly-funded employer.

Although the Registry is not embedded in legislation or regulation, public employers are required to report every suspension or termination for alleged client, patient and/or resident abuse to the Registry. Publicly funded employers listed with the Registry must not employ care aides who are not active registrants on the Registry.

As the first of its kind in Canada, implementation of the Registry was set up as a phased in approach; this allowed the process of registering and investigating allegations of abuse to occur quickly while developing other longer term activities requiring significant stakeholder participation (e.g. educational review process).

On June 20, 2012, the Honourable Minister de Jong announced a detailed review of the Registry would be completed by the fall and committed to making any changes necessary to ensure that "residents, patients, their families and the care homes themselves have the confidence to know the registry is operating as it was intended to"<sup>1</sup>. This announcement was predicated by a number of issues occurring in the system, including:

- the Ombudsperson's report *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*, released February 14, 2012, that included a recommendation to protect seniors through consistent reporting and tracking of abuse and neglect;
- resolutions made by the BC Care Providers Association (BCCPA) which included asking the Minister of Health to initiate an independent review of the Registry; with findings and proposed actions to be tabled by the end of the year; and
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<sup>1</sup> <http://www.theglobeandmail.com/news/british-columbia/bcs-elder-caregiver-registry-to-face-review/article4358946/>

*Improving Care for B.C. Seniors: An Action Plan* identified six action themes, including prevention. The draft *Elder Abuse Prevention in BC: A Blueprint for Action*, identifies building on the review of the BC Care Aide Registry to protect persons in care as one of the actions going forward.

#### REGISTRY GENESIS:

- In 2008, a small number of elder abuse incidents in the public care homes received widespread media attention. In response, the Honourable Minister Abbott committed to establishing a mechanism to track and respond to behavioral “transgressions” for unregulated HCAs in cases of alleged abuse.
- The development of the Registry took place expeditiously. During 2009, the Ministry of Health (the Ministry) consulted with employers, unions, educators, and Health Employers Association of BC (HEABC) to establish the model and responsibilities for the Registry. These consultations lead to the decision the Registry’s mandate should include:
  1. Protection of vulnerable patients/clients under the care of HCAs;
  2. Assurance of minimum levels of training for all HCAs;
  3. Resources for HCAs, including career opportunities and professional development activities.
- The Registry’s consent form, investigative and removal process was negotiated by HEABC, and the Facilities Bargaining Association and Community Bargaining Association.
- The Registry first went live in January 2010, and was housed at Health Match BC, under the umbrella of HEABC. Due to the limited development timeframe and resources allotted, a phased approach to reach full mandate was undertaken.
- The goal is to have the Registry and the related supports/services behave similarly to the registry function of a professional college. The Registry is intended to support and improve quality care, training, access to employment and the recognition of care aides and community health workers.
- The Registry’s purpose is not to discipline care aides. It will only register, suspend or remove registrants in response to an employer’s action to suspend or terminate an employee for alleged abuse of a patient, resident or client. Public employers are required to report every suspension pending investigation for alleged abuse or termination of an employee for alleged abuse. The removal of a registrant from the Registry will affect ability to hold employment as a HCA.
- There is a non-binding appeal process for removed individuals. Removal may be for a limited time period with conditions, or it may be permanent depending on the employers proposed resolution or the findings of an appointed special investigator and/or arbitrator. All investigations are confidentially managed with the employer, union, and the employee. To date, 45 cases have gone to an outside third party investigator appointed by the Registry (see Appendix 1).
- From January 29, 2010 – April 29, 2010 publicly employed HCAs, upon consent, were grandparented into the Registry and did not require formal assessment of credentials. Post April 29, 2010, all individuals must submit proof of completion at an accredited BC health care assistant training program, or an equivalent.

- Though private employers have not been mandated to participate in the Registry, some private employers have participate voluntarily.
- The Ministry currently provides funding to support the Registry (\$500,000 annually). HCAs do not pay to be registered nor do employers pay to access data on the Registry. Costs of investigations are shared between the employer and union. This was done so both parties had vested interest in the investigation procedure. For facilities that are not unionized, the Registry covers full costs.
- Once fully operational, the Registry will provide content related to support services and key information for care aides, schools and employers, such as support for career mobility and educational opportunities.

#### **RECENT ACTIVITIES AND INTENT TO REVIEW:**

- 2011 was the first full year of the Registry's operations, and during this time sustainable funding was secured.
- The BCCPA 2011 Annual General Meeting (AGM) passed resolutions questioning the equity of cost sharing for employers in the Registry's investigative process.
- A HCA Education Advisory Group was established in 2011 to recommend:
  - 1) Education standards and monitoring of delivery for HCA programs in BC for both public and private sector educators;
  - 2) Formal structures, mechanisms and guiding principles to support a provincially mandated authority that will be responsible for the implementation of policies and processes for appraisal and recognition of BC HCA programs; and
  - 3) Processes for assessing, recognizing and registering qualified care aides and community health workers from outside BC and Canada.
- On January 17, 2012, the BCCPA met with members of the Ministry, HMBC and Registry staff to maintain ongoing dialogue about the Registry's development.
- On February 14, 2012, the BC Ombudsperson released a special report on seniors which contained findings and recommendations specifically pertaining to the Registry, including doubt regarding the Registry's effectiveness and a call to include the private sector in its mandate.
- The Honourable Minister de Jong provided the opening remarks at the May 2012 BCCPA conference and stated the Ministry would ensure that strategies and measures are in place to prevent and protect seniors from abuse and neglect. The AGM resolutions echoed the findings of the BC Ombudsperson report and continued to question investigation costs to employers. The BCCPA encouraged the Minister of Health to conduct a review of the Registry and requested that the findings and proposed actions be tabled by the end of the year.
- In April 2012, the Registry undertook essential web portal and database upgrades and re-design, as well as developed educational processes for employers and registrants.
- In an June 21, 2012, interview with the Globe and Mail, the Honourable Minister de Jong announced the Ministry's intent to review the Registry's operations to ensure the public protection mandate was being met.
- In July 2012, the HEU wrote the Honourable Minister de Jong and expressed concerns regarding his announcement of the registry review; including the fact that no concerns with the investigative process had been brought to the Registry's advisory committee attention. In August 2012, the BCGEU wrote a similar letter. The Unions were advised that the

independent review was intended to provide an opportunity to build on existing successes, as well as identify potential gaps and was not intended to be a mechanism by which previous and ongoing collaborative efforts would be invalidated.

- On December 15, 2012, the Ministry received a Freedom of Information (FOI) application requesting the release of the report. The request was denied under Section 20 of the *Freedom of Information and Protection of Privacy Act*, citing the report would be released to the public within the next 60 business days (March 19, 2013).

#### **REVIEW PROCESS AND TIMING**

It was important that the Ministry contract with individuals that would be seen as unbiased by both the Unions, as well as the BCCPA. Dr Vicki Foerster and Mr James Murtagh were selected based upon previous reviews completed for the ministry. In their review, Dr Forester and Mr Murtagh were asked to cover the following 9 areas:

1. Registry role and mandate
2. Occupations included in the Registry
3. Registration eligibility
4. Information collected on registrants
5. Impact of non-registration on currently employed HCAs
6. Registry costs to HCAs
7. Access to the Registry database
8. Registry suspension and removal process
9. Governance

Initially the interviews and final report were to be completed by Fall 2012; however, due to complexity of the issues being addressed; the level of interest in participating in the review process; as well as concerns raised by the Unions, the Ministry agreed to an extension to ensure that all key stakeholders had a chance to voice their opinions. Between September and October, 2012, over 50 stakeholder semi structured interviews were conducted from three broad groups: (a) Registry architects, overseers and staff members; (b) potential users of the Registry, e.g., managers; and (c) investigators and managers from investigated sites.

The draft report was presented to the Ministry November 22, 2012 for review and comments. Internal reviews of the report were conducted by the various program areas that would be impacted by recommendations flowing from the report until January 17, 2013. During this period, discussions regarding the response to the recommendations also occurred, with special attention paid to the assessment of broadening the Registry to include both privately and publically funded organizations. Questions and points of clarification were submitted to the authors and the final report was submitted to the Ministry February 1, 2013.

Prior to the release of the report, it is recommended that meetings with the union bargaining associations, HEABC, the BCCPA and the Registry Advisory Committee be conducted to share information on the report and the Ministry's response.

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**Date:** February 22, 2013  
**File Name with Path:** 966065 MINISTER BN Background on the BC Care Aide Registry -FEB 22.docx

# Background Numbers

966065 Appendix 1

Year	2010	2011	2012	Total
Number of registrants	33,858	5,277	5,330	44,465
Alleged abuse cases reported	19	47	72	138
Terminations for abuse	13	29	40	82
Suspensions for abuse	6	18	32	56
Registry investigations	7	20	18	45
HCA's permanently removed from the Registry after an investigation	1	4	2	7
HCA's reinstated to the Registry after an investigation and remedial conditions fulfilled by the HCA	5	9	9	23
HCA's reinstated to the Registry after an investigation with no remedial conditions imposed	1	7	7	15
HCA's removed with no Registry investigation and no dispute by the union or the individual	6	9	22	37
The union and the employer resolved the issue at stage 3 of the grievance procedure	0	4	6	10

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Pages 100 through 101 redacted for the following reasons:

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S. 13, S. 17

## **Review of the BC Care Aide & Community Health Worker Registry: An Action Plan**

### **Introduction**

In January of 2010, British Columbia became the first province in Canada to implement a registry for care aides and community health workers – also known as Health Care Assistants (HCAs) – with a mandate to protect the public. The BC Care Aide and Community Health Worker Registry (the Registry) was developed as a safeguard for vulnerable British Columbians under the care of HCAs. Currently, registration with the Registry is a requirement for employment with all publicly-funded employers, though some private employers have opted to participate voluntarily.

The Registry's role is to track and respond to cases of alleged abuse, as well as to ensure minimum levels of training and provide professional development resources for HCAs. The Registry's model was developed in partnership with the Health Employers Association of BC, and in consultation with health employers, educators, and unions. Since its onset, implementation of the Registry has been a phased approach.

In order to fulfill the Registry's patient protection mandate, employers are required to report instances in which an HCA is suspended or terminated for allegations of abuse. Upon receiving this report, the HCA is removed from the Registry until either the incident is investigated by the Registry or resolved through the union grievance process. If the matter is resolved and the HCA is found not to have committed abuse that merits removal from the Registry, they are reinstated. If a lesser infraction is found, the HCA may be required to complete further education or training before being reinstated on the Registry. However, if abuse that merits removal occurred – or goes unchallenged by the HCA or the union – the HCA will not be reinstated and is no longer eligible to work with publicly-funded or participating private employers.

### **Public Protection to Date**

As of February, 2013, the Registry is responsible for removing a total of 44 HCAs from the Registry. In these cases, removals fall into two categories: 1) investigations determined that abuse was committed, or 2) no investigation was requested by the employee or the union following termination. As they are no longer able to register, these individuals are permanently prevented from seeking further positions with publicly-funded employers.

### **Intent to Review**

In June of 2012, the Honourable Minister de Jong – former Minister of Health – announced the Ministry of Health's intent to conduct an external review of the Registry's current operations to ensure that the public protection mandate was being met. This decision was in part due to the BC Ombudsperson report on seniors' care that was released in February 2012 that questioned the degree to which the Registry was meeting its abuse prevention mandate. Also, as a new model for patient safety, the review was an opportunity to ensure that ongoing implementation efforts were leading development in the best possible direction.

### **British Columbia Care Aide & Community Health Worker Registry: A Review**

The report *British Columbia Care Aide & Community Health Worker Registry: A Review*, provides clarity on the strengths and weaknesses of the Registry as it exists today. Building upon interviews with key stake holder groups (including Registry staff, health authority staff, the Registry Advisory Council, BC Care Providers Association, public and private care facilities, registry investigators, representatives of investigated sites, as well as Ministry of Health Staff in the program areas of Health Human Resources, Home Community and Integrated Care; Seniors' Directorate, and Professional Regulation), the report provides four recommendations for improvement to the Ministry of Health regarding the Registry's operating mandate, protection mandate, governance structure and sustainability:

**Recommendation 1:** The Ministry of Health should review the suitability of the enabling framework under which the Registry exists/operates (i.e., the Letter of Understanding and 'Appendix A') with particular attention to mandate clarity/focus, the implications for the Registry's scope (e.g., inclusion of private sector employers/employees) and ability to ensure the participation of employers and HCAs.

**Recommendation 2:** The Ministry of Health should ensure an appropriate governance structure exists for the Registry and that, within the context of the Registry's enabling framework, it is vested with the necessary authority to pursue the Registry's objectives and to establish a management structure charged with implementing strategic direction, developing operating policy/procedure, etc.

**Recommendation 3:** The Ministry of Health should take steps to redress current gaps in the Registry's protection mandate. Minimally, this would include: addressing the exclusion of private sector HCAs; establishing an oversight role related to abuse accusations handled outside the Registry's investigation process; eliminating loopholes (e.g., resignation of an accused HCA) that frustrate the Registry's ability to investigate; broadcasting Registry suspensions to employers; and compelling HCA registration as a condition of employment and employer participation in Registry investigations, etc.

**Recommendation 4:** The Ministry of Health should review the Registry's funding model with a view to ensuring a sustainable funding base as well as an equitable allocation of expenses. Given that the Registry's intent parallels, in some dimensions, the function of a regulatory college, and given that the Registry's creation is in part a response to failed human resource processes, charges to registrants and employers cannot be precluded. Existing inequities related to investigation costs (e.g., higher costs for facilities geographically distant from investigators and no costs for non-union facilities) should also be addressed.

### **Approach to Acting on the Recommendations**

The ministry continues to be committed to ensuring that the Registry's mandate to protect vulnerable adults from abuse by caregivers while receiving care in a variety of settings in BC, as well as ensuring high quality service and standards of care among the care aide and community health worker occupations is met.

Since its onset, the Ministry's approach to the Registry's development has been one of partnership with key stakeholders including, among others: health authorities, employers, unions, educators and Registry managers at HEABC. This action plan builds upon these partnerships and sets out the framework that will ensure that we implement the changes necessary to ensure that residents, patients, their families - and the care homes themselves - have the confidence to know the registry is operating as it was intended to. Broad and on-going consultations with stakeholders will be essential to determining considerations for moving forward with the recommendations. While some actions, such as developing procedural materials and conducting a feasibility assessment to broaden the Registry's mandate to include criminal records checks, will be quick wins; others actions, given the level of complexity involved (e.g. the requirement of an Union negotiations process, the requirement of extensive consultations to broaden the Registry's mandate to include privately funded employers) will need a longer term approach that spans multiple years.

#### **Actions to Address the Registry's Enabling Framework (Recommendation 1)**

The Registry's enabling framework is the Letter of Understanding (LOU) that was signed by HEABC, the Facilities Bargaining Association (FBA) and the Community Bargaining Association (CBA) in 2010. Appendix A of the LOU outlines the Registry's investigative and removal process. Additionally, the consent form for HCAs that was negotiated with the unions comprises an important piece of the Registry's capacity to collect and share HCA information. The current enabling structure does not extend to private sector employers. Because any changes to the Registry framework (LOU and Appendix) require the agreement of the union's bargaining association through a negotiation process, there is a risk that desired changes may not be achieved in total, or on the recommended timeline: therefore, engaging them on the need for changes in the public interest will be key.

Sect 17

Sect 17 S. 13

#### **Short-Term Actions (Target Completion Fall/Winter 2013)**

- Conduct an assessment of the private sector in order to understand the scope and implications of expanding the Registry to include privately funded.
- Assess potential mechanisms for mandating private employer participation;
- Review Registry framework documents and identify language issues, Registry procedures and employer requirements that allow for loopholes in the Registry protection mandate;
- Engage unions to discuss changes to the Registry consent form for the purpose of collecting necessary information from applicants;
- Assess options for disentangling employment status from Registry status.

**Mid-Term Actions (Target Completion Spring 2014)**

- Review findings from the private sector assessment and draft a recommended approach to implementation of a private sector mandate;
- Develop a process to make necessary changes to the Registry framework documents, procedures, and employer requirements to ensure that no loopholes impede the Registry's abuse prevention mandate;
- Implement changes to the Registry consent form that will allow the Registry to collect adequate registrant information.

**Long-Term (commencing April 2014)**

- Implement strategy that will mandate private sector participation in all aspects of the Registry;
- Implement changes to the Registry's enabling framework and clarify the roles and responsibilities of all parties to ensure alignment so that the protection mandate is being met;
- Disentangle employment status from Registry status, except where individuals are permanently removed from the Registry.

**Actions to Address Governance (Recommendation 2)**

Currently, the Registry is housed at Health Match BC (HMBC), under the purview of HEABC. The Ministry of Health acts in a stewardship role while operational details are handled by the Registry manager at HMBC. Additionally, the Registry Advisory Committee – representing health employers, unions, educators, and HCAs – is responsible for selecting Registry investigators. The review identified a need for further role definition, clarity of policies and procedures, and a review of decision-making structures. In response the Ministry of Health will pursue the following actions:

**Short-Term Actions (Target Completion Fall/Winter 2013)**

- Add a Ministry of Health representative to the Registry Advisory Committee, and revisit the Committee's Terms of Reference to ensure a mechanism to bring forward the issues it raises;
- Work with Registry investigators to develop procedural standards for Registry investigations of alleged abuse.

**Mid-Term Actions (Target Completion Spring 2014)**

- Implement procedural standards for the Registry's investigative process.
- Develop a public campaign to inform HCAs, employers, educators, and members of the public regarding the purpose and role of the Registry.

**Long-Term (Commencing April 2014)**

- Launch a public campaign to inform HCAs, employers, educators, and members of the public regarding the purpose and role of the Registry.

### **Actions to Address Gaps in the Registry's Protection Mandate (Recommendation 3)**

While ratifying the Registry's enabling framework and expanding its mandate to include private sector employers will address the majority of the issues identified in the review, further gaps in the Registry's protection mandate will require consideration. Additional actions will include:

#### **Short-Term Actions (Target Completion: Fall/Winter 2013)**

- Assess privacy concerns associated with sharing of information between employers in cases of abuse;
- Assess feasibility of adding criminal records checks to the Registry application process;

#### **Mid-Term Actions (Target Completion: Spring 2014)**

- If deemed feasible, implement criminal records checks as a part of the Registry application process;
- Review privacy assessment and engage unions to discuss options for sharing HCA's Registry status with employers in cases of abuse.

#### **Long-Term (Commencing April 2014)**

- Develop an appropriate mechanism to inform employers when an HCA has been removed from the Registry for abuse.

### **Actions to Address the Registry's Funding Model (Recommendation 4)**

The Ministry of Health is committed to supporting the Registry's operational and development costs for the 2013/14 fiscal year. While there are no current plans to change the basic funding model at this time, inequities in the cost of investigations warrant review in the short term. Longer term, the cost of operating the registry with a broader mandate to include the private sector will need to be reviewed. The Ministry of Health plans on undertaking the following actions:

#### **Short-Term Actions (Target Completion: Fall/Winter 2013)**

- Determine short-term solutions for resolving investigation costing inequities for geographically isolated employers.

#### **Mid-Term Actions (Target Completion: Spring 2014)**

- Assess the financial implications of expanding the Registry's mandate to include the private sector.

#### **Long-Term (Commencing April 2014)**

- Review funding model options and implement the most equitable approach to covering operational and investigative costs.

### **Actions for Ongoing Registry Implementation**

Since the Registry was developed with a phased approach to implementation, activities to implement the full public sector mandate are ongoing. These activities will include:

**Short-Term Actions (Target Completion: Fall/Winter 2013)**

- Launch the new Registry website and database to meet the needs of the current volume of Registrants;
- Continue development activities for the Registry's education recognition processes.

**Mid-Term Actions (Target Completion: Spring 2014)**

- Work with the Ministry of Advanced Education, Innovation and Technology and the Ministry of Jobs, Tourism and Skills Training to implement a pilot of the Prior Learning Assessment Recognition process for applicants without a recognized BC HCA certificate;
- Conduct a feasibility study to move forward with the Registry's mandate of professional development and career opportunities for HCAs.

**Long-Term (Commencing April 2014)**

- Implement all education recognition processes to ensure the minimal training requirement mandate is fully met;
- Implement professional development and career opportunity resources for registrants on the Registry website.

**Moving Forward with the Registry**

The Ministry of Health recognizes the value of the collaborative efforts to date that have led to the Registry as a new model for patient protection. As the Registry continues to develop through the phased approach, the recommendations in the report, *British Columbia Care Aide & Community Health Worker Registry: A Review*, provide a framework to build on these efforts and ensure greater success in the future. The Registry's mandate of patient protection supports the Ministry of Health's commitment to seniors care and elder abuse prevention, as well as the common goal of achieving the best possible health and safety for all British Columbians.

Cliff # 956643

**To: Honourable Dr. Margaret MacDiarmid, Minister  
Ministry of Health**

**Re: Minister Roundtable Briefing on Health Human Resources Planning**

In the fall of 2012 you requested a briefing on health human resources from Medical Services Health Human Resources Division (MSHHRD), with a focus on nurse practitioners, physician assistants, and scope of practice. It was determined the best method to provide information on the subject was to utilize several topic specific briefing notes followed by a roundtable dialogue to support your understanding of BC's health human resources history, current challenges and successes. Currently within MSHHRD there are several key health human resources initiatives underway to support the Ministry's Innovation and Change Agenda and Key Result Area 9, 'optimizing use of health human resources to improve clinical care and productivity.' For the upcoming roundtable, we have prepared four briefing notes on the following topics:

1. An overview of health human resources planning within BC's health sector, including the multiple key stakeholders, health system challenges and plans to develop a BC Health Sector Human Resources Strategy.
2. Information on how scope of practice can assist with health human resources planning and the current work underway in BC, such as implementing a shared scope of practice/restricted activities regulatory model under the *Health Professions Act* (HPA).
3. The current status of nurse practitioners in BC's healthcare workforce, an overview of recent legislative changes, the benefits to the health system and a highlight of the various streams of practice (family, adult and paediatric).
4. Highlights on the utilization of physician assistants across Canada, an overview of the work accomplished in BC and the conditions required to implement this model within BC's healthcare workforce.

I trust this documentation will assist in our future discussion and I look forward to the upcoming roundtable <insert date> to engage further on the health human resources planning portfolio.

Regards,

Graham Whitmarsh  
Deputy Minister

pc Sandra Carroll, Associate Deputy Minister & Chief Operating Officer  
Nichola Manning, Assistant Deputy Minister



**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff #** 953261

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister -  
**FOR INFORMATION**

**TITLE:** Minister Roundtable Briefing  
– Health Human Resources, Nurse Practitioners

**PURPOSE:** To provide background information on Nurse Practitioners to facilitate discussions.

**BACKGROUND:**

- The *Nurses (Registered) and Nurse Practitioners Regulation* under the *Health Professions Act* was enacted in August 2005, enabling the introduction of Nurse Practitioners (NPs) in British Columbia.
- NPs are Registered Nurses (RNs) with advanced education, knowledge and decision-making skills in assessment, diagnosis and health-care management of patients and clients. They are authorized to perform the full range of basic nursing functions plus additional functions involving diagnosing, prescribing, ordering diagnostic tests, managing common acute and chronic illnesses, and referring patients to specialists.
- NPs are registrants of the College of Registered Nurses of British Columbia (CRNBC). Three streams of practice are used by CRNBC to register NPs: Family, Adult and Paediatric (see Appendix 1 – Nurse Practitioner Streams of Practice). BC educates for the Family stream only at this time.
- NPs are Masters-prepared or have equivalent clinical experience and education. Applicants must be RNs, and have two to three years of clinical nursing practice.
- The NP education program builds upon RN practice and includes a combination of core theory courses and focused practice courses. Students learn pathophysiology, advanced health assessment, pharmacology, clinical skills, and primary care therapeutics, including health promotion. The program also includes regular clinical practice where students are exposed to a full range of clinical experiences with various preceptors.
- NPs were introduced to BC in 2005 to assist in improving access to primary health care services (see Appendix 2 – NP Job Description for an example of a typical role). While the majority of NP positions are in primary/community care, NPs also play a role in acute care settings – and this is an area where NPs' utilization could be increased (e.g., NPs' role in assisting with emergency department decongestion).
- In Fall 2011, BC introduced Bill 10 – the *Nurse Practitioners Statutes Amendment Act*. Twelve acts were amended and eleven were brought into force August 1, 2012, (the exception is for the changes to the *Mental Health Act*). The bill removed a number of legislative barriers to NP practice and facilitated a fuller use of their scope of practice.
- In October 2012, changes to the *Hospital Act* and *Hospital Insurance Act Regulations* provided the framework to enable NPs to admit and discharge patients.

## DISCUSSION:

According to CIHI's report *Regulated Nurses: Canadian Trends, 2006-2010*<sup>1</sup> there were 2,486 NPs in Canada in 2010; a 120.2 percent growth rate since 2006. BC was the third largest province to utilize NPs (129) behind Ontario (1,482) and Alberta (263).

Approximately 27 schools across Canada educate NPs and the number of graduates continues to increase annually (379 graduates in 2010; 408 graduates in 2011).

Each province/territory utilizes NPs differently. While several provinces have focussed on using NPs in acute care settings, Ontario, similarly to BC, has focussed their efforts on NPs in primary care roles as part of their provincial strategy designed to reduce the number of unattached patients and improve access to comprehensive primary care in underserved areas of the province. Since 2007, the Ontario Ministry of Health and Long Term Care has provided funding (both salary and overhead) to create 26 NP-led clinics – a primary healthcare delivery model where NPs lead the provision of direct care to people of all ages, using interprofessional teams of health care professionals to develop and implement services and programs to address the needs of specific populations. Ontario has negotiated an \$800/month stipend for General Practitioners (GPs) to be available to NPs for consultation.

When NPs were introduced to BC, a number of benefits were identified, including:

- *Access to health care*: providing primary health care in areas which cannot support a regular physician or where there are orphan patients;
- *System innovation*: developing economical, effective, integrated, patient-centred models of delivering care, including prevention, education and chronic disease management;
- *Patient choice*: providing patients a choice among health care providers.

Today there are approximately 250 NPs registered in BC; however, not all registrants are working within their field. The most consistently cited barrier to full NP implementation is the lack of additional and sufficient funding.

The recent funding announcement of \$22.2 million over the next three years has been well received – both by the NP community and by GPs. The first intake resulted in the Ministry receiving 60 completed applications (some for more than 1 full time equivalent) for the 45 positions available; 41 proposals have been approved for a total of 45 NP positions being funded (13 of the 41 awarded proposals have a First Nations focus). While this three-year funding program addresses the immediate concern that BC continued to graduate NPs without creating job opportunities, long term solutions must still be considered.

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<b>Date:</b>	February 14, 2013
<b>File Name with Path:</b>	z:\clinical\admin 100-499\executive services 280\20 bns, bullets & adm asgmts\2012\briefing notes\953261-hhr nurse practitioners-xref 949247 953284-w hhrp-c feb 14 revisions.docx

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<sup>1</sup> [https://secure.cihi.ca/free\\_products/RegulatedNursesCanadianTrends2006-2010\\_EN.pdf](https://secure.cihi.ca/free_products/RegulatedNursesCanadianTrends2006-2010_EN.pdf)

**Nurse Practitioner (Family)** - is educated to provide health care services to persons of all ages, including, newborns, infants, toddlers, children, adolescents, adults, pregnant and postpartum women, and older adults. They bring advanced knowledge and experience with persons and families of all ages to the context of practice that is usually in, but not limited to, community clinics, health care centres or other community settings. The nurse practitioner (family) develops and sustains partnerships with clients of all ages and may serve as the primary care provider to individuals and their families.

Entry-level nurse practitioners (family) are prepared with the competencies to work independently with clients of all ages in general primary care settings. They are able to effectively diagnose and treat acute/episodic health conditions, diseases and disorders, and chronic illnesses prevalent to the client population served. Mental health at the primary care level is included in the entry-level competencies of the nurse practitioner (family).

At the time of beginning practice, the nurse practitioner (family) is not prepared to independently provide care for clients with complex health problems or chronic diseases with multiple co-morbidities, such as one would find in specialty practice areas, acute care settings and complex residential care. The entry-level nurse practitioner (family) may go on to develop the competencies to provide care for clients with higher acuity and complexity or specialized needs through practice experience, mentorship and formal and informal education.

**Nurse Practitioner (Adult)** - is educated to provide health care services to young, middle-aged and older adults. Care of older adolescents may also be provided by a nurse practitioner (adult) in some instances when the adolescent's developmental age and/or lifestyle may more closely approximate that of an adult. Nurse practitioners (adult) can be found in acute and residential care as well as community settings. They develop and sustain partnerships with adults and their families and may serve as the primary care provider for adults.

Entry-level nurse practitioners (adult) are prepared with the competencies to enter practice in environments such as acute and residential care settings where clients with acute and complex care needs and multi-system problems are found. They are prepared with the same primary care competencies for the care of adults as the nurse practitioner (family) and then focus on the care of adults with higher acuity, complexity and co-morbidities. The competencies to care for the frail older person with complex care needs and co-morbidities are included in the preparation of the nurse practitioners (adult).

Their broad preparation allows them to practise across the continuum of care and to serve as the primary care provider to adults. At the time of beginning practice, the nurse practitioner (adult) is not prepared with specialized competencies unique to a particular practice area. The entry-level nurse practitioner (adult) may go on to provide care for adults with specialized needs through practice experience, mentorship and formal and informal education.

**Nurse Practitioner (Pediatric)** - is educated to provide health care services to children, including newborns, infants, toddlers, children and adolescents. The term "children" in the following description refers to this age range. In some instances, nurse practitioners (pediatric) may provide care to young adults whose developmental age may closely approximate that of a child or adolescent rather than that of an adult, or a young adult who has been receiving care from the nurse practitioner (pediatric) for a chronic disease since childhood (e.g., cystic fibrosis). Nurse practitioners (pediatric) can be found in acute and residential care as well as community settings. They develop and sustain partnerships with children and their families and may serve as the primary care provider to children. They attend to transition issues to ensure ongoing care from other providers as the adolescent becomes an adult.

Entry-level nurse practitioners (pediatric) are prepared with the competencies to enter practice in environments, such as acute and residential care settings where clients with acute and complex care needs and multi-system problems are found. They are prepared with the same primary care competencies for the care of children as the nurse practitioner (family) and then focus on the care of children with higher acuity, complexity and co-morbidities.

Their broad preparation allows them to practise across the continuum of care and to serve as the primary care provider to children. At the time of beginning practice, the nurse practitioner (pediatric) is not prepared with specialized competencies unique to a particular practice area. The entry-level nurse practitioner (pediatric) may go on to provide care for children with specialized needs through practice experience, mentorship and formal and informal education.

**Interior Health  
Nurse Practitioner Job Description**

**Job Summary**

The Nurse Practitioner is responsible and accountable for the comprehensive assessment of patients/clients/residents including diagnosing diseases, disorders, and conditions. The Nurse Practitioner initiates treatment including health care management, therapeutic interventions and prescribes medications in accordance with the statutory and regulatory standards, limits, and conditions, and employer policies and procedures. The Nurse Practitioner provides professional guidance to other health professionals and practices autonomously and interdependently within the context of an interdisciplinary health care team, making referrals to specialist physicians and others as appropriate.

The position collaborates with patients/clients/residents and other health professionals to identify and assess trends and patterns that have implications for patients/clients/residents, families and communities; develops and implements population and evidence based strategies to improve health and participates in policy-making activities that influence health services and practices. The position participates in peer review and self review to evaluate the outcome of services at the patient/client/resident, community and population level.

**Typical Duties and Responsibilities**

- Diagnoses and treats previously undiagnosed patients/clients/residents for undifferentiated diseases, disorders, and conditions within the Nurse Practitioner's scope of practice; writes orders for treatment and medications; provides first line care in emergencies.
- Monitors ongoing care, orders appropriate screening diagnostic investigations; interprets reports of investigations and analyzes information to monitor progress and plan treatment.
- Establishes priorities for management of health, diseases, disorders, and conditions; provides follow-up treatment; communicates with patients/clients/residents and families about health findings, diagnoses and priorities, outcomes and prognoses; supports and counsels patients/clients/residents in their responses to diseases, disorders and conditions.
- Collaborates and consults with physicians or other health care and social service providers as appropriate to assess and diagnose patient/client/resident status. Develops and implements treatment plans. May admit and discharge patients/clients/residents to facilities according to organizational policies.
- Prescribes drugs within the statutory and regulatory standards, limits, and conditions for Nurse Practitioners and within applicable employer policies and procedures.
- Assigns work to other nursing and health care personnel; evaluates work and provides education and supervision as necessary; hires staff, and evaluates staff performance.

- Participates in research contributing to improved patient/client/resident care and advances in nursing, health policy development and population health.
- Maintains population health focus by implementing screening and health promotion activities for populations at risk.
- Participates in interdisciplinary staff and nursing education through case presentations, mentoring, role modeling and facilitating the exchange of knowledge in the classroom, the clinical setting and the community; fosters health care partnerships.
- Develops, implements, and evaluates policies and procedures related to nursing, interdisciplinary care, and health system practices.
- Performs other duties as required.

### **Qualifications**

- Current registration as a Nurse Practitioner with the College of Registered Nurses of British Columbia (CRNBC)
- Recent relevant clinical nursing experience.

### **Skills and Abilities**

- Ability to communicate and collaborate with patients/clients/residents and families about health findings, diagnosis, treatment, self care and prognosis.
- Ability to collaborate, consult with and formally refer patients/clients/residents to physicians and other health professionals when appropriate.
- Ability to critically assess and evaluate health research literature to determine best practices; ability to introduce education and evidence based research.
- Ability to assess and recognize population health trends; ability to plan and implement strategies for population based prevention and health promotion.
- Ability to implement and evaluate planned change.
- Ability to supervise others and evaluate the care they deliver.
- Ability to lead a team and work within a team.
- Ability to self-direct, interact, and adapt effectively with other professionals in complex, dynamic situations.
- Ability to transfer knowledge, teach, coach and mentor others.
- Ability to identify and respond appropriately to legal and ethical issues that may arise in patient/resident/client care.
- Ability to self-assess performance and assume responsibility and accountability for own professional development, educational or consultative assistance when appropriate.

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 953439**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister -  
FOR INFORMATION

**TITLE:** Minister Roundtable Briefing –  
Health Human Resources Planning

**PURPOSE:** To discuss the Health Human Resources Planning process.

**BACKGROUND:**

Health human resources planning provides a strategic basis for making proactive human resource decisions, as well as developing strategic approaches for addressing present and anticipated workforce challenges that align with the system's strategic direction. The process is complex and comprised of a number of key tasks, such as: environmental scans; supply/demand analysis and forecasting; workforce plan development; skills gap analysis; workforce plans (i.e., key strategies/actions) implementation; as well as monitoring, assessing, and revising on a cyclical basis.

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Since 2008, the Health Employers Association (HEABC), working with key stakeholders, has produced an annual forecast report for over 20 nursing and allied health professions. New professions are added as the needs are identified (note: it was agreed that the 2012 report would not be produced due to bargaining data production requirements).

**DISCUSSION:**

Currently in BC, health human resources planning across the health sector is challenged by a number of factors, which include but are not limited to the following:

- Traditional models of health human resources planning do not support government's current models of care, or new service delivery models in the future;
- Sect 13 uncoordinated health human resources planning across the sector, and duplication of efforts and inconsistency in approaches (i.e., data collection/forecasting – different models and numbers being used) by HEABC, health authorities and government;
- A highly complex, multi-party health system (i.e., government, health authorities, post-secondary institutions, regulatory bodies, associations, unions, etc.);
- A workforce distributed across both public and private health systems;

- No formalized health human resources planning cycle.

Traditionally, the health human resources planning for nursing, allied health professions, and physicians has occurred in silos, with a recent shift to look at nursing and allied health professions more collectively. To ensure we are using our human resources to our greatest ability requires a shift so that future health human resources planning incorporates the skill sets of all three groups (nursing, allied health professions and physicians) in an effort to be proactive, produce different results and build capacity to optimize the use of health human resources to improve clinical care and productivity.

The Ministry - partnering with AEIT and JTI - will lead the way, providing provincial oversight and system-wide direction for health human resources planning across the health sector. The Ministry will develop a British Columbia Health Sector Human Resources Strategy that will build cohesiveness in the delivery of health services, and the development of health professionals, through a shared vision, framework and workforce plan, resulting in an effective and sustainable health care system in BC.

In order to optimize the health workforce that supports BC's publicly funded health system, the Ministry will need to collaborate with various industry sectors to address the challenges and demands within the health system, such as:

- The shift to patient focussed, inter-professional team-based care;
- Labour mobility;
- Internationally educated health professionals;
- Health education planning;
- Clinical placement capacity;
- Human resource planning in both a private/public funded health system; and
- Integrated health human resources planning.

Navigating through a complex landscape will require a multi-faceted, integrated approach, one that will coordinate human resource planning with changes to service delivery redesign and a population needs based approach that will optimize the health workforce to have the right people, with the right skills, in the right place, at the right cost, at the right time, doing the right things. This focus will leverage the Province's ability to deliver the changes necessary to enable the service transformation as outlined in the Ministry's Innovation and Change Agenda.

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<b>Program ADM/Division:</b>	Nichola Manning, ADM, MSHHRD
<b>Program Contact (content):</b>	Sharon Stewart, ED, HHRP (Nursing & Allied Health Professions)
<b>Drafter:</b>	Lisa Stark/Sharon Stewart
<b>Date:</b>	December 4, 2012
<b>File Name with Path:</b>	z:\clinical\admin 100-499\executive services 280\20 bns, bullets & adm asgmts\2012\briefing notes\953439 - info bn for minister - roundtable brief - health human resources planning - ed aprvd.docx



## MEETING MATERIAL

Cliff #: 964167

**PREPARED FOR:** Minister MacDiarmid, Meeting February 8, 2013, [location]

**TITLE:** Minister Margaret MacDiarmid meeting with the Licensed Practical Nurses Association of BC (LPNABC).

**MEETING REQUEST / ISSUE:** LPNABC wishes to discuss concerns regarding stakeholder input into the Ministry's proposed new *Nurses (Licensed Practical) Regulation*.

**SHOULD MINISTRY STAFF ATTEND THIS MEETING:** Yes.

Sandra Carroll, Chief Operating Officer; Nichola Manning, Assistant Deputy Minister, Medical Services and Health Human Resources Division; Sharon Stewart, Executive Director, Health Human Resources Planning (Nursing and Allied Health Professions); Daryl Beckett, Director, Professional Regulation, Policy and Planning Branch.

### BACKGROUND:

- As of January 10, 2013, there are 11,258 practicing Licensed Practical Nurses<sup>1</sup> (LPNs) in BC. LPNs are regulated through the College of Licensed Practical Nurses of BC (CLPNBC). For the past few years, the relationship between the CLPNBC and the LPNABC has been strained.
- The LPNABC was formed in 1951. LPNABC is committed to promoting LPN full scope of practice to be autonomous, and to be utilized to current level of education and training with a strategy for standardization of LPN education in BC<sup>2</sup>.
- Current total membership of the LPNABC is 68 LPNs – less than one percent of the total number of practicing LPNs. Faced with significant financial challenges, LPNABC closed 18 out of 19 regional Chapters (the Fraser Valley Chapter being the only one remaining), downsized administrative office, infrastructure, staffing and other costs and is working to increase their membership, including offering incentives such as cutting membership fees by 50 percent.
- BC is currently implementing a shared scope of practice/restricted activities regulatory model under the *Health Professions Act (HPA)*. Under the model, many elements of the scope of practice of each regulated profession may overlap, or be shared, with those of other regulated professions, and may also be performed by unregulated persons to the extent that either no restricted activities are involved in the service, or the unregulated person is delegated or authorized to perform a restricted activity under supervision.
- The current LPN regulations are obsolete. For several years, health authorities and others have been pressing for modernization. Recently, both the LPN entry-to-practice competencies and the provincial LPN education curriculum have been updated, clearing the way for regulation change. The Ministry of Health (the Ministry) is now in the final stages of preparing a new *Nurses (Licensed Practical) Regulation* under the *HPA*:

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<sup>1</sup> College of Licensed Practical Nurses of British Columbia, – Sara Telfer, Deputy Registrar via email, January 10, 2013. 11,258 practicing

<sup>2</sup> LPNABC Briefing Note to the Honourable Michael de Jong, Minister of Health – June 14, 2012

- The public consultation posting period closed December 21, 2012, and stakeholder and public input is currently under review. Based upon the feedback, minor changes are anticipated that may require a second, shorter public consultation period.
- The LPNABC contributed a substantial submission in response to the Ministry's request for stakeholder input.
- LPNABC strongly favours, and actively lobbies for, Alberta's LPN regulatory model to be adopted in BC:
  - The Alberta LPN regulatory model, however, utilizes terminology that is not aligned with BC's model (i.e., "certified practice"), has a different list of restricted activities to BC's, and does not utilize the formal separation of "with an order or without an order."
  - Additionally, the Alberta model provides in-depth detail related to how restricted activities are performed in relation to education, which in BC is the responsibility of the CLPNBC through its standards, limits and conditions of practice.
- In June 2012, the LPNABC raised a number of concerns to the former Minister of Health, including LPNs not working to full scope and labour mobility. Minister de Jong was scheduled to meet with the LPNABC in July 2012 but the meeting did not occur. It is likely that the LPNABC will raise similar concerns at the February 8, 2013, meeting:
  - Specific LPN practice is driven by population and service delivery needs and public safety considerations. This will vary both between and within health authorities. Health authorities are looking at how to fully utilize LPNs within their scope of practice (e.g., LPN roles in renal, maternity, emergency room, etc.). Care Delivery Models are being reviewed with a lens to optimization of all team members, including LPN roles.
  - The new provincial Practical Nurse (PN) Curriculum meets national standards and thus supports inter-provincial labour mobility. The new Curriculum, in its currently accepted format, has been criticised by LPNABC as not going far enough toward preparing LPNs for independent nursing practice. Programs delivering this Curriculum prepare graduates to meet the 2012-16 Competencies and to write the Canadian Practical Nurse Registration Exam (CPNRE).

#### ADVICE:

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**Program ADM/Division:** Nichola Manning, ADM, Medical Services & Health human Resources Division

**Telephone:** 250- 952-3166

**Drafter:** Alan Wood, Manager Nursing, HHRP (Nursing & Allied Health Professions)

**Date:** February 1, 2013

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## MINISTRY OF HEALTH INFORMATION BRIEFING NOTE

**Cliff #** 949247

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister -  
**FOR INFORMATION**

**TITLE:** Minister Roundtable Briefing –  
Health Human Resources, Scope of Practice

**PURPOSE:** To Discuss How Shared Provider Scopes of Practice May Assist with  
Health Human Resources Planning.

### **BACKGROUND:**

- British Columbia is currently implementing a shared scope of practice/restricted activities regulatory model under the *Health Professions Act* (HPA).
- The shared scope of practice/restricted activity model removes the historical view of professional exclusivity in which legislation prohibits any person, other than a member of the profession, from performing certain services or procedures - except where another profession is also specifically authorized in legislation.
- Under the new model many elements of the scope of practice of each regulated profession may overlap, or be shared, with those of other regulated professions and may also be performed by unregulated persons to the extent that either no restricted activities are involved in the service, or the unregulated person is delegated or authorized to perform a restricted activity under supervision (see Appendix 1 – Definitions, for terminology used by the Ministry of Health<sup>1</sup>).
- This approach supports enhanced interprofessional and multidisciplinary practice and increased consumer choice, while maintaining patient safety and public protection.
- As of October 2012, regulations for the following professions incorporate the shared scope regulatory model under the HPA: audiology, chiropractic, dentistry, hearing instrument dispensing, medicine, midwifery, naturopathic medicine, optician, optometry, pharmacy, registered nursing, speech language pathology, and podiatric medicine.
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<sup>1</sup> <http://www.health.gov.bc.ca/professional-regulation/scopeofpracticereform.html>

## DISCUSSION:

Health Human Resources Planning is one of the foundational functions that support the overall Innovation and Change Agenda. When considering the system's health human resources requirements, we must take the needs for the health care system (e.g., population access, services) into account, as well as:

- New service delivery models (e.g., use of interprofessional teams);
- Expanded scopes of practice (e.g., prescribing pharmacists) and emerging health provider roles (e.g., nurse practitioners, physician assistants); and
- The distribution of the workforce across the Health Authority; in particular, rural and remote areas.

One of the key actions in the Innovation and Change Agenda under the strategic area of "improved innovation, productivity and efficiency in the delivery of health services" is to ensure that all health professionals are working to their full scope of practice and ensuring providers are being utilized to the full extent of their training.

Additionally, interprofessional collaboration and patient-centred care are integral to addressing a number of key health care priorities, including patient safety, recruitment and retention of health care professionals, primary health care delivery, and timely access to services.

The traditional approach to health human resources planning has relied primarily on a profession-specific, supply-side analysis of past utilization trends to respond to short-term concerns. This results in planning that is based on traditional service delivery models rather than considering new ways of organizing or delivering services to meet needs, including organizing our scarce human resources differently.

Working within a shared scope of practice/restricted activity regulatory model provides the flexibility to determine how services should be delivered in order to meet population health needs, as well as the human resources required. This approach optimizes the ability of the health system to deliver services based upon the health needs of BC's population by aligning/identifying the skills/competencies required for these needs (planners consider the competencies rather than the professions required to meet the needs of the population).

This approach also supports the Council of the Federation's Health Care Working Group's priority on team-based health care delivery models, which encourages all health professionals to work to their full professional capacity in order to meet patient and population needs in a safe, competent and effective manner.

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<b>Program ADM/Division:</b>	Nichola Manning, ADM, MSHHRD
<b>Program Contact (content):</b>	Sharon Stewart, ED, HHRP (Nursing & Allied Health Professions)
<b>Drafter:</b>	Debbie McLachlan/Sharon Stewart
<b>Date:</b>	February 13, 2013
<b>File Name with Path:</b>	<a href="z:\clinical\admin 100-499\executive services 280\20 bns, bullets &amp; adm asgnmts\2012\briefing notes\949247-info bn for minister-roundtable brief-hhr, scope of practice-xref 953261,953284-ed aprvd.docx">z:\clinical\admin 100-499\executive services 280\20 bns, bullets &amp; adm asgnmts\2012\briefing notes\949247-info bn for minister-roundtable brief-hhr, scope of practice-xref 953261,953284-ed aprvd.docx</a>

## **949247 Appendix 1 – Definitions**

- Scope of Practice Statements are concise descriptions that, in broad, non-exclusive terms define the procedures, actions, and processes that the professional is educated and authorized to perform. While these activities are established through legislation and are complemented by standards, limits and conditions set by the profession's regulatory college or licensing body (i.e., College of Registered Nurses of British Columbia), they are not exhaustive lists of every service the profession may provide, nor do they exclude other regulated professions (i.e., Pharmacist) or unregulated persons (i.e., Respiratory Therapist) from providing services that fall within a particular profession's scope of practice.
- Restricted Activities are a narrowly defined list of invasive, higher risk activities that must not be performed by any person in the course of providing health services, except members of a regulated profession that has been granted specific authority to do so in their regulations, based on their education and competence, and unregulated persons who have been delegated the authority to perform the restricted activity, or who have been authorized to perform the restricted activity, by a member of a regulated profession that has been granted the restricted activity.

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 970034**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health, and  
Honourable Ralph Sultan, Minister of State for Seniors  
**- FOR INFORMATION**

**TITLE:** Better at Home – New funding

**PURPOSE:** To provide information on the new funding designated for the Better at Home program.

**BACKGROUND:**

On February 14, 2012, the Minister of Health announced \$15 million in funding to the United Way of the Lower Mainland (the United Way) to develop and manage a provincial non-medical home support program for seniors. The new program was announced as one of the key actions, under the theme of Flexible Services, in the Ministry's *Improving Care for BC Seniors: An Action Plan*.

The Better at Home program supports seniors to remain in their own homes longer by giving them access to simple services such as transportation to appointments, housekeeping, yard work and friendly visiting. As of January 2013, the United Way has identified 56 communities that will have the opportunity to become locations for Better at Home programs. Community development processes are underway to identify the lead agencies that will provide the services.

**DISCUSSION:**

The United Way is receiving an additional \$5 million through the Provincial Health Services Authority (PHSA) to extend and expand the Better at Home program for seniors. This additional funding will enable the United Way to expand the number of Better at Home sites funded from 60 to 68 sites, and extend the funding period for the program from March 2015 to December 2015.

An agreement is currently being developed between the PHSA and the United Way for the new funding. The agreement will include provisions setting out requirements for enhanced reporting on program activities and expenditures, and joint public communications of program milestones.

The new funding will be announced publicly by the Government of British Columbia and the United Way in a joint provincial news release issued before the end of March 2013.

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**Program Contact (for content):** Debbie Andersen, A/Director, Seniors' Directorate

**Drafter:** Robin Burgess

**Date:** March 12, 2013

**File Name with Path:** I:\Seniors Healthy Living Secretariat\Briefing\_Material\InProgress\BRIEFING NOTES 2013\New BH funding.doc

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 959368**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health -  
**FOR INFORMATION**

**TITLE:** Health Canada's Proposed Changes to Regulations for Medical Cannabis

**PURPOSE:** To explain highlights of Health Canada's proposed changes to its Marihuana Medical Access Regulations and their implications for British Columbia.

**BACKGROUND:**

Cannabis, or marijuana (spelled *marihuana* in Canadian federal legislation), is listed in the *Controlled Drugs and Substances Act* and is not generally legal for Canadians to produce or possess. Health Canada's current Marihuana Medical Access Regulations and accompanying Program were implemented in 2001, following 1998 and 2000 court decisions that determined Canadians have a constitutional right to access and use cannabis for therapeutic purposes. The Marihuana Medical Access Program allows patients to grow their own cannabis, designate another person to grow it for them, or purchase dried cannabis through a single agency contracted by Health Canada. As of 2011, BC had the most authorized medical cannabis patients of any province, totalling 4866, which is 40 percent of the total amount of Canadian licenses.

On June 17, 2011, Health Canada announced proposed changes to the Marihuana Medical Access Regulations to address concerns such as: risk of exploitation by criminal elements; complexity, length and administrative burden of the application process; need for more current medical information for physicians; and public health and safety risks associated with home cannabis cultivation.

A working group within the Ministry of Health and other Ministries (Justice; Social Development; Community, Sport and Cultural Development; Agriculture; and Environment's Climate Action Secretariat) was established to review the new regulations and provide coordinated feedback. Based on stakeholder discussions in September 2011 and February 2012 with Health Canada, and discussions with healthcare practitioners, the BC working group provided feedback and concerns to Health Canada about possible impacts of the proposed changes.

On December 15, 2012, Health Canada published the details of its proposed Marihuana for Medical Purposes Regulations (see <http://www.gazette.gc.ca/rp-pr/p1/2012/2012-12-15/html/reg4-eng.html>), which were quite similar to the initial proposed changes. When they take effect on March 31, 2014, they will authorize:

- the possession of dried marihuana by individuals who have the support of an authorized healthcare practitioner to use marihuana for medical purposes;
- the production of dried marihuana by licensed producers only; and
- the direct sale and distribution of dried marihuana by specific regulated parties to individuals who are eligible to possess it.

Under the new regulations, patients would obtain a medical document from an authorized healthcare practitioner (physicians, and if permitted by provincial governments and a professional licensing body, also nurse practitioners) and purchase marijuana directly from a licensed producer (or, if permitted by provincial governments and a professional licensing body, pharmacists). Patients would no longer have to apply to Health Canada for authorization meet requirements to have specific symptoms or conditions, obtain support of a specialist for some conditions, or be permitted to grow their own cannabis. Healthcare practitioners would no longer be required to make specific declarations with respect to the use of cannabis for medical purposes, the effectiveness or appropriateness of other therapies, or the regulatory status of cannabis.

#### **DISCUSSION:**

Health Canada is accepting comments from the general public and key stakeholders (including Provinces) until February 28, 2013. The previously formed inter-Ministry working group has started reviewing the proposed regulations and will provide coordinated feedback before the deadline.

Challenges for healthcare practitioners and regional health authorities in dealing with patients who are authorized to use cannabis already exist, and these are expected to increase as it is likely that the number of people seeking authorization will continue to increase. The resistance of physicians to recommending medical cannabis can be expected to continue, as the educational programs will take a long time to be taken up, and it is not clear that, even with education and resources, physicians will be willing to take on this responsibility. There is much uncertainty regarding affordability for patients, as their only legal option for procuring cannabis will be through the licensed commercial market. The Ministry of Health already receives requests to cover costs associated with medical cannabis, and these requests can be expected to continue. Other concerns include patient satisfaction about range of cannabis products available (as some strains may be commercially unviable to produce) and risks of arrest and incarceration of patients who choose to continue to grow their own cannabis supply.

#### **ADVICE:**

Staff are concerned about the short timelines to respond to the announcement of the details, and potential impacts both to British Columbians who benefit from medical cannabis and to the provincial health system. Staff will collate input from the Ministry of Health and other Ministries and provide feedback on this proposal, continue to closely monitor the development and implementation of the new Marijuana for Medical Purposes Regulations, and maintain contacts with other Ministries.

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<b>Program ADM/Division:</b>	Arlene Paton
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<b>Drafter:</b>	Kenneth Tupper
<b>Date:</b>	January 9, 2013
<b>File Name with Path:</b>	R:\CDAP\CDAP\AI Admin\Executive 280\20 BNs\20 PSU\PSU 2013\959368 - Health Canada Medical Cannabis Changes.docx



**MINISTRY OF HEALTH  
DECISION BRIEFING NOTE**

Cliff # 962967 xref 959368

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
- **FOR DECISION**

**TITLE:** Marihuana for Medical Purposes Regulations Briefing

**PURPOSE:** To brief the Minister on a draft response to proposed regulation changes to the federal marihuana medical access program (date TBD).

**BACKGROUND:**

Health Canada's current Marihuana Medical Access Program (the Program) and accompanying regulations were implemented in 2001 following court decisions that there must be a constitutionally viable medical exemption to the prohibition against the possession and cultivation of marihuana. As of December 31, 2012, British Columbia had the most federally authorized medical cannabis patients (13,362; 48 percent of Canada; 9,369 for personal use production, 2,232 for designated production, and 1,761 for simple authorizations to possess<sup>1</sup>).

Following consultations to update the Program that began on June 17, 2011, Health Canada published details of its proposed Marihuana for Medical Purposes Regulations on December 15, 2012, with a deadline for feedback due by February 28, 2013 (see <http://www.gazette.gc.ca/rp-pr/p1/2012/2012-12-15/html/reg4-eng.html>).

The proposed changes are intended to address concerns about the Program such as risk of exploitation by criminal elements; complexity, length and administrative burden of the application process; need for more current medical information for physicians; and public health and safety risks associated with home cannabis cultivation.

Under the proposed changes, planned to take effect on March 31, 2014:

- patients would obtain a document from their health care practitioner (physician, or nurse if provincially authorized), then submit it to a licensed producer to purchase cannabis (or through a pharmacist if provincially authorized);
- patients would no longer be permitted to grow their own cannabis or designate others to grow it, and existing authorizations to produce would be phased out, as the market is expected to provide competitive prices;
- categories of conditions or symptoms needed for authorization, and the specialist consultation requirement that some people had to obtain would be eliminated;
- health care practitioners would no longer be required to make specific declarations with respect to use of cannabis for medical purposes, the effectiveness or appropriateness of other therapies, or the regulatory status of cannabis;
- improved information for health care practitioners would be developed;
- a new secure supply and distribution system for cannabis that uses only licensed commercial producers subject to quality standards would be instituted; and
- health care practitioners would be able to sell cannabis for therapeutic purposes.

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<sup>1</sup> Client Services, Bureau of Medical Cannabis, Health Canada, personal communication, email January 23, 2013.

A working group within the Ministry of Health and with other ministries (Justice; Social Development; Community, Sport and Cultural Development; Agriculture; Environment - Climate Action Secretariat) reviewed the proposals and provided feedback.

#### **DISCUSSION:**

The consolidated feedback from the inter-ministry working group, which contains many concerns, questions, and recommendations (see Appendices 1-3), is reflective of the very limited federal/provincial/territorial engagement as part of this process. In particular, the proposal for health practitioners to be able to sell cannabis, which is new and was not part of the consultation, is very concerning because of the potential to put practitioners in a conflict of interest position due to the financial incentive of selling. No rationale for this was provided and, as the plan is for patients to be able to obtain their cannabis directly by mail, or through their health care practitioner's office, this seems to be unnecessary. To preserve clinical objectivity and avoid conflict of interest, it is of fundamental importance to separate the selling of "dried marihuana" from the authorization to obtain "dried marihuana", which is given by a medical document provided by a health care practitioner. This concern is shared by the College of Physicians and Surgeons, the College of Registered Nurses, and other provinces and territories.

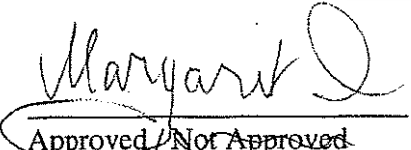
#### **OPTIONS:**

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**FINANCIAL IMPLICATIONS:** Uncertain

#### **RECOMMENDATION:**

Sect 13

  
Approved / Not Approved  
Margaret MacDiarmid  
Minister of Health

Feb. 25, 2013  
Date Signed

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<b>Program ADM/Division:</b>	Arlene Paton
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<b>Drafter:</b>	Brian Emerson
<b>Date:</b>	February 19, 2013
<b>File Name with Path:</b>	Y:\MC\UDocs PROCESSING\Briefing Documents\2013\Approved\PPH\962967 - Marihuana for Medical Purposes Regulations Briefing.docx

## British Columbia response to Health Canada's proposed Marijuana for Medical Purposes Regulation – General Comments

Comments from British Columbia are below, with recommendations indicated by *italics*. A number of these comments have been expressed in the past and some are also mentioned in the “Section Specific Comments” feedback document. We are iterating them here as we feel they have not yet been fully addressed.

### Consultation/Collaboration Process

*There should be ongoing consultation with provinces and territories regarding further development, implementation, and evaluation of this program.*

### Program Planning Framework

*The program should be described using a program planning framework.* This would include articulating the program vision, principles, goals, objectives, and indicators of success, as these elements are foundational to good health care program planning and evaluation. This description is important so that the program aims can be understood, monitored and evaluated. Additional comments related to this recommendation are in the “Performance Measurement and Evaluation Plan Comments” feedback document.

### Supports for Health Care Practitioners

*The removal of categories of conditions or symptoms will need to be supported with clear information about the indications, contraindications, adverse effects, and interactions, etc., for use of cannabis for therapeutic purposes.*

Health Canada has an important role to play in providing health care practitioners with effective and appropriate education and support.

As there are many professional, scientific, and health policy issues being raised by this program we are interested in the work of Expert Advisory Committee that will be providing advice, and whether they will be creating guidelines for health care providers. Outputs of this committee could have important influences on how this program relates to the provincial health care system. *Strong links should be established with national and provincial health care guideline making bodies to support development and dissemination of this information.*

## Health Care Practitioners as Gatekeepers

Requiring health care practitioners to act as the gatekeeper imposes a regulatory function on them, which results in them having the responsibility to authorize possession of what is otherwise a prohibited, unregulated substance of variable quality and potency, and with modes of consumption that have not been scientifically evaluated for safety and efficacy. As Health Canada is aware, physicians have many concerns about this role and responsibility which has been and may continue to be rejected by physicians for a variety of reasons, thus impairing access. This role and responsibility could lead to health care practitioners/patient conflicts and health care practitioner conflicts with Health Canada and other regulatory bodies. *We recommend that the appropriate role for physicians with respect to cannabis for therapeutic purposes is as patient advisors rather than as surrogates for regulatory gatekeepers.*

In addition, imposing a role on health care practitioners as the gatekeeper potentially opens their practices to Health Canada scrutiny, which could be a potential additional intrusion in to health care practice.

In summary, Health Canada should not be abdicating their regulatory role in favour of health care practitioners picking up the responsibility to determine access to medical cannabis.

*Therefore, we recommend a collaborative exploration of other options to allow access that does not involve imposing requirements on health care practitioners to act as the gatekeepers.*

## Health Care Practitioners Selling “Dried Marihuana”

We note the proposal that health care practitioners will be authorized, pursuant to sections 124, 126, and 127 of the proposed Marihuana for Medical Purposes Regulation to sell “dried marihuana” for therapeutic purposes. This proposal was not mentioned in the consultation document published June 17, 2011, nor was it mentioned in the only two consultation sessions that Health Canada held with BC.

We have very serious concerns about this authorization to sell due to the potential for putting health care practitioners in a conflict of interest, because practitioner judgement can be influenced by the monetary incentive of both providing the authorization for the product, and then selling the product based on that authorization. To preserve clinical objectivity and avoid conflict of interest it is of fundamental importance to separate the selling of dried marihuana from the authorization to obtain dried marihuana, which is given by a medical document provided by a health care practitioner. Further, as the plan is for patients to be able to obtain their cannabis directly by mail, or through their health care practitioner’s office, it seems to be unnecessary to include this option.

Therefore, we are hereby registering our objection to this authorization for health care practitioners to sell “dried marihuana” in the strongest of terms, and we request that this be deleted from the regulation prior to it being finalized.

### **Product Promotion**

We note that “advertising” appears to be allowed in the proposed regulation, yet according to page 14 of the Health Canada impact analysis, “Advertising any narcotic to the general public is prohibited under the NCR.” We are concerned about the opportunities for advertising and request clarification on how the regulatory impact analysis statement and the mention of advertising in the regulations are to be reconciled.

One of the most important lessons learned from the commercialization of tobacco and alcohol, and the promotion of opioids for treating non-chronic cancer pain, is that product promotion is a significant driver of consumption and consequent increases in population harms. Therefore, all promotion of cannabis for therapeutic purposes should be prohibited.

Promotion comes in many forms and includes advertising, branding/naming, sponsorship, gifting, product association with film, leading personality recruitment, associating use with attractive activities such as sporting, socialization, sex, and vacations; pricing reductions (i.e. loss leaders); labelling suggestive of pleasure, enhanced performance, over stated benefits; creating similar products for children (i.e. chocolate cigarettes) or youth attractive products (e.g. alcopops, flavoured cigarettes and cigars); and other information presentations suggestive of performance enhancement. *The regulations should be much more explicit about prohibitions on all forms of product promotion.*

Branding is critical to promotion, and once branding is allowed promotion is very difficult to prevent. *Therefore, to prevent promotional activities, branding should not be allowed, and products should only be available in generic packaging.*

### **Patients Needs/Demands and Related Issues**

*A description is needed about how patients will receive advice and guidance e.g. indications, contraindications, how to use, options for use, different strains, different preparations, cautions, side effects to watch for and how to manage them.* Provision of this level of detailed information will likely be beyond what could be expected to be provided by physicians and may have to be met by other intermediate service providers. *Including intermediate service providers in the regulatory scheme, such as dispensaries with appropriate expertise to meet patient needs, warrants serious consideration.*

**Product**

We note the lack of access to cannabis in non-smokable forms, i.e., oral mists, liquids, baked products, etc., for patients that prefer alternatives to smoking cannabis. *This program should include production of non-smoked product options to allow of reducing potential harms of smoked products, and to meet patient needs.*

**Accommodation for People with Accessibility Challenges**

*Measures are needed to ensure that this program is accessible for people who have difficulty in accessing public programs, e.g., people with disabilities, disabling medical conditions, communication challenges, low literacy, and geographically isolated people.*

**Health and Social Services**

*Guidance documents and other educational resources for health care facilities need to be developed i.e. to address facilities management of requests for smoking cannabis on-site, issues related to home care use (worker exposure - safety and comfort), risk and liability of a facility or worker if they store/handle/administer cannabis.*

**Conflict of Interest**

*In order to prevent conflict of interest there should be rules about having financial interest in production operations for those who provide authorization, i.e. health care practitioners. It will be important that those who provide authorizations do not have such a conflict.*

**General Public and School Based Education**

*Information about this program developed to meet literacy levels of the general public, and tailored for school communities, should be developed.*

**Cost Pressures**

There is a potentially large unmet demand that could result in increased provincial costs due to paying physicians for medical cannabis-related visits. Although visits to fill out forms are not billable, in practice there could be increased visits to review symptoms which would be billable.

There will be potential pressure for the Ministry of Health to pay physicians for filling out forms.

There will be potential pressure on the Ministry of Health or other ministries to subsidize/cover the costs of cannabis or related drug-delivery products (e.g., vaporizers).

## Supply and Distribution Control

The proposed direct producer/retailer to consumer relationship raises the possibility of producers/retailers providing incentives and promoting their products to retain their customers, which could lead to inappropriate practices and promotions of use. This could be mitigated by using an impartial third party as a distributor, as is used for liquor distribution. See also our comments regarding “Product Promotion” and comments regarding the United Nations convention requirements below.

Direct producer/retailer to consumer relationship could also bring up a variety of consumer protection issues and complaints such as false advertising/poor service or product. How will these be resolved or addressed?

Specifically, regarding “pharmacy distribution”, BC is not supportive of pharmacists dispensing dried marihuana for medical purposes. Pharmacists dispense drug products that have received a Notice of Compliance (NOC) from Health Canada and that have a product monograph. The NOC indicates that the manufacturer has met Health Canada’s regulatory requirements for the safety, efficacy and quality of a product, and the product monograph is intended to provide the necessary information for the safe and effective use of a new drug. Marihuana has not received a NOC and does not have a product monograph. Therefore, pharmacists are unable to provide the necessary information for the safe and effective use of marihuana, and furthermore, pharmacists do not have knowledge and experience in dispensing marihuana.

### Addressing Diversion and Security Concerns

The known contributors of criminal abuses of the current Medical Marihuana Access Program are not sufficiently addressed. The security clearance required for licensing does not seem sufficient to address the known possibility of licensed producers being controlled by organized crime. Similarly, the conditions for transportation of the product are not tethered to licensing, and the physical security requirements of the production operations are not clearly delineated thereby creating an opportunity for diversion.

*Therefore we recommended the requirement for all employees of production facilities to undergo criminal reference checks by the producer/employer (in addition to key production staff being subject to security clearance by Health Canada – already proposed). Recommendations have also been made for more specific requirements around the transportation of marijuana and the security of growing operations.*

## Personal and Designated Production Phased Out

Leaving the market to set the price without a personal production option could lead to prices that are too high for some patients, i.e., for low income people or those on disability, and could potentially limit product options. *Addressing the needs of patients with limited financial means warrants consideration.*

Patients could put pressure on BC ministries to pay for marijuana if the market sets the price higher than what they can afford.

Some patients will continue to grow for their own use, which leads to the possibility of criminal sanctions for these people. The combination of removal of personal production and the recent introduction of mandatory minimum sentences related to cannabis could result in increasing the rate of incarceration for people growing cannabis for personal use, and coincidentally increased costs and risks to health consequent to incarceration. *We recommend that careful consideration be given to developing measures to mitigate the potential adverse impacts of these changes on patients who are growing their own supply or who are having it grown for them.*

## Safety and Security

There are outstanding safety concerns regarding the sites used for commercial production. Consideration for local public safety issues also seem to be underemphasized. More information is needed, particularly with regard to personnel and to safety and security requirements.

*Regular audits and inspections by Health Canada (i.e., not just when one applies for or attempts to renew a production license), a schedule of audits/inspections, and clear information on what may be included in an audit/inspection (i.e., physical security of the location, compliance with local bylaw and building codes, access to client and personnel records, access to inventory records) are recommended.*

## Indoor Production Requirement

This limitation may result in unnecessary greenhouse gas production due to increased energy requirements. *There should be incentives or support for new licensed producers to utilize energy efficient equipment and use clean or renewable energy where possible and to undertake energy efficiency measures in their building. There should be consideration of outdoor growing with appropriate security that meets the program objectives while enabling use of sun energy for product production.*



*Any growing facility should be required to maintain (and be regularly inspected against) local building, safety and electrical standards and/or zoning and other bylaws. As well, restrictions should be placed on pesticide use and the facilities should be subject to regular environmental inspections.*

### **Transition Plan**

*More details are needed about the transition plan, specifically regarding the transition plan for phasing out personal production licenses, i.e., How will existing producers be informed? What may be done to ensure producers are aware of the illegality of continuing to produce marijuana without license? What is the plan to inspect license properties to ensure discontinuation after the license expires? What is the plan to deal with potentially unsafe properties formerly used for medical marijuana production?*

### **Compliance and Enforcement**

#### Legal Possession

As identification of eligible users relies on the possession of a marked container, there is a potential lack of clarity around proof of legal possession for enforcement purposes: once the product is taken from the marked container or the labelling and security of packaging is compromised there is a difficulty with proving a client's legal possession.

*The development of a central repository or database in which commercial production facilities would be required to register their clients is recommended. With a 24-hour contact line, this database could be used by law enforcement to confirm legal possession of marijuana. This database can also be checked by producers upon receipt of a new medical document to prevent multiple dispensing to one individual (similar to how PharmaNet can be used by pharmacists).*

#### Information Sharing

Despite the requirement to notify local government, police, and fire of the intention to establish a commercial grow operation at the time of application, the proposed regulation does not give ongoing consideration of these groups in compliance and enforcement activities.

*Two-way information sharing between Health Canada and local governments, fire, and police to ensure that any criminal or safety concerns uncovered during inspection are communicated to the relevant body for follow-up is recommended. Additionally, there should be a requirement for producers to show proof of local government permit(s) to Health Canada prior to being given a production license as this would ensure that the production facility is in accordance with local building, safety and electrical standards, and/or zoning or other bylaws would be appropriate.*

## Compliance with the United Nations Single Convention on Narcotic Drugs

As we understand the *UN Single Convention on Narcotic Drugs* (Articles 28 and 23 2 d. - see below) governments which allow cultivation of cannabis must establish "one or more government agencies...to carry out the functions required under this article.", that "All cultivators of [cannabis] shall be required to deliver their total crops of [cannabis] to the Agency.", that "The Agency shall purchase and take physical possession of such crops...", and that the Agency "shall... have the exclusive right of wholesale trading."

In other words, it appears that the Convention requires that countries which permit cultivation of cannabis must establish a system to manage the cannabis supply that operates in a similar manner to the way provincial alcohol monopolies operate. For example in BC the Liquor Distribution Act mandates the Liquor Distribution Branch to manage the distribution of all BC manufactured and imported liquor, as is similar to other provincial alcohol monopolies.

Our interest in this is that the alcohol regulation evidence indicates that alcohol monopolies help to protect public health from alcohol related harms by inserting additional government control into the relationship between producers, retailers and consumers. We are aware that some tobacco control experts advocate for placing tobacco under a government monopoly type of system (see references below) to protect public health. The Single Conventions requirement for a government cannabis distribution agency does seem to be important from a public health protection point of view, and seems to be required by the UN convention.

*As the proposed program does not include an intermediate agency as mandated in the Single Convention Article 23 , we request that Health Canada clearly articulate how it interprets the requirements of the Single Convention, in particular the requirement for a central agency to take possession of the crop prior to distribution, and for it to control cannabis production and distribution, with respect to the Health Canada proposal to license commercial producers that provide cannabis directly to consumers. If the International Narcotics Control Board has commented on the proposed Health Canada model we would request a copy of their comments.*

***THE SINGLE CONVENTION ON NARCOTIC DRUGS, 1961***

([http://www.incb.org/pdf/e/conv/convention\\_1961\\_en.pdf](http://www.incb.org/pdf/e/conv/convention_1961_en.pdf))

***Article 28*****CONTROL OF CANNABIS**

1. If a Party permits the cultivation of the cannabis plant for the production of cannabis or cannabis resin, it shall apply thereto the system of controls as provided in article 23 respecting the control of the opium poppy.
2. This Convention shall not apply to the cultivation of the cannabis plant exclusively for industrial purposes (fibre and seed) or horticultural purposes.
3. The Parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant.

***Article 23*****NATIONAL OPIUM AGENCIES**

1. A Party that permits the cultivation of the opium poppy for the production of opium shall establish, if it has not already done so, and maintain, one or more government agencies (hereafter in this article referred to as the Agency) to carry out the functions required under this article.
2. Each such Party shall apply the following provisions to the cultivation of the opium poppy for the production of opium and to opium:
  - a) The Agency shall designate the areas in which, and the plots of land on which, cultivation of the opium poppy for the purpose of producing opium shall be permitted.
  - b) Only cultivators licensed by the Agency shall be authorized to engage in such cultivation.
  - c) Each licence shall specify the extent of the land on which the cultivation is permitted.
  - d) All cultivators of the opium poppy shall be required to deliver their total crops of opium to the Agency. The Agency shall purchase and take physical possession of such crops as soon as possible, but not later than four months after the end of the harvest.
  - e) The Agency shall, in respect of opium, have the exclusive right of importing, exporting, wholesale trading and maintaining stocks other than those held by manufacturers of opium alkaloids, medicinal opium or opium preparations. Parties need not extend this exclusive right to medicinal opium and opium preparations.

3. The governmental functions referred to in paragraph 2 shall be discharged by a single government agency if the constitution of the Party concerned permits it.

Tobacco Control Monopoly References

Borland R. A strategy for controlling the marketing of tobacco products: a regulated market model. Tobacco Control 2003;12:374-82.

Callard C, Thompson D, Collishaw N. Curing the addiction to profits: a supply-side approach to phasing out tobacco. Ottawa: Canadian Centre for Policy Alternatives; 2005.

## British Columbia response to Health Canada's proposed Marijuana for Medical Purposes Regulation – Section Specific Comments

***Note to Health Canada – there are many questions included here to which we request a response.***

### DEFINITIONS

**1. (1)** The following definitions apply in these Regulations.

- “brand name” means, with reference to cannabis, the name, in English or French,
  - (a) that is assigned to it;
  - (b) that is used to distinguish it; and
  - (c) under which it is sold or advertised.
- Packaging should be of a generic nature, and branding should not be permitted, as branding enables many forms of product promotion, including advertising. All product promotion should be prohibited. See additional comments in the “Product Promotions” section of the BC “General Comments” document.

### POSSESSION

#### **3 (1) (a) and (b) Obtaining dried marijuana and cannabis**

- Is this how those transporting marijuana from the producer to the user are able to be in possession of it? If not, how are these individuals legally able to be in possession of it?

#### **3 (2) (b) Possession – Dried Marijuana**

A person who requires dried marijuana for their profession

- This section makes it sound as if their job makes them need to use marijuana. Perhaps this could be worded as ‘is required to have marijuana in their possession by virtue of their profession and their role in dispersing it.’

#### **3 (2) (b) (ii) Possession – Dried Marijuana**

The following persons may possess dried marihuana: a health care practitioner who is registered and entitled to practice in the province in which they have that possession.

- Health care practitioner needs to be defined. Perhaps reference a definition found in another act?
- Will health care practitioners be audited to ensure that marijuana is not being diverted to the illegal market?

**3 (3) (b) Possession – Cannabis**

- Is possession for individuals in these jobs not already exempt somewhere else? If not, how does this new allowance for legal possession fit with the *Criminal Code of Canada* and the *Controlled Drugs and Substances Act*?

**3 (4) and (5) – Employee, Agent or Mandatory**

- Mandatory needs to be defined with examples included.

**GENERAL PROVISIONS****8 Inspection of Site**

- Can licensed producers be inspected at any time? Or only when they are applying, amending or renewing their licence? Will Health Canada be creating a schedule of audits? There need to be regular inspections to ensure ongoing compliance and inspectors should be able to conduct these inspections at any time.
- Will inspections only be conducted based on information reported by the licensee in the information they are required to keep?
- What will a site inspection entail? Can records be inspected (i.e., including client lists, financial records, employee records, etc.)?

**PART 1 - LICENSED PRODUCERS****DIVISION 1 - PERMITTED ACTIVITIES AND GENERAL OBLIGATIONS****12 Dwelling Place**

- What will be done to inform MMAR production licence holders of the illegality of continuing to produce marijuana?
- What measures will be put in place to deal with those who continue to produce as if their MMAR licences were still valid?
- Will inspections be conducted to ensure discontinuation of production after the licence expires and to establish the safety of the premises that is no longer to be used for production?
- Additionally, regulations should specify that a licenced production facility cannot be located in close proximity to a school, daycare or playground.

**15 Identification of Licensed Producer**

"A licensed producer must include their name, as set out in their licence, on all the means by which the producer identifies themselves in relation to cannabis, including advertising, product labels, orders, shipping documents and invoices."

- "Themselves" should say "themselves".
- This section refers to "advertising". According to the *"Packaging and Labelling"* section of the Health Canada Regulatory Impact Analysis Statement, "Advertising any narcotic to the general public is prohibited under the NCR." BC recommends that all advertising be prohibited. See our more detailed comments in the Product Promotion section of our General Comments document.

**18 Safekeeping during Transportation**

- If the producer is liable for the safety of the shipments how liable is the company that is transporting the marijuana? How liable is the producer if the shipment is lost or stolen?
- When they say “a licenced producer must, when transporting” does it mean that the licenced producer transports the marijuana themselves. If so, what if the marijuana is transported by another company?
- The licensee should be accountable for the care and control of the drug for as long as possible and/or appropriate. This accountability should be tied to the licence and infractions in this regard should have sanctions – it would be far too easy to allow diversion of the product while in transit.

**19 Report of loss or theft**

- This relies on self reporting. If a licensee chooses to not report the loss, how will Health Canada know?
- What are the consequences to the licensee if cannabis is lost or stolen? Is there a reason the licensee may choose to not report the loss?

**20 (3) (a) Witness to destruction**

- Who is the senior person in charge? Will it be a person working for the producer? The producer themselves?

**DIVISION 2 - LICENSING****21 Eligible persons**

- Does it matter that the age of “adult” varies from province to province?

**23 Notice to local authorities**

- Health Canada will receive a copy of the letter, but how will they ensure that the letter has been sent and received by the local authority? Local authorities should be contacted by Health Canada to ensure that not only are they aware of the application but also that they approve of the presence of that business and its location within their community.
- Licensees should be required to show permits from local authorities proving compliance with local requirements before they are granted a licence. For example, there could be a two step process: (1) applicants apply to Health Canada and are given tentative approval to begin setting up a commercial production facility and then (2) applicants conform to Health Canada and local authority requirements, are inspected for compliance, and then have their licence issued.
- Local authorities should be informed by Health Canada when licence infractions are found during an inspection so that the local authorities may conduct additional inspections as they see fit.
- How does Health Canada plan to respond to concerns voiced by local authorities about specific licenced production operations?

**24 (1) (a) (i) Application for licence**

“To apply for a producer’s licence, a person must submit to the Minister an application that contains the following information: if the applicant is an individual, the individual’s name, date of birth and gender and any other name registered with a province, under which the individual intends to identify themselves or conduct the activities for which the licence is sought (referred to in this section as “the proposed activities”).”

- “Themselves” should say “themselves”.

**24 (5) Method of keeping records**

- Additional information needs to be given (e.g., how often audits may occur, what the scope of the audit may include? (i.e., site inspections and access to records).

**25 Security clearance required**

- All staff of the licenced producer should be subject to records checks by the employer and the "key personnel" should be subject to a more in-depth security clearance by Health Canada.
- Are these clearances sufficient to address the possibility of licenced production operation being controlled by organized crime?

**26 (h) and (i) Issuance of licence**

- When would it be applicable to place a maximum quantity produced, sold, and/or provided on a licence and when would it not? Presumably the maximum quantity would be tied to the security requirements for the facility and therefore a maximum amount should be specified on all licences.

**27 (1) (f) and (i) Grounds for refusal**

The Minister must refuse to issue, renew or amend a producer's licence in the following cases: the applicant does not have in place the security measures set out in the Security Directive and Division 3 in respect of an activity for which the licence is requested and any of the following persons does not hold a security clearance.

- The Security Directive only mentions cannabis sativa, its preparations, derivatives, and similar synthetic preparations. What about Marijuana?
- Considerations for electrical safety and ground water contamination may be regulated by other levels of government, but perhaps there should be recognition that these other considerations should be met?
- "following persons does not" should say "following persons do not."

**27 (2) Grounds for refusal**

- How will an individual be expected to correct having contravened an act or regulation?

**29 (1) Application for renewal**

- Would it be appropriate to suggest that licenses be issued with conditions on them and that the conditions could be added to if certain breaches were observed. This would offer more flexible governance and would also require Health Canada to monitor the process between issuance and cancellation or expiry of licenses. It seems that a licensee can apply for an amended license but can the Minister impose conditions after a license is issued on his/her own accord? I.e., can the Minister amend a license based on interim/spot inspection (if those may be conducted)?

**33 (1) (c) Notice to Minister – various changes**

- Changes to site security should be approved first: producers may not be sufficiently knowledgeable about physical security to determine whether or not their change affects the security level of the production facility.

**37 (1) (e) Revocation – other grounds**

Subject to subsection (2), the Minister must revoke a producer's licence in the following circumstances: information received from a peace officer, a competent authority or the United Nations raises



reasonable grounds to believe that the licensed producer has been involved in the diversion of a controlled substance or precursor to an illicit market or use.

- This is a fundamental section for law enforcement. Will this be elaborated on in policy or procedure? For example, what will constitute “reasonable grounds”? Is this a potential link to enforcement under *the Controlled Drugs and Substances Act* and where individuals use this legislation to circumvent the *Controlled Drugs and Substances Act*?
- Can the Minister amend a license (for example, a producer may be required to let go of certain staff members if organized crime links are found or otherwise face suspension of the licence)?

### **37 (2) Revocation – exceptions**

- How is an individual expected to correct having contravened an act or regulation?

### **38 (1) Suspension**

- Are there circumstances (e.g., lack of compliance with some administrative requirements) that should also lead to the suspension of a licence?
- Do individuals have an opportunity to make corrections based on the outcome of audits or is their licence suspended immediately before they can make changes?
- What does suspension entail? Does it mean licensees don’t ship marijuana to their clients? Do they keep growing? Do they continue to have access to the facility? Presumably they cannot continue to function as normal. If this causes an interruption in the supply, what happens to the clients who are expecting their next shipment and don’t receive it? Do those clients have to get another medical document and find another producer and get set up and wait for it to be shipped before they could get their prescribed amount of marijuana? This seems contrary to HC’s intended outcome of ensuring access.

### **38 (3) Opportunity to be heard**

- Once a licence is suspended, what happens to the plants? Does the licensee have to stop tending them? If so, what happens if their licence is given back but their plants died from lack of care?

## **DIVISION 3 - SECURITY MEASURES**

This section is too light on safety issues related to production. Could another section be added to cover the physical safety hazards of production facilities? MMPR should specifically require that applicants ensure that production facilities comply with all federal, provincial and municipal legislation, regulation and bylaw relating to building safety, health, fire, electrical, environmental and air quality standards.

### **41 (1) and (2) Restricted Access**

- What activities must occur in “restricted areas”?

## DIVISION 4 - GOOD PRODUCTION PRACTICES

### 48 Microbial and chemical content

- Set restrictions on pesticide and fertilizer usage and require regular environmental inspections.

### 53 Recall

- This is broad and could be interpreted in many ways. Will there be policy outlining what this entails?

### 57 Adverse Reactions

- This should include a provision that any information obtained by the Minister pursuant to this section may be shared with a provincial or territorial government and health care practitioner regulatory licensing body of the jurisdiction in which the adverse reaction happened.

## DIVISION 5 - PACKAGING, LABELLING AND SHIPPING

### 61 (a) Client label

- Is there any concern that without the packaging law enforcement may not be able to confirm whether or not an individual is a registered user? What will happen if police stop an individual for using their prescription and that individual – though legally allowed to possess – is unable to prove they are in legal possession?

### 63 Department of Health Document

- To save on paper, printing, and associated costs and consumption of environmental resources perhaps recipients should be given the option of receiving the information electronically, or waiving the requirement to receive the document with every shipment.

### 64 Presentation of information — label

- Is forgery of labels a concern?

### 66 Reference to Act or regulations

- This section refers to “advertisements”. According to the “*Packaging and Labelling*” section of the Health Canada Regulatory Impact Analysis Statement, “Advertising any narcotic to the general public is prohibited under the NCR.” BC recommends that all advertising be prohibited. See our more detailed comments in the “Product Promotion” section of the BC “General Comments” document.

### 67 Shipping

- Is there a concern that the contents of the packages could still be identified because the return address of the licensee will be on the package and all licensee addresses will be published on the internet? Safekeeping needs to be defined. What would be considered “safekeeping” and who will be responsible for the shipment during transit?
- The licensee should be accountable for the care and control of the drug for as long as possible and/or appropriate. This accountability should be tied to the licence and infractions in this regard

should have sanctions – it would be far too easy to allow diversion of the product after it leaves the facility in which it is produced.

## **DIVISION 7 - SECURITY CLEARANCES**

- Greater clarity needs to be given on what security clearances entail. Is this only a criminal record check? If so, that is only a criminal record check and not a security clearance. Will background checks also be conducted?
- All staff of the licenced producer should be subject to records checks by the employer with “key personnel” subject to more in-depth security clearance by Health Canada.

### **84 Checks and verifications**

- This may be a significant power for police agencies to influence the licensing process where it is determined that an applicant may pose a security risk through direct or indirect links to organized crime. Will the role of law enforcement agencies need to be clarified under this section?

### **85 (c) Minister’s decisions**

- Would an individual’s financial state possibly factor into an assessment of “whether there are reasonable grounds to suspect that the applicant is in a position in which there is a risk that they be induced to commit an act or to assist or abet any person to commit an act that might constitute a risk to the integrity of the control of the production and distribution of cannabis”? If so, should a financial check of key personnel be conducted?

## **DIVISION 8 - COMMUNICATION OF INFORMATION**

### **94 Information concerning registered clients**

- If this is not a 24/7 service provided by licensees, how will law enforcement be able to confirm whether or not an individual is legally allowed to be in possession of marijuana if they need to make the inquiry outside of business hours?

### **94 (3) Use of information**

- This assumes that police have a degree of authority under this Act. If so, where are the provisions outlining their authority?

### **96 Information concerning licensed producers**

- Would contraventions here move the case into the realm of the *Controlled Drugs and Substances Act*?

### **98 Providing information to foreign organizations**

- Is this akin to providing information to the DEA, FBI, or Homeland Security? Will this compromise the security or ability of producers to travel internationally?

### **101 Security clearance – law enforcement agency**

- The information needs to flow both ways between Health Canada and law enforcement, not just from law enforcement to Health Canada (i.e., for relevant infractions found during inspections or any other time).

- Will the Minister be able to act on information from other local authorities (i.e., fire or local government)? Also, Health Canada should inform local government/fire if inspections suggest that a production facility may not be compliant with building codes.

## **PART 2 - REGISTRATION AND ORDERING REGISTRATION**

### **103 Registration application**

- Will there be a central repository for this information that will be used by all licensees to coordinate service and to track clients' prescriptions? This would assist police in requesting information on who is legally entitled to possess marijuana as well as provide a method to prevent individuals from "double dipping" as PharmaNet currently does for prescription drugs.

### **103 (1) (b) (ii) Registration application**

If the applicant ordinarily resides in Canada but has no dwelling-place, the address, as well as, if applicable, the telephone number, facsimile number and email address of a t;

- In the case that a package is delivered to a shelter, hostel or similar institution that provides food, lodging or other social services to the applicant, who will ensure the security of the package as it waits to be picked up? These are not secure locations and the possibility that there is more than one person having their marijuana stored at a particular location makes it a more likely target for theft.

### **103 (1) (f) (iii) Registration application**

- If Health Canada no longer reviews use applications what is to stop someone from ordering the marijuana and selling it? In this instance the medical document is written by and the marijuana is shipped to the same person.

### **103 (5) Homeless applicant**

- What prevents shelters, hostels or similar institutions from becoming illegal selling/distribution points? Individuals with no security clearance would be in possession of the substance and there are no security requirements at these locations. Additionally, individuals keeping the marijuana for the user would not have a maximum amount that they are allowed to possess at one time.

### **105. Verification of medical document**

- If Health Canada is not keeping track of individual users, what is to stop individuals from going to different doctors and getting multiple medical authorizations and then going to different producers and thus obtaining more than the legally allowed amount of marijuana? There should be a database of information used by all licensees so that applications can be cross-referenced.
- This verification process could result in significant requirements for paper work for health care practitioners. We request additional details on how this process is anticipated to work in order to minimize administrative burden on health care practitioners.

### **118 Shipping**

- This seems to preclude shipments to pharmacists or other intermediaries for provision to the client? Does this section preclude shipping to pharmacies?

**119 (1) (d) Refusal**

A licensed producer must refuse to fill an order referred to in section 117 if the order has been previously filled in whole or in part.

- This seems to mean that a registered client can't receive the rest of their prescription if they've received part of it earlier?
- What would happen if the user lost their prescribed quantity of marijuana?

**PART 3 - REGISTERED CLIENTS AND OTHER AUTHORIZED USERS****122 Prohibition — obtaining from more than one source**

- What are the sanctions related to this prohibition?
- If it is not prohibited or unusual for an individual to have more than one medical document, what prevents individuals from obtaining multiple documents and then getting more than they would otherwise be allowed?

**123 (3) Return to licensed producer**

- Who is responsible for the security of the package when a registered client returns dried marijuana to the licensed producer?

**PART 4 - HEALTH CARE PRACTITIONERS****124 Authorized activities**

- BC objects to the authorization for health care practitioners to sell "dried marihuana" in this section, as well as sections 126 and 127 in the strongest of terms, and we request that this authorization to sell be deleted from the regulation. See our more detailed comments in the BC "General Comments" document.
- If a medical practitioner can provide a medical document, obtain marijuana from an authorized source, and sell, provide or administer dried marijuana, are medical practitioners audited to ensure marijuana is not diverted.
- If Health Canada no longer reviews applications, what is to prevent a medical practitioner from ordering marijuana for fictitious persons and then selling it?

**126 Labelling of dried marihuana**

- Is there any concern regarding the use of discarded or stolen medical marijuana packages to hide illegal marijuana possession?

**PART 5 - SALE OR PROVISION BY A LICENSED PRODUCER TO A PERSON OTHER THAN A REGISTERED CLIENT****128 (2) (a) Order required — dried marihuana**

- Are hospitals, pharmacists and health care practitioners that distribute marijuana to users subject to audits? If so, where in the MMPPR does it say that individuals and organizations (other than licensed producers) that distribute marijuana to users can be audited by Health Canada?

**128 (4) Signature**

"A licensed producer must verify in a reasonable manner the identity of the person who placed the order if the signature on the order is not known to the producer."

- The signature for comparison is provided as part of the application (per 103 (3)), but how qualified is the licenced producer to do a signature comparison? And if the signature doesn't match, what is a "reasonable manner" to verify identity?

**PART 6 - RECORD KEEPING BY LICENSED PRODUCERS**

- Are these records to be stored in a secure location to prevent alteration?
- What does the licensed producer do with the records? Do they send the records to Health Canada? Can they be required to show records to Health Canada, if requested, during inspections? Are they required to report out on any of this information?

**PRODUCTION AND INVENTORY****141 (2) Destroyed Cannabis**

"A licensed producer must keep, for each instance in which they destroy cannabis, a statement signed and dated by each of the witnesses referred to in paragraph 20(2) (b) stating that they have witnessed the destruction and that the cannabis was destroyed in accordance with section 20."

- This should say "witnessed the destruction of x weight" so that it is clear in the records that the witness saw destroyed all the marijuana that was reported as destroyed.

**GENERAL OBLIGATIONS****144 Information required by Minister**

- Who will ensure that the licenced producer is not growing too many plants? How does Health Canada plan to ensure compliance?
- This should include a provision that any information obtained by the Minister pursuant to this section may be shared with a provincial or territorial government.

## British Columbia Response to Health Canada's proposed Marijuana for Medical Purposes Regulation

### Performance Measurement and Evaluation Plan Comments

The lack of a program planning framework mentioned in our General Comments document has resulted in some important gaps in the evaluation plan. To reiterate, a comprehensive program planning framework would include clear articulation the program vision, principles, all of the goals, objectives, and indicators of success. Describing these elements is foundational to good health care program planning and evaluation. This description is important so that the program aims can be understood, monitored and evaluated.

For example, there is a lack of objectives with regards to creating access to cannabis for patients, including no definition of access, no assessment of the current level of access, and no objectives with respect to how the proposed changes are designed to improve patients' access.

Other program areas needing goals, objectives and outcomes include:

- Effects on patients' health of e.g. What health improvements are anticipated as outcomes of the program? What adverse health events for patients are of concern? How are the benefits and adverse events being monitored?
- Patient satisfaction
- Affordability for patients
- Health care provider knowledge, attitudes, competency and behaviours with respect to advising and recommending cannabis for therapeutic purposes
- Health care provider participation in the program
- Public knowledge about the risks and benefits of cannabis for therapeutic purposes
- How well the commercial supply meets patient needs
- Unintended benefits of the program such as reduced prescription medication use or reduced health care utilization.

Surveys of the authorized patients and authorizing providers should be done to monitor the implementation of the program with respect to the issue mentioned above.

We note that the evaluation plan does not include indicators to help understand the population for which this program is intended e.g. regular population based surveys should be done to measure populations rates of use of cannabis for therapeutic purposes, with collection of information such that analysis could be done by age, gender, geography, reason for use, duration of use, and beneficial and adverse effects.

We note that there are no plans to evaluate the health and social impacts of the changes on patients who rely on growing their own supply, or having their supply grown for them, the undesirable consequences of prior license holders continuing to grow such as justice system encounters for previously licensed growers who continue to grow, and consequences such as fines and incarceration of patients who continue to grow.

As part of the evaluation plan we would have expected to see dedicated funding for research as this is a substantially new and untested program.

*We recommend that Health Canada report annually with regards to the implementation of this new program.*

Expected Result / Output	Performance Indicator	Data Source	Frequency of Data Collection	Target*	Date to Achieve Target**	Responsible for data collection
<b>Outputs</b>						
O1. Information e.g guides, fact sheets, web content; responses to enquiries via telephone, fax, mail, email, etc.	-Number of Information/ publication materials produced / year	Clients services and internal administrative data	Quarterly	Target number to be set after base year	Target to be achieved by Year V	OCS
O2.New/renewed/amen ded Licences; Import/Export permits; licence refusal , notices, etc.	-Number of licences and permits issued/renewed / amended per year; -Percent of applications processed within Service Standard per year	Internal Health Canada records/ operational data	Annually	Target to be set after Service Standard determined in base year	Target to be achieved by Year V	OCS
O3. Inspection/ audit reports, follow-up letters, suspension and revocation notices, events, etc.	-Percent of inspection/ audit reports completed/year out of total planned	Internal Health Canada records/ operational data	Annually	Target completion rates to be set after base year	Target to be achieved by Year V	OCS
<b>Immediate Outcomes</b>						

**Comment [A1]:** How does the number of materials produced say anything about how effective these materials are? Perhaps how many individuals/organizations took these materials and how many they took? But even then it doesn't really speak to how helpful they are.

**Comment [t2]:** How many information publications are they planning to have each year? Once the initial information sheets are made, are more necessary each year? This is only relevant to 1<sup>st</sup> year. Timeliness to public inquiries should be tracked in 1<sup>st</sup> and future years.

**Comment [t3]:** This is just an output measure that does not indicate success. Suggest collecting number of users served by licence holders in addition to this.



# Appendix 3

DRAFT February 7 2013

S1. Stakeholders are aware of regulatory provisions for access	-Level of stakeholder awareness of access provisions -Number of web hits/month -Number of enquiries (calls, emails) for information per year	-Proxy data ( e.g. licence application, licence producer records); -HC website statistics	Annually	Targets to be set with reference to base year levels	Target to be achieved by Year V	OCS/OPSP
S2. Licensed producers set up, produce and distribute marihuana	-Number of active licensed producers /month -Percent of licensed producers licensed to grow / distribute per year	Internal HC administrative data; Inspection reports;	Quarterly	Target to be set after base year	Target to be achieved by Year V	OCS

**Comment [b4]:** There should be objectives about provider knowledge, attitudes, behaviour and participation rates with respect to advising and recommending medical documents.

**Comment [A5]:** Is a large number of enquiries a good thing because it shows many people were educated this way? Or is a large number bad because it shows that many people didn't understand and needed to phone in for information?

Expected Result / Output	Performance Indicator	Data Source	Frequency of Data Collection	Target*	Date to Achieve Target**	Responsible for data collection
S3. Licensed Producers aware of and comply with regulatory requirements	-Proportion of licence producers compliant with health/safety and security requirements/year -Number of licences suspended or revoked/year -Number of product recalls/ year reported to Health Canada by licensed producers	Inspection and audit reports; Other internal administrative internal data;	Annual	95% compliance with health and safety requirements.	Target to be achieved by Year V	OCS/RAPB
Intermediate Outcomes						

**Comment [t6]:** What would this be audited against? Relevant building/electrical code? Where are they health and safety requirements compiled and maintained?

**Comment [A7]:** Numbers should be included on: (1) how many licensees fix things and become compliant after an audit and (2) what kind of things licensees lose their licence for and how many of each kind of thing

# Appendix 3

DRAFT February 7 2013

M1. Regulated market has adequate capacity to maintain reasonable access to legal supply of marihuana	<ul style="list-style-type: none"> <li>- Trend in volume of products ( by weight) sold by licensed producers/quarter</li> <li>-Trend in registered licensed producers' clientele/quarter</li> <li>-Trend in number of active licensed producers; participating authorized health care practitioner/year</li> </ul>	Licence producer records; Inspection/ audit reports Other internal Health Canada administrative data	Annual	Trend in products sold consistent with trend in registered clientele	Target to be achieved by Year V	OCS
M2. Quality-controlled marihuana produced in Health Canada-licensed and inspected facilities	<ul style="list-style-type: none"> <li>- Trend in proportion of licence producers compliant with health/safety and security requirements/year</li> <li>- Trend in number of product recalls reported to Health Canada/ year by licensed producers</li> </ul>	In-house reports and internal administrative data	Annual	See Target under S3	Target to be achieved by Year V	OCS
M3. Marihuana for medical purposes securely produced and distributed	- Proportion ( and trend) of licence revocations/suspensions related to security	Internal Health Canada administrative data	Annual	See Target under S3	Target to be achieved by Year V	OCS

**Comment [b8]:** Reasonable access needs to be defined. Objectives with regards to access should be established.

**Comment [A9]:** Will anyone be keeping track of what amount of marijuana people are being prescribed?

**Comment [A10]:** Data should be collected on theft. E.g., at what stage in the process it occurs, how it occurs, quantities stolen.

Pages 151 through 152 redacted for the following reasons:

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S. 13

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 961607**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
– **FOR INFORMATION**

**TITLE:** Release of a Methadone Maintenance System Indicators Report by the  
Provincial Health Officer

**PURPOSE:** To inform the Minister of Health about the release of a report on various key indicators of British Columbia's Methadone Maintenance System by the Office of the Provincial Health Officer (PHO).

**BACKGROUND:**

Methadone maintenance treatment is scientifically recognized as a best practice both for treating opioid dependence and for preventing blood-borne pathogens such as HIV and hepatitis C (through reduced injection and needle sharing). In the mid-1990s, BC's methadone maintenance system began to be scaled up, going from approximately 2,800 patients in 1996 to more than 13,000 in 2012. This rapid scale up of the program led to a number of positive health and social outcomes, but some aspects of the program—including accessibility, equitability, quality of care, oversight, and fiscal concerns—were identified as issues that led the Ministry of Health (the Ministry) to commission an independent review of the system by the University of Victoria's Centre for Addictions Research of BC and the University of BC's Centre for Health Evaluation and Outcome Sciences, in 2009. A summary report from this review was made public in September 2010, along with a provincial government response to the report. At the same time, the Office of the PHO agreed to provide ongoing monitoring and reporting on BC's methadone maintenance system, which has led to the internal preparation of a report that will be posted publicly on the PHO's website in late January 2013 (see Appendix A – "Methadone Maintenance System Performance Measures, 2011/12").

**DISCUSSION:**

The PHO report on BC's methadone maintenance system includes recent data on patient numbers, retention, hospitalization, and mortality, as well as pharmacist numbers, physician numbers, physician adherence to dosing guidelines, and provincial expenditures for methadone maintenance. The report will also be shared directly with key health system partners (e.g., health authorities, College of Physicians and Surgeons, College of Pharmacists, College of Registered Nurses, and First Nations and Aboriginal Tripartite partners) as background for a meeting with representatives from these groups (as well as several methadone maintenance patients) that is being convened on January 28, 2013.

Methadone maintenance is identified as a key action in *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*, specifically: “Enhance and improve B.C.’s methadone maintenance treatment system (including medical, pharmaceutical and psychosocial support components)” (p. 33). The outcome target is that: “By 2015, 90 per cent of methadone prescribers will adhere to optimal dose guidelines and 60 per cent of people started on methadone maintenance treatment will be retained at 12 months” (p. 34). The new PHO report indicates that in 2011/2012 fewer than 55 percent of physicians adhered to the minimum effective stabilization dose recommended by the College of Physicians and Surgeons’ Methadone Maintenance Handbook (e.g., 60 mg/day), and that in 2010/2011 approximately 42 percent of patients who started methadone maintenance were retained at 12 months.

Several divisions of the Ministry have a role in components of the Province’s methadone maintenance system. The Medical Services Division funds fee-for-service payments to physicians for methadone maintenance. The Pharmaceutical Services Division funds methadone maintenance pharmacy costs—including drug fees, dispensing fees and daily witnessed ingestion fees—and also oversees a contract with the College of Physicians and Surgeons pertaining to physician training for methadone maintenance prescribing and care. The Health Authorities Division oversees health authority mental health and substance use programs, which may provide psychosocial supports and other ancillary care for opioid dependent patients. The Population and Public Health Division—cognizant of the effectiveness of methadone maintenance in preventing blood-borne pathogen transmission—led the 2009 independent methadone maintenance system review and continues to provide ongoing stewardship for system performance monitoring. In addition, the Ministry of Social Development (MSD) provides a supplement for income assistance clients (up to \$500/year, an average of \$41.66/month) to cover costs of substance dependence counselling or related services, including clinic user fees ostensibly for services not paid for by the Medical Services Plan. The total annual expenditure by MSD for the addiction counselling supplement in 2011/2012 was \$2.37 million (a majority of which goes to methadone patients).

Following the completion of the 2010 methadone review, the various Ministry divisions listed above, along with MSD, established an Inter-ministry Methadone Maintenance Treatment Steering Committee which is chaired by the Executive Director, Policy Outcomes Evaluation and Research in the Pharmaceutical Services Division. The Inter-ministry Methadone Maintenance Treatment Steering Committee members have all received and reviewed the new PHO report on the methadone maintenance system.

#### **ADVICE:**

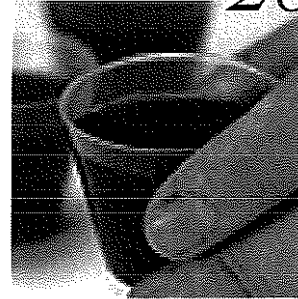
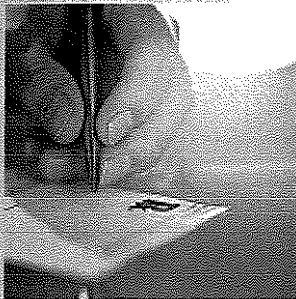
The Ministry should continue to work with health authorities, professional organizations and other key health system partners with a role in the Province’s methadone maintenance system to improve system performance and patient outcomes.

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<b>Program ADM/Division:</b>	Arlene Paton – Population and Public Health Division
<b>Telephone:</b>	250-952-1731
<b>Program Contact (for content):</b>	Warren O’Brian/Perry Kendall
<b>Drafter:</b>	Kenneth Tupper, Director, Problematic Substance Use Prevention
<b>Date:</b>	January 23, 2013
<b>File Name with Path:</b>	R:\CDAP\CDAP\A1 Admin\Executive 280\20 BNs\20 PSU\PSU 2013\961607 - PHO
MMS Indicators Report Release.docx	

DRAFT

# *Methadone Maintenance System Performance Measures 2011/12*



**Office of the Provincial Health Officer**

With contributions by:  
Pharmaceutical Services Division &  
Population and Public Health Division,  
British Columbia Ministry of Health

December 2012



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# 1. Introduction

Opioid dependence is a chronic, recurrent medical illness associated with co-morbid mental illness, transmission of infectious diseases (such as HIV/AIDS and hepatitis C), and premature mortality.<sup>1</sup> Methadone maintenance is widely regarded as both a highly effective treatment for opioid dependence and an evidence-based harm reduction intervention to prevent the transmission of blood-borne pathogens. Additionally, numerous studies have found that methadone maintenance reduces harms associated with non-medical opioid use, including injection-related risks and criminal activity, and increases the social functioning and quality of life of patients.

British Columbia's (BC) *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in B.C.* outlines key actions and outcomes that relate to BC's Methadone Maintenance System:

- Enhance and improve B.C.'s methadone maintenance treatment system (including medical, pharmaceutical and psychosocial support components);
- By 2015, 90 per cent of methadone prescribers will adhere to optimal dose guidelines and 60 per cent of people started on methadone maintenance treatment will be retained at 12 months.
- Where appropriate, expand the reach and range of harm-reduction services that prevent and reduce the health, social and fiscal impacts of illegal drug use; and
- By 2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities.

The effectiveness of the province's Methadone Maintenance System depends on multidisciplinary approach with three key components: prescribing, dispensing, and counselling or other adjunct services and supports. Two professional regulatory bodies are responsible for the prescribing and dispensing components of the Methadone Maintenance System: the College of Physicians and Surgeons of British Columbia (CPSBC) and the College of Pharmacists of British Columbia (CPBC).

CPSBC oversees the prescribing component through its Methadone Maintenance Program under the advisement of its Methadone Maintenance Committee, composed of physicians with expertise in addictions medicine and opioid substitution treatment. The objective of CPSBC's program is to support physicians to safely and effectively prescribe methadone for maintenance purposes. CPSBC develops guidelines and provides education to physicians for prescribing methadone and submits applications on behalf of physicians to the federal Minister of Health for exemptions to the Controlled Drugs and Substances Act so that methadone can be legally prescribed.

CPBC licenses and regulates pharmacists, pharmacy technicians and the places in which they practice. CPBC provides policy guidance and training for pharmacists who purchase and dispense methadone. Pharmacists must complete the College's Methadone Maintenance Treatment training as identified in the 2010 CPBC Policy

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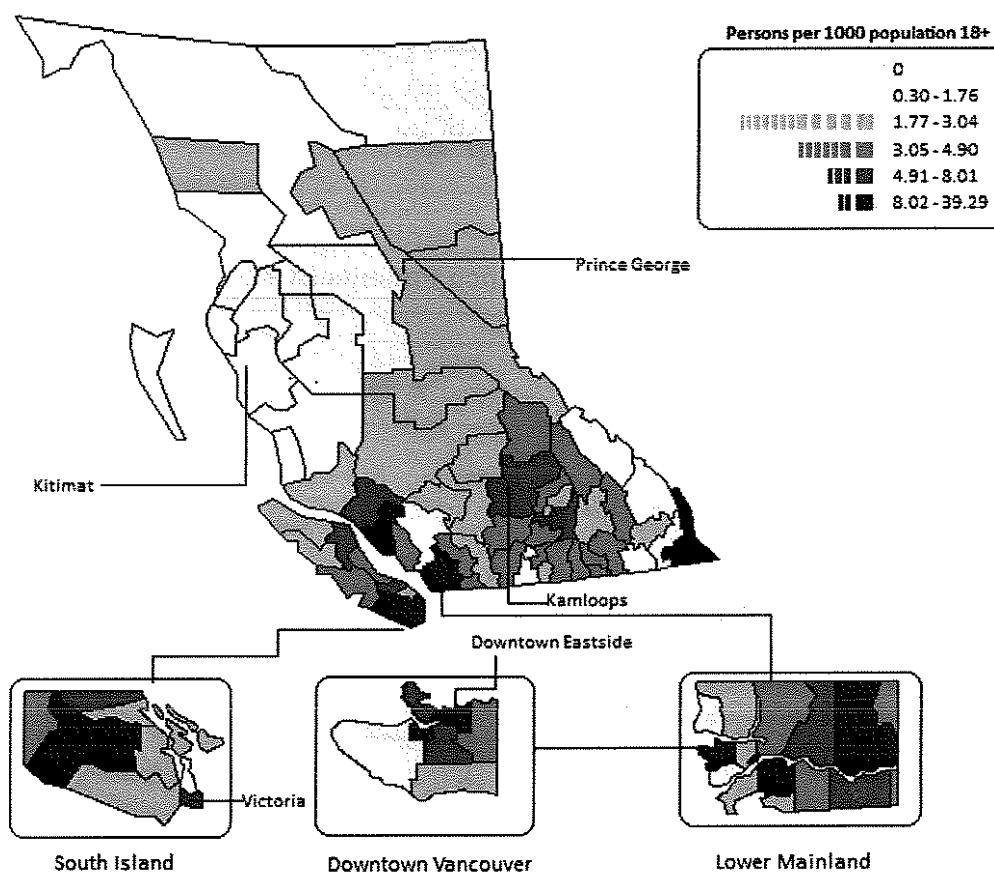
<sup>1</sup> Nosyk, et al (2009). An Evaluation of Methadone Maintenance Treatment in British Columbia: 1996-2007. Vancouver, BC.

## 2. Methadone Maintenance System Measures

The reach of BC's Methadone Maintenance System (MMS) can be summarized by reporting on key indicators of participation in the MMS. These include numbers of patients with methadone maintenance prescriptions (whose medication is covered by PharmaCare), numbers of physician prescribers of methadone for maintenance purposes, and numbers of methadone-dispensing pharmacists and pharmacies. This section also provides a summary of the direct costs of methadone maintenance and the PharmaCare program associated with BC's MMS.

### 2.1 Methadone Maintenance Patients

#### Methadone Maintenance Patients by Local Health Area, 2011/12



The above map shows the rates of engagement in methadone maintenance across the province in 2011/12. Higher rates are found in BC's larger urban areas such as the Lower Mainland, Victoria, Nanaimo and Kamloops. However, high rates (i.e., 5 to 8 patients per 1,000) also exist in smaller population centres such as Powell River, Lake Cowichan and Campbell River.

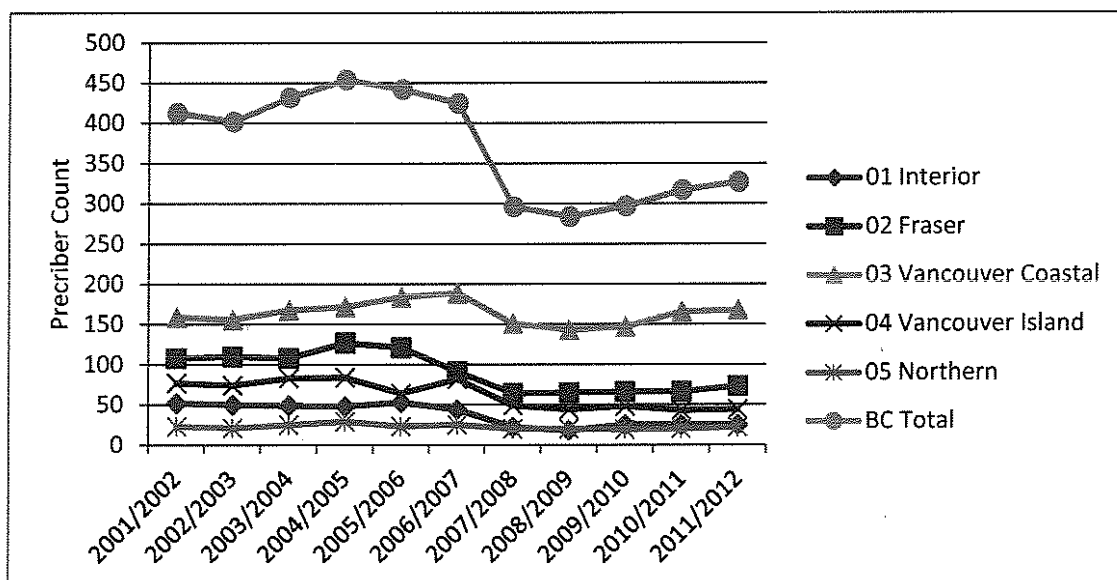


## 2.2 Methadone Maintenance Program Prescribers

Physicians who want to prescribe methadone for maintenance purposes are required to receive authorization by the College of Physicians and Surgeons of British Columbia (CPSBC). The requirements for authorization include attending a day long certification course, complying with prescribing guidelines (which are monitored by CPSBC) and re-certification on an ongoing basis.

In 2011/12, there were 11,980 professionally active physicians in British Columbia. Of these, 433 physicians were authorized to prescribe methadone for maintenance purposes, and 327 actually prescribed for patients during that 12-month period, 168 (51%) of whom were based in the geographical region served by Vancouver Coastal Health Authority. The chart below provides the annual physician prescriber count by Health Authority since 2001/02.

**Chart 2.2(a): Methadone Maintenance Program Active Prescribers by Health Authority**



There was a decrease of over 100 prescribers between 2006/07 and 2007/08. During this time, the Medical Service Plan (MSP) payments for methadone maintenance treatment consultations changed from one payment per visit to one per week, which may have led some physicians to discontinue methadone maintenance prescribing. This decline in methadone prescribers appears to have little effect on the numbers of patients initiating methadone maintenance; on average, physicians continuing to prescribe methadone have individually taken on more patients.

## 2.3 Methadone Maintenance Pharmacists and Pharmacies

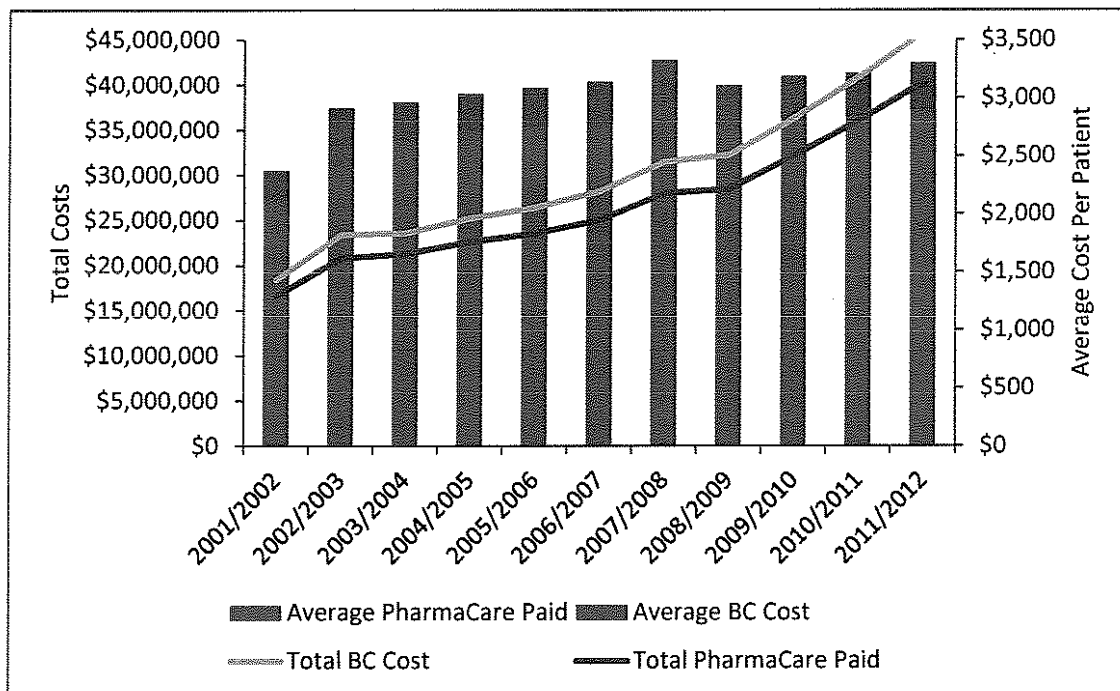
Similar to prescribing physicians, pharmacists in BC must meet specific training and certification requirements to be eligible to dispense methadone for maintenance purposes. Pharmacists dispense measured doses of methadone in liquid form for

## 2.4 Methadone Maintenance Expenditures

PharmaCare helps British Columbians with the cost of eligible prescription drugs and designated medical supplies. PharmaCare reimburses methadone ingredient costs and dispensing fees, as well as interaction fees for pharmacists who witness ingestion on-site. Patients registered with PharmaCare Plan C (for recipients of BC income assistance) are eligible for full reimbursement of their methadone costs for prescribing and dispensing. Patients registered with Fair PharmaCare pay deductibles and co-pays, based on family income. For some patients, private insurance will cover a portion of these costs.

The total pharmacy costs for methadone maintenance in BC reached nearly \$46 million in 2011/12, \$40 million of which was paid by PharmaCare. Chart 2.6 summarizes the trend in costs over time.

**Chart 2.4(a): Provincial Government and PharmaCare Methadone Expenditures**



Note: Methadone costs include costs of ingredients, dispensing fees and interaction fees. Total costs in British Columbia include payments made by PharmaCare, patients, and third party insurers. Payments for interaction fees are made in bulk to pharmacies; therefore, it is difficult to disaggregate costs to patient Health Authorities.

### 3. System Outcome Measures

This section summarizes system outcome measures that are indirectly associated with BC's MMS through the impacts of methadone maintenance on the underlying health conditions (including opioid dependence) of participants in the program.

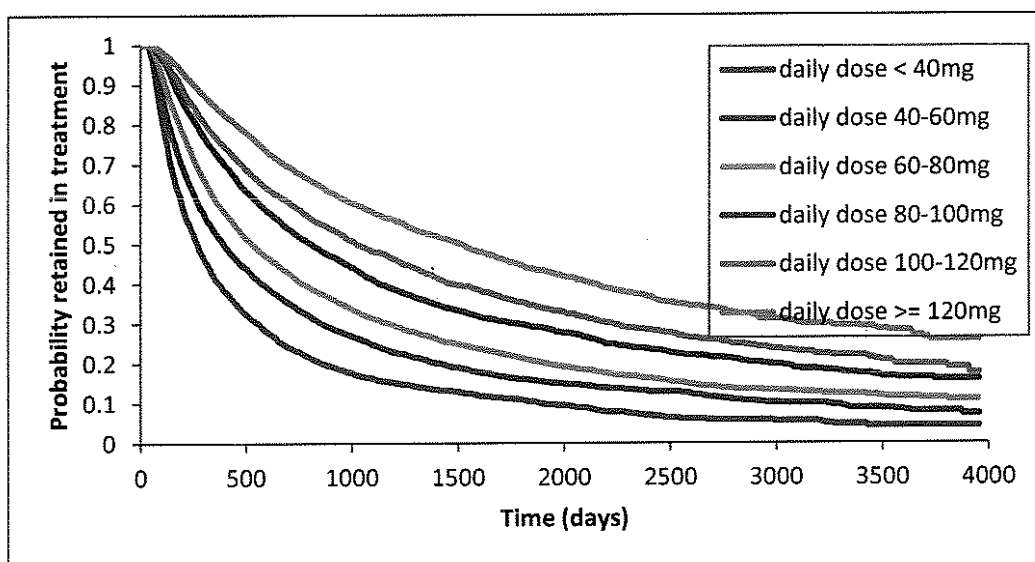
All outcome measures presented here are for episodes of methadone maintenance treatment, defined as continuous dispenses of methadone (plus additional days supplied for off-site use). A gap of more than 30 consecutive days determines the end of an episode of treatment.

An important caveat for this section is that the outcome measures were obtained without an attempt to isolate the effect of methadone maintenance (versus no treatment or other treatments). Therefore, the material presented here is intended to be hypothesis-generating and may initiate further analysis of more specific outcomes using observational study designs.

#### 3.1 Methadone Maintenance Duration and Retention

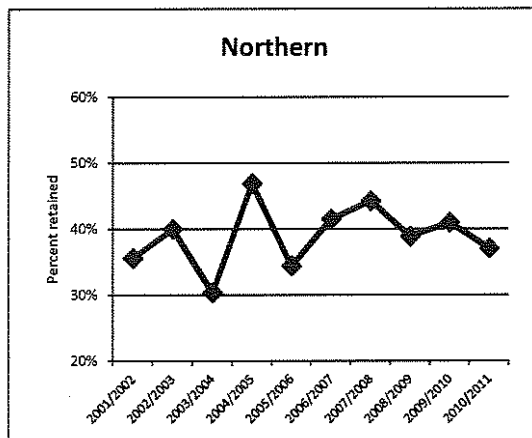
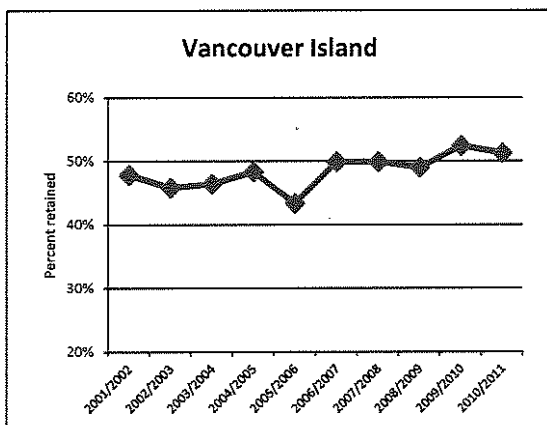
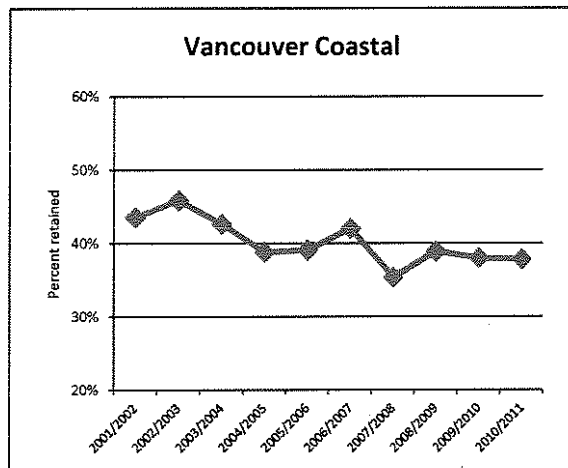
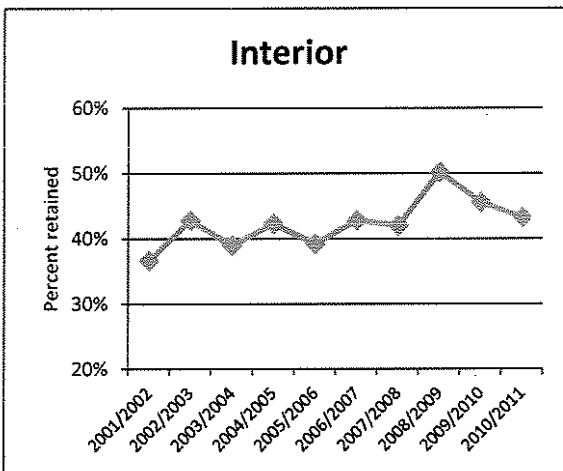
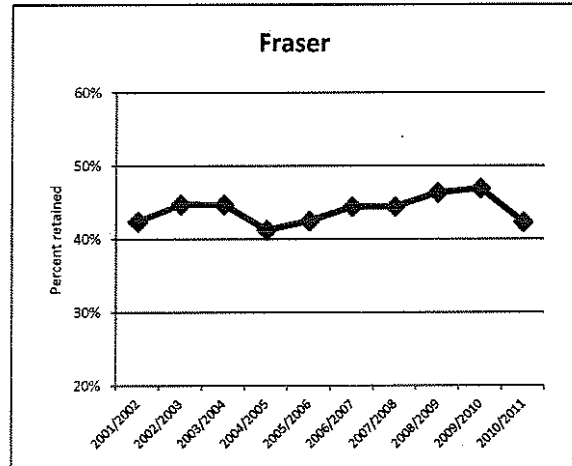
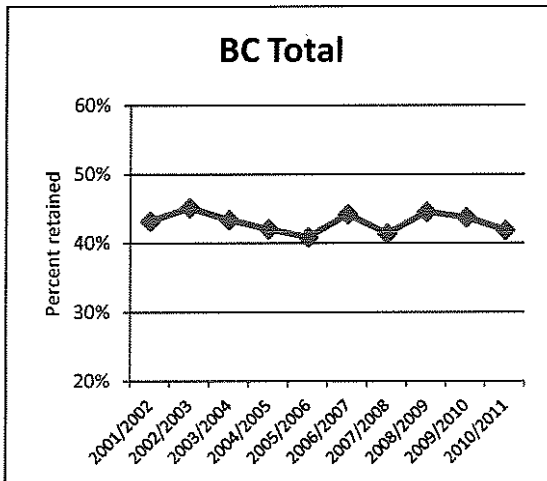
Methadone maintenance duration is measured in days of maintenance per each episode, and is an important indicator of treatment effectiveness. Studies referenced in Nosyk et al. (2009) suggest that longer treatment duration is associated with improved post-treatment outcomes. Nosyk et al. (2009) also found a significant correlation between dose and treatment retention, with probability of being retained in treatment lowest for patients receiving maintenance doses below 40mg per day and highest for patients receiving above 100mg per day (the College of Physicians and Surgeons of British Columbia's 2009 Methadone Maintenance Handbook recommends stabilization doses of between 60 to 120 mg per day as optimal for most patients).

**Chart 3.1(a): Effect of daily dose on methadone maintenance treatment retention (Kaplan-Meier Curve)**

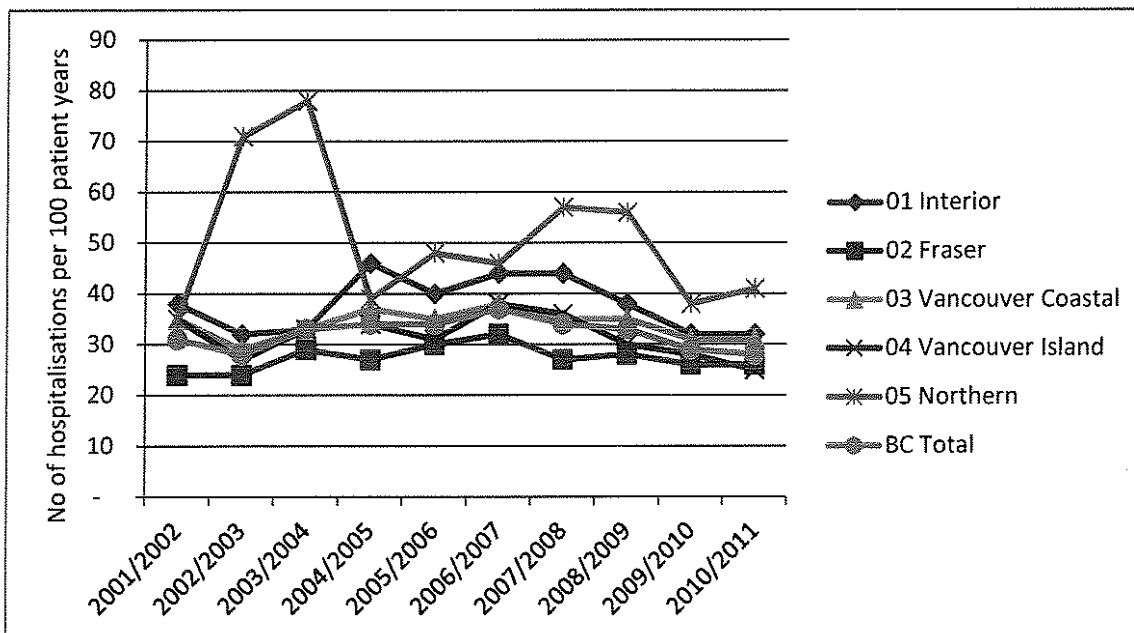


**Chart 3.1(c): Percentage of people started on methadone maintenance treatment retained at 12 months, by Health Authority**

Methadone maintenance retention rates in Vancouver Island Health Authority are consistently higher than the BC average, while rates in Vancouver Coastal appear lower than the average in more recent years.



**Chart 3.2(b): Hospitalizations per 100 Person Years During Methadone Maintenance by Health Authority**



### 3.3 Mortality

This section provides measures of mortality during methadone maintenance. Mortality is measured in terms of deaths from any cause recorded within 30 days of an episode of methadone maintenance.

**Table 3.3(a): All-cause Mortality During Methadone Maintenance Treatment by Fiscal Year**

	No. of Deaths	
	Total	Rate per 100 person years
2001/02	18	1.9
2002/03	34	1.5
2003/04	45	1.6
2004/05	60	1.7
2005/06	71	1.8
2006/07	73	1.6
2007/08	81	1.5
2008/09	74	1.2
2009/10	84	1.2
2010/11	89	1.1
2011/12	97	1.1

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## 4. Conclusion

Methadone maintenance treatment for opioid dependence in British Columbia has undergone significant growth over the past decade. Greater access to methadone maintenance, along with other harm reduction initiatives, has helped contribute to the lower incidence of HIV infection among people who inject drugs.<sup>3</sup> This report provides relevant data on key indicators of BC's methadone maintenance system. The information it presents is important for improving health service delivery and health system planning—and, ultimately, achieving better health outcomes for opioid-dependent people—in the province.

## 5. Resources

The websites listed below provide relevant information about BC's Methadone Maintenance System.

### British Columbia methadone program websites

- \* BC Ministry of Health [www.health.gov.bc.ca/cdms/methadone.html](http://www.health.gov.bc.ca/cdms/methadone.html)
- \* College of Physicians & Surgeons of BC [www.cpsbc.ca/node/94](http://www.cpsbc.ca/node/94)
- College of Pharmacists of BC  
[www.bcpharmacists.org/about\\_us/key\\_initiatives/index/articles144.php](http://www.bcpharmacists.org/about_us/key_initiatives/index/articles144.php)

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<sup>3</sup> Gilbert, M., Buxton, J.A., & Tupper, K.W. (2011). *Decreasing HIV infections among people who use drugs by injection in British Columbia: Potential explanations and recommendations for further action*. Office of the Provincial Health Officer: Victoria, BC. <http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf>

DRAFT

# METHADONE MAINTENANCE SYSTEM

## *Performance Measures* 2011/12



**Office of the Provincial Health Officer**

**With contributions by:**

Pharmaceutical Services Division &  
Population and Public Health Division,  
British Columbia Ministry of Health

**December 2012**



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**Acknowledgements:** The Ministry of Health would like to thank Dr. Bohdan Nosyk (BC Centre for Excellence in HIV/AIDS) and his colleagues at UBC's Centre for Health Evaluation and Outcome Sciences for their earlier work in analyzing methadone maintenance data in BC, which provided some of the methodological foundations for this report. The Ministry would also like to thank Ray Ghouse, Christine Voggenreiter, Patrick Day, Brett Wilmer, Kenneth Tupper and River Chandler for their work developing this report.



# 1

## INTRODUCTION

Opioid dependence is a chronic, recurrent medical illness associated with co-morbid mental illness, transmission of infectious diseases (such as HIV/AIDS and hepatitis C), and premature mortality.<sup>1</sup> Methadone maintenance is widely regarded as both a highly effective treatment for opioid dependence and an evidence-based harm reduction intervention to prevent the transmission of blood-borne pathogens. Additionally, numerous studies have found that methadone maintenance reduces harms associated with non-medical opioid use, including injection-related risks and criminal activity, and increases the social functioning and quality of life of patients.

British Columbia's (BC) *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in B.C.* outlines key actions and outcomes that relate to BC's Methadone Maintenance System:

- Enhance and improve BC's methadone maintenance treatment system (including medical, pharmaceutical and psychosocial support components)
- By 2015, 90% of methadone prescribers will adhere to optimal dose guidelines and 60% of people started on methadone maintenance treatment will be retained at 12 months
- Where appropriate, expand the reach and range of harm reduction services that prevent and reduce the health, social and fiscal impacts of illegal drug use
- By 2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities

The effectiveness of the province's Methadone Maintenance System depends on a multidisciplinary approach with three key components: prescribing, dispensing, and counselling or other adjunct services and supports. Two professional regulatory bodies are responsible for the prescribing and dispensing components of the Methadone Maintenance System: the College of Physicians and Surgeons of British Columbia (CPSBC) and the College of Pharmacists of British Columbia (CPBC).

CPSBC oversees the prescribing component through its Methadone Maintenance Program under the advisement of its Methadone Maintenance Committee, composed of physicians with expertise in addictions medicine and opioid substitution treatment. The objective of CPSBC's program is to support physicians to safely and effectively prescribe methadone for maintenance purposes. CPSBC develops guidelines and provides education to physicians for prescribing methadone and submits applications on behalf of physicians to the federal Minister of Health for exemptions to the Controlled Drugs and Substances Act so that methadone can be legally prescribed.

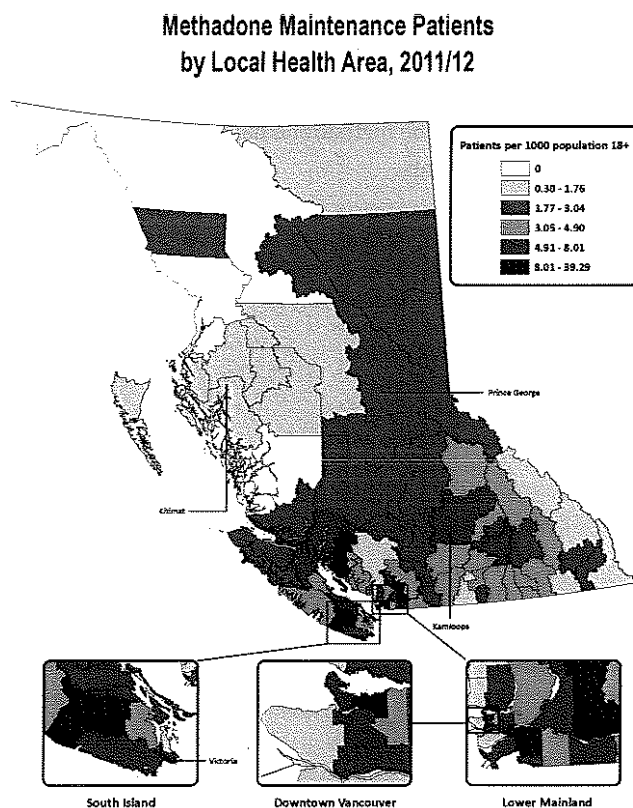
CPBC licenses and regulates pharmacists, pharmacy technicians and the places in which they practice. CPBC provides policy guidance and training for pharmacists who purchase and dispense methadone. Pharmacists must complete the College's Methadone Maintenance Treatment training as identified in the 2010 CPBC Policy Guide, and meet the necessary practice requirements prior to providing methadone-related pharmacy services.

<sup>1</sup> Nosyk et al (2009). *An Evaluation of Methadone Maintenance Treatment in British Columbia: 1996-2007*. Vancouver, BC.

## 2. METHADONE MAINTENANCE SYSTEM MEASURES

The reach of BC's Methadone Maintenance System (MMS) can be summarized by reporting on key indicators of participation in the MMS. These include numbers of patients with methadone maintenance prescriptions (whose medication is covered by PharmaCare), numbers of physician prescribers of methadone for maintenance purposes, and numbers of methadone-dispensing pharmacists and pharmacies. This section also provides a summary of the direct costs of methadone maintenance and the PharmaCare program associated with BC's MMS.

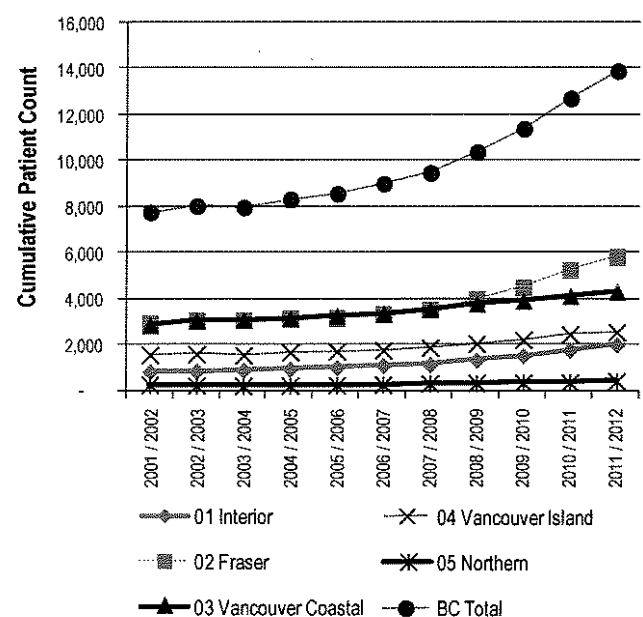
### 2.1 Methadone Maintenance Patients



The map shows the rates of engagement in methadone maintenance across the province in 2011/12. Higher rates are found in BC's larger urban areas such as the Lower Mainland, Victoria, Nanaimo and Kamloops. However, high rates (i.e., 5 to 8 patients per 1,000) also exist in smaller population centres such as Powell River, Lake Cowichan and Campbell River.

In 2011/12, PharmaCare provided coverage for methadone maintenance pharmacy costs for 13,894 patients. This is a 9% increase from the previous year and a 79% increase from 2001/02, the first year of a new payment structure for methadone maintenance pharmacies. Charts 2.1(a) and 2.2(a) break down methadone maintenance patient counts by Health Authority.

**Chart 2.1(a): Methadone Maintenance Patients  
by Health Authority**



## 2.3 Methadone Maintenance Pharmacists and Pharmacies

Similar to prescribing physicians, pharmacists in BC must meet specific training and certification requirements to be eligible to dispense methadone for maintenance purposes. Pharmacists dispense measured doses of methadone in liquid form for witnessed oral ingestion on-site or in carry-out packaging as appropriate for certain patients.

The numbers of BC pharmacists and pharmacies dispensing methadone for maintenance purposes have more than doubled since 2001/02. Charts 2.3(a) and 2.3(b) plot these figures by Health Authority.

Chart 2.3(a): Methadone Maintenance Pharmacists by Health Authority

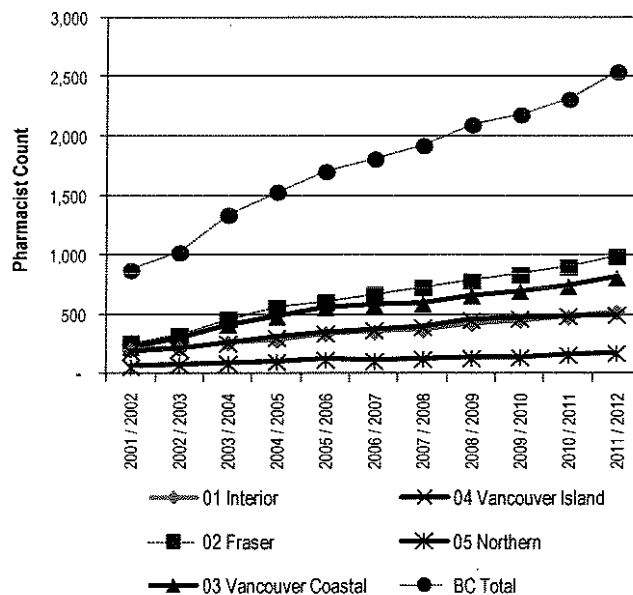
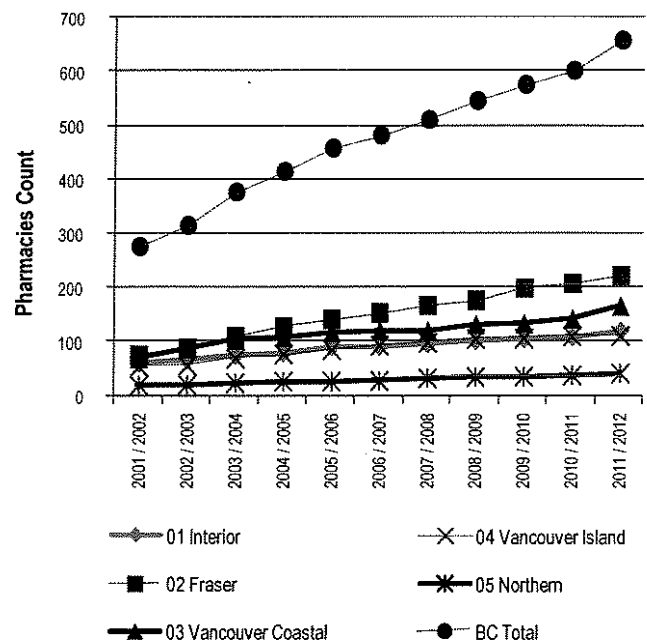


Chart 2.3(b): Methadone Maintenance Pharmacies by Health Authority



## 2.4 Methadone Maintenance Expenditures

PharmaCare helps British Columbians with the cost of eligible prescription drugs and designated medical supplies. PharmaCare reimburses methadone ingredient costs and dispensing fees, as well as interaction fees for pharmacists who witness ingestion on-site. Patients registered with PharmaCare Plan C (for recipients of BC income assistance) are eligible for full reimbursement of their methadone costs for prescribing and dispensing. Patients registered with Fair PharmaCare pay deductibles and co-pays, based on family income. For some patients, private insurance will cover a portion of these costs.

The total pharmacy costs for methadone maintenance in BC reached nearly \$46 million in 2011/12, \$40 million of which was paid by PharmaCare. Chart 2.4(a) summarizes the trend in costs over time.

# 3. SYSTEM OUTCOME MEASURES

This section summarizes system outcome measures that are indirectly associated with BC's MMS through the impacts of methadone maintenance on the underlying health conditions (including opioid dependence) of participants in the program.

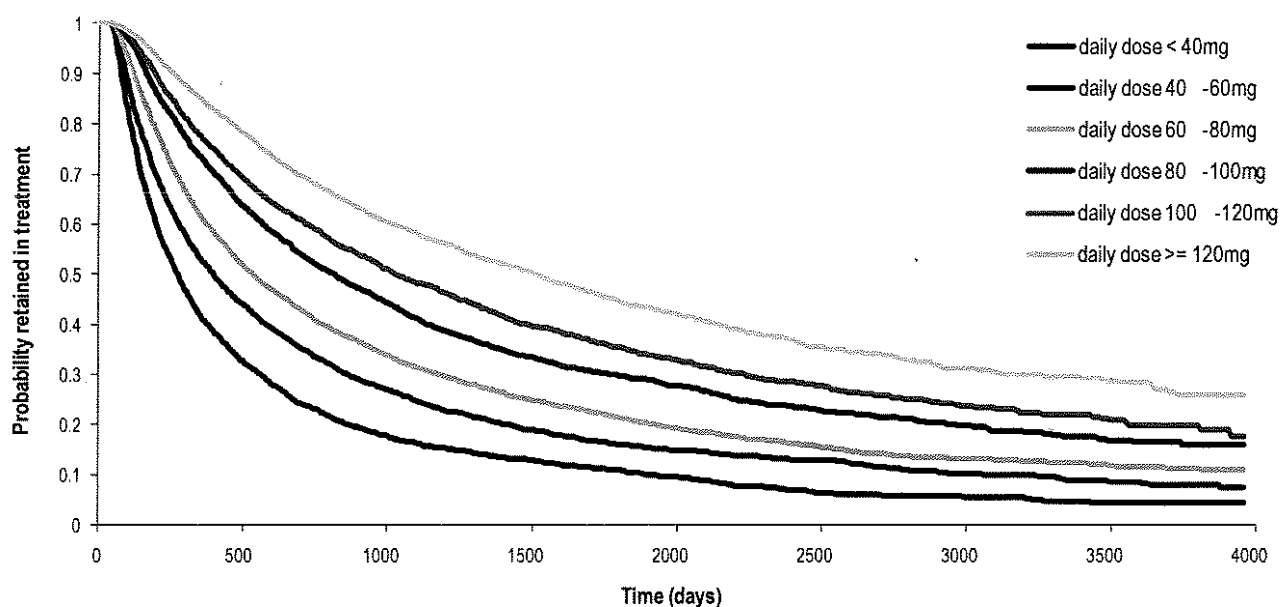
All outcome measures presented here are for episodes of methadone maintenance treatment, defined as continuous dispenses of methadone (plus additional days supplied for off-site use). A gap of more than 30 consecutive days determines the end of an episode of treatment.

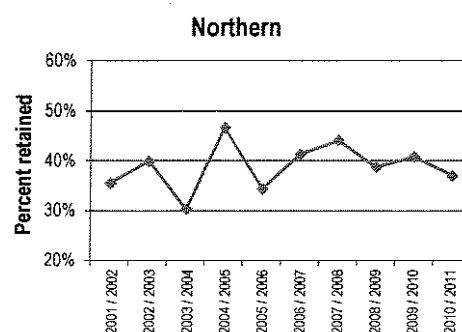
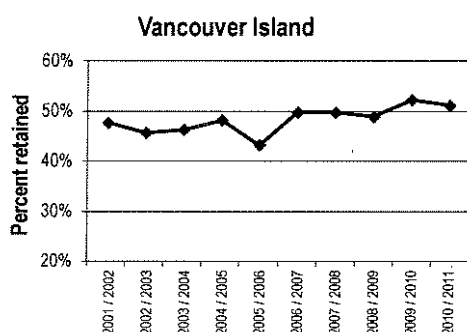
An important caveat for this section is that the outcome measures were obtained without an attempt to isolate the effect of methadone maintenance (versus no treatment or other treatments). Therefore, the material presented here is intended to be hypothesis-generating and may initiate further analysis of more specific outcomes using observational study designs.

## 3.1 Methadone Maintenance Duration and Retention

Methadone maintenance duration is measured in days of maintenance per episode, and is an important indicator of treatment effectiveness. Studies referenced in Nosyk et al. (2009) suggest that longer treatment duration is associated with improved post-treatment outcomes. Nosyk et al. (2009) also found a significant correlation between dose and treatment retention, with probability of being retained in treatment lowest for patients receiving maintenance doses below 40mg per day and highest for patients receiving above 100mg per day (CPSBC, 2009, *Methadone Maintenance Handbook* recommends stabilization doses of between 60 to 120 mg per day as optimal for most patients).

Chart 3.1(a): Effect of Daily Dose on Methadone Maintenance Treatment Retention (Kaplan-Meier Curve)





## 3.2 Hospitalizations and Costs

This section examines methadone patients' hospitalizations (for any cause) and the costs associated with hospitalizations. Table 3.2(a) summarizes the incidence and cost of hospitalizations while patients are engaged in methadone maintenance treatment.

The total cost of hospitalizations for patients engaged in methadone maintenance reached a high of \$14.5 million

in 2008/09. The average cost per patient was \$1,721. While the corresponding total cost for total hospitalization in 2010/11 increased again to \$14.2 million, the average cost was at its lowest level since 2002/03 at \$1,299.

Chart 3.2(b) shows the number of hospitalizations per 100 person years for patients engaged in methadone maintenance.

**Table 3.2(a): Hospitalizations and Costs During Methadone Maintenance by Fiscal Year**

	No. of Admissions		Hospital Cost	
	Total	Rate per 100 person years	Total	Average
2001/02	299	31.0	\$2,739,177	\$1,039
2002/03	650	28.0	\$4,038,741	\$1,032
2003/04	935	33.0	\$6,383,645	\$1,422
2004/05	1,179	34.0	\$8,372,147	\$1,583
2005/06	1,339	34.0	\$9,682,807	\$1,635
2006/07	1,688	37.0	\$11,775,471	\$1,770
2007/08	1,802	34.0	\$13,314,521	\$1,817
2008/09	1,955	33.0	\$14,452,144	\$1,721
2009/10	2,022	29.0	\$12,566,345	\$1,323
2010/11*	2,249	28.0	\$14,192,650	\$1,299

\*2010/11 figures may be incomplete because patients admitted to hospitals in 2009/10 but not discharged until 2011/12 will not appear in 2010/11 data. Median costs were \$0 because fewer than 50% of patients were hospitalized each fiscal year.

## 4. CONCLUSION

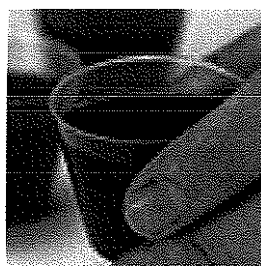
Methadone maintenance treatment for opioid dependence in British Columbia has undergone significant growth over the past decade. Greater access to methadone maintenance, along with other harm reduction initiatives, has helped contribute to the lower incidence of HIV infection among people who inject drugs.<sup>3</sup> This report

provides relevant data on key indicators of BC's methadone maintenance system. The information it presents is important for improving health service delivery and health system planning—and, ultimately, achieving better health outcomes for opioid-dependent people—in the province.

<sup>3</sup> Gilbert, M., Buxton, J.A. & Tupper, K.W. (2011). *Decreasing HIV infections among people who use drugs by injection in British Columbia: Potential explanations and recommendations for further action*. Victoria, BC: Office of the Provincial Health Officer. <http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf>

# BC METHADONE MAINTENANCE SYSTEM

## *Performance Measures* 2011/2012



### Office of the Provincial Health Officer

#### With contributions by:

Pharmaceutical Services Division &  
Population and Public Health Division  
British Columbia Ministry of Health

February 2013



Office of the  
Provincial Health Officer

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# 1. INTRODUCTION

Opioid dependence is a chronic, recurrent medical illness associated with co-morbid mental illness, transmission of infectious diseases (such as HIV/AIDS and hepatitis C), and premature mortality.<sup>1</sup> Methadone maintenance is widely regarded as both a highly effective treatment for opioid dependence and an evidence-based harm reduction intervention to prevent the transmission of blood-borne pathogens. Additionally, numerous studies have found that methadone maintenance reduces harms associated with non-medical opioid use, including injection-related risks and criminal activity, and increases the social functioning and quality of life of patients.

British Columbia's *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*<sup>2</sup> outlines key actions and outcomes that relate to BC's Methadone Maintenance System:

- Enhance and improve BC's methadone maintenance treatment system (including medical, pharmaceutical and psychosocial support components)
- By 2015, 90% of methadone prescribers will adhere to optimal dose guidelines and 60% of people started on methadone maintenance treatment will be retained at 12 months
- Where appropriate, expand the reach and range of harm reduction services that prevent and reduce the health, social and fiscal impacts of illegal drug use
- By 2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities

The effectiveness of the province's Methadone Maintenance System depends on a multidisciplinary approach with three key components: prescribing, dispensing, and counselling or other adjunct services and supports. Two professional regulatory bodies are responsible for the prescribing and dispensing components of the Methadone Maintenance System: the College of Physicians and Surgeons of British Columbia (CPSBC) and the College of Pharmacists of British Columbia (CPBC).

CPSBC oversees the prescribing component through its Methadone Maintenance Program, under the advisement of its Methadone Maintenance Committee, composed of physicians with expertise in addictions medicine and opioid substitution treatment. The objective of CPSBC's program is to support physicians to safely and effectively prescribe methadone for maintenance purposes. CPSBC develops guidelines and provides education to physicians for prescribing methadone and submits applications on behalf of physicians to the federal Minister of Health for exemptions to the Controlled Drugs and Substances Act so that methadone can be legally prescribed.

CPBC licenses and regulates pharmacists, pharmacy technicians and the places in which they practice. CPBC provides policy guidance and training for pharmacists who purchase and dispense methadone. Pharmacists must complete the College's Methadone Maintenance Treatment training as identified in the 2010 CPBC Policy Guide,<sup>3</sup> and meet the necessary practice requirements prior to providing methadone-related pharmacy services.

A 2010 review of methadone maintenance in BC identified the delivery of the psychosocial services component as one of the system's biggest challenges.<sup>4</sup> Psychosocial services and supports are an integral part of methadone maintenance and are provided by health authorities, private physicians, counsellors, and other allied health professionals.

This report presents data related to the prescribing and dispensing components of British Columbia's Methadone Maintenance System and addresses the recommendation in the Centre for Addictions Research of BC report, *Methadone Maintenance Treatment in British Columbia, 1996-2008*<sup>4</sup> to report regularly on the province's Methadone Maintenance System. The indicators that are reported on reflect available Ministry of Health provincial-level data, and may not capture all aspects of methadone maintenance services. Data tables for the figures in this report will be made available on the website of the Office of the Provincial Health Officer: <http://www.health.gov.bc.ca/pho/>

The performance measures in this report are provided on a fiscal year basis (April–March). The outcome measures in this report are based on the publication *An Evaluation of Methadone Maintenance Treatment in British Columbia: 1996-2007*, by Nosyk et al.<sup>1</sup>

## Data Sources

Data in this report was drawn from the Ministry of Health's HealthIdeas Data Warehouse. The databases from which specific Ministry program area data were drawn are as follows:

- i. PharmaNet (records of prescription drug claims dispensed at community pharmacies)
- ii. MSP Genesis (Medical Services Plan fee-for-service claims)
- iii. DAD (hospital discharge abstract data)
- iv. HealthIdeas Client Registry (client age, gender, date of death)

The report does not include data on methadone maintenance services provided to on-reserve First Nations patients, whose health services and medications for eligible clients are provided through Health Canada's non-insured health benefits program.

**Acknowledgements:** The Ministry of Health would like to thank Dr. Bohdan Nosyk (BC Centre for Excellence in HIV/AIDS) and his colleagues at UBC's Centre for Health Evaluation and Outcome Sciences for their earlier work in analyzing methadone maintenance data in BC, which provided some of the methodological foundations for this report. The Ministry would also like to thank Ray Ghouse, Christine Voggenreiter, Patrick Day, Brett Wilmer, Kenneth Tupper and River Chandler for their work developing this report. Special thanks to the Centre for Addictions Research of BC for its assistance with layout and production of the report.

## 2. METHADONE MAINTENANCE SYSTEM MEASURES

The reach of BC's Methadone Maintenance System (MMS) can be summarized by reporting on key indicators of participation in the MMS. These include numbers of patients with methadone maintenance prescriptions (whose medication is covered by PharmaCare), numbers of physician prescribers of methadone for maintenance purposes, and numbers of methadone-dispensing pharmacists and pharmacies. This section also provides a summary of the direct costs of methadone maintenance and the PharmaCare program associated with BC's MMS.

### 2.1 Methadone Maintenance Patients

**Figure 1. Methadone Maintenance Patients by Local Health Area, 2011/2012**

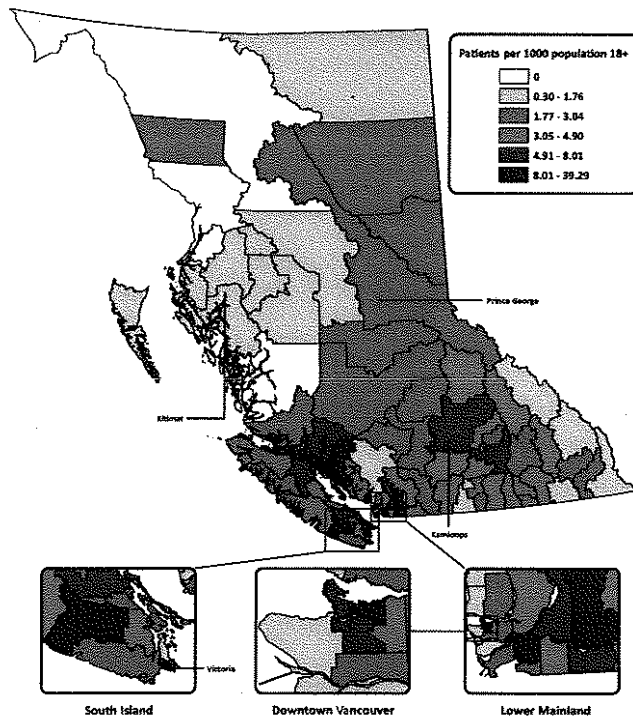
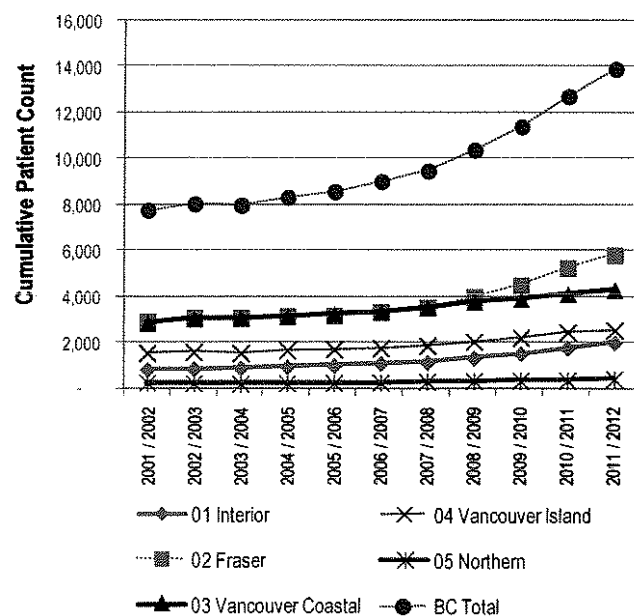


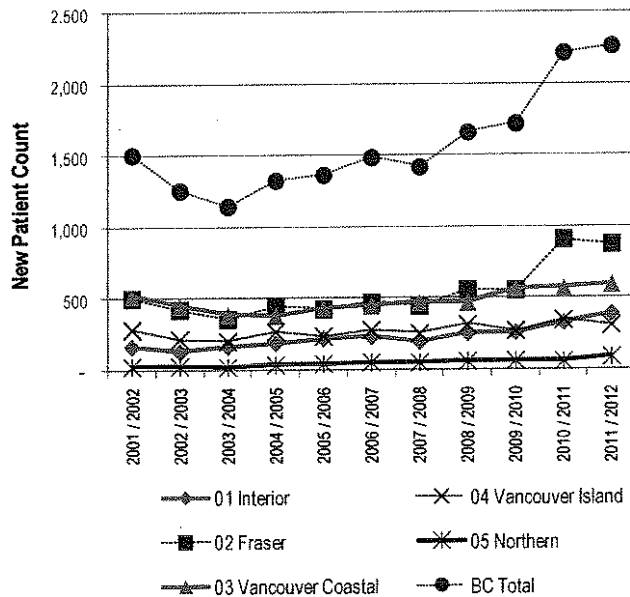
Figure 1 shows the rates of engagement in methadone maintenance across the province in 2011/2012. Higher rates are found in BC's larger urban areas such as the Lower Mainland, Victoria, Nanaimo and Kamloops. However, high rates (i.e., 5 to 8 patients per 1,000) also exist in smaller population centres such as Powell River, Lake Cowichan and Campbell River.

In 2011/2012, PharmaCare provided coverage for methadone maintenance pharmacy costs for 13,894 patients. This is a 9 per cent increase from the previous year and a 79 per cent increase from 2001/2002, which was the first year of a new payment structure for methadone maintenance pharmacies. Figures 2 and 3 break down methadone maintenance patient counts by health authority.

**Figure 2. Methadone Maintenance Patients by Health Authority, BC, 2001/2002 to 2011/2012**



**Figure 3. New Methadone Maintenance Patients by Health Authority, BC, 2001/2002 to 2011/2012**

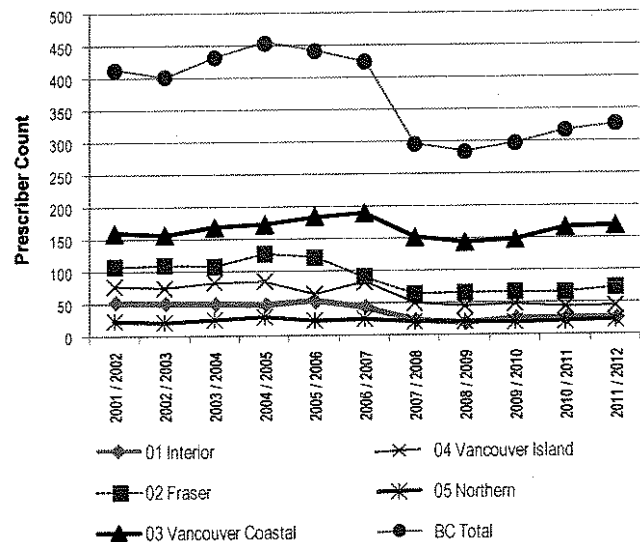


## 2.2 Methadone Maintenance Program Prescribers

Physicians who want to prescribe methadone for maintenance purposes are required to receive authorization by CPSBC. The requirements for authorization include attending a day-long certification course, complying with prescribing guidelines (which are monitored by CPSBC) and re-certification on an ongoing basis.

In 2011/2012, there were 11,980 professionally active physicians in British Columbia. Of these, 433 were authorized to prescribe methadone for maintenance purposes, and 327 actually prescribed for patients during that 12-month period, 168 (51 per cent) of whom were based in Vancouver Coastal Health Authority. Figure 4 provides the annual physician prescriber count by health authority since 2001/2002.

**Figure 4. Methadone Maintenance Program Active Prescribers by Health Authority, BC, 2001/2002 to 2011/2012**



As shown in Figure 4, there was a decrease of over 100 prescribers between 2006/2007 and 2007/2008. This decline in methadone prescribers appears to have little effect on the numbers of patients initiating methadone maintenance; on average, physicians continuing to prescribe methadone have individually taken on more patients. The Ministry of Health is investigating the reasons for this decrease and the Office of the Provincial Health Officer will provide an online update to this report when these are determined.

## 2.3 Methadone Maintenance Pharmacists and Pharmacies

Similar to prescribing physicians, pharmacists in BC must meet specific training and certification requirements to be eligible to dispense methadone for maintenance purposes. Pharmacists dispense measured doses of methadone in liquid form for witnessed oral ingestion on-site or in carry-out packaging as appropriate for certain patients.

The numbers of BC pharmacists and pharmacies dispensing methadone for maintenance purposes have more than doubled since 2001/2002. Figures 5 and 6 plot these numbers by health authority.

Figure 5. Methadone Maintenance Pharmacists by Health Authority, BC, 2001/2002 to 2011/2012

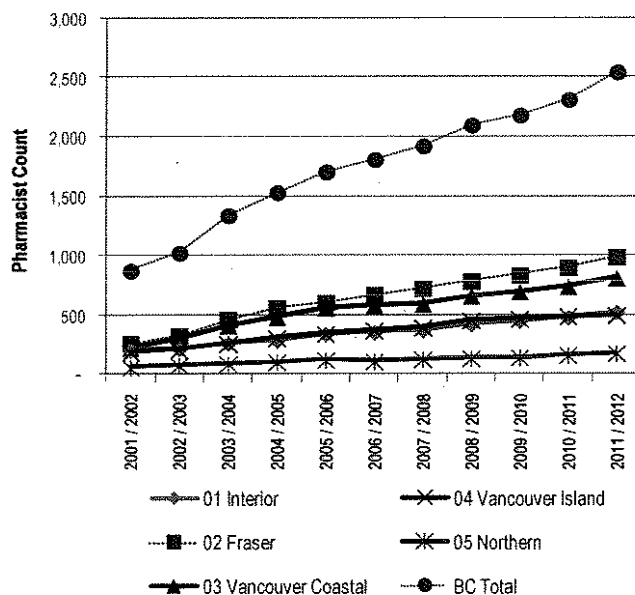
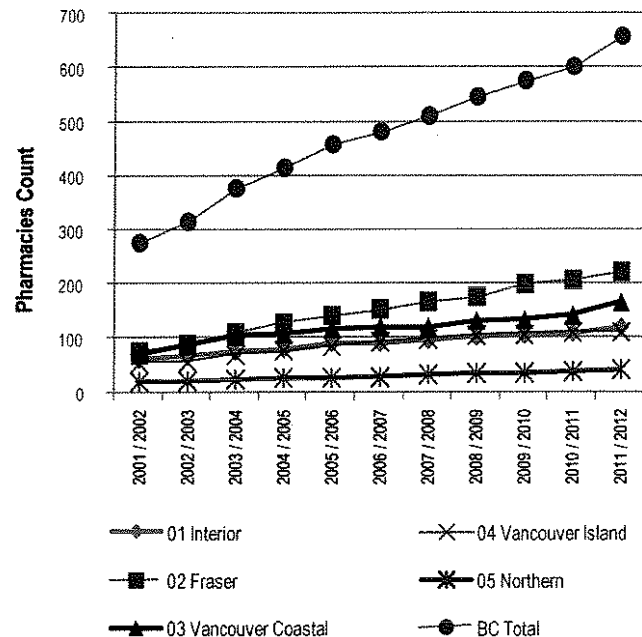


Figure 6. Methadone Maintenance Pharmacies by Health Authority, BC, 2001/2002 to 2011/2012

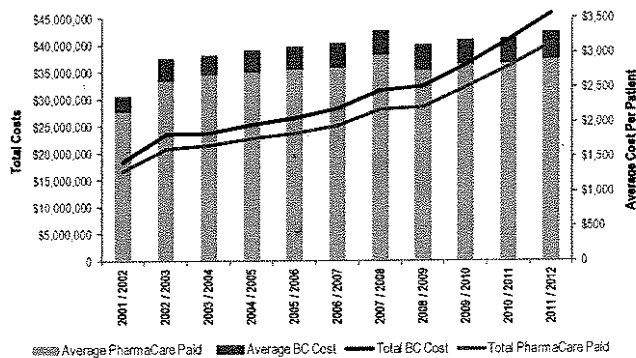


## 2.4 Methadone Maintenance Expenditures

PharmaCare helps British Columbians with the cost of eligible prescription drugs and designated medical supplies. PharmaCare reimburses methadone ingredient costs and dispensing fees, as well as interaction fees for pharmacists who witness ingestion on-site. Patients registered with PharmaCare Plan C (for recipients of BC income assistance) are eligible for full reimbursement of their methadone costs for prescribing and dispensing. Patients registered with Fair PharmaCare pay deductibles and co-pays, based on family income. For some patients, private insurance will cover a portion of these costs.

The total pharmacy costs for methadone maintenance in BC reached nearly \$46 million in 2011/2012, \$40 million of which was paid by PharmaCare. Figure 7 summarizes the trend in costs over time.

**Figure 7. Provincial Government and PharmaCare Methadone Expenditures, BC, 2001/2002 to 2011/2012**

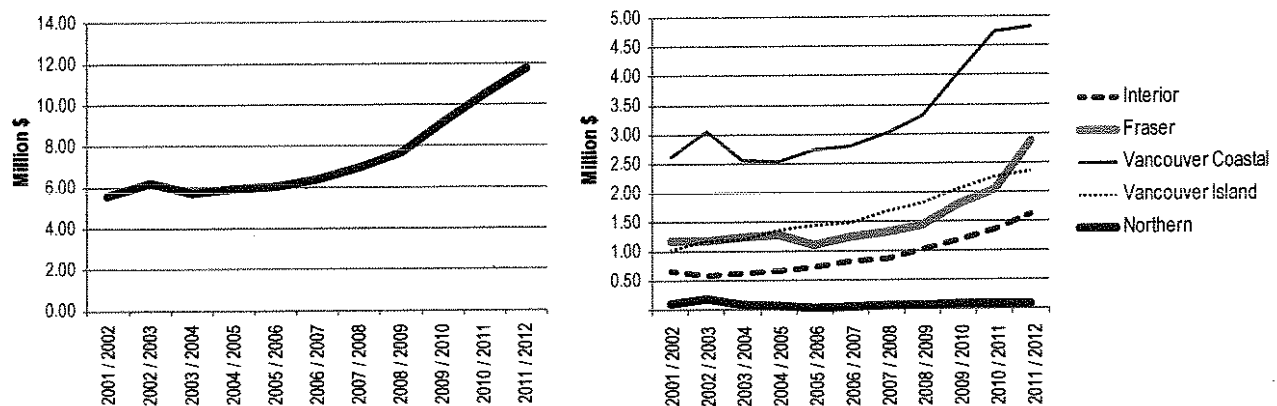


Note: Methadone costs include costs of ingredients, dispensing fees and interaction fees. Total costs in BC include payments made by PharmaCare, patients, and third party insurers. Payments for interaction fees are made in bulk to pharmacies; therefore, it is difficult to disaggregate costs to patient by health authority.

As shown in Figure 7, average per patient pharmacy costs have dropped slightly from 2007/2008 levels. In 2011/2012, average annual methadone costs per patient were \$3,301 (\$2,899 of which was paid by PharmaCare). This decline is likely due to the Frequency of Dispensing policy, which limits the number of dispensing fees that PharmaCare will pay on a daily basis. The increase in overall costs may be due to inflation, patient population growth, and more complex care needs.

Medical Services Plan (MSP) payments for physician fee-for-service claims have seen an equivalent increase since fiscal year 2001/2002 (see Figure 8).

**Figure 8. Medical Services Plan Methadone Expenditures for Methadone Maintenance Treatment Only, by Health Authority (right), BC (left), 2001/2002 to 2011/2012**



Note: Includes only MSP payment for physician fee-for-service claims specifically for the purposes of methadone maintenance treatment (and Suboxone as a limited coverage benefit of November 2010) (fee item 39). Excludes alternative payments and physician salaries.

A Ministry of Social Development (MSD) supplement provides income assistance clients with up to \$500 per calendar year (average of \$41.67 per month) for costs of substance use counselling or related services where no other resources are available. This includes user fees charged by some methadone clinics. The MSD

supplement pays for user fees ostensibly for services not paid for by MSP. The total annual expenditure by MSD for the addiction counselling supplement in 2011/2012 was \$2.37 million (a majority of which goes to methadone patients).

# 3. SYSTEM OUTCOME MEASURES

This section summarizes system outcome measures that are indirectly associated with BC's MMS through the impacts of methadone maintenance on the underlying health conditions (including opioid dependence) of participants in the program.

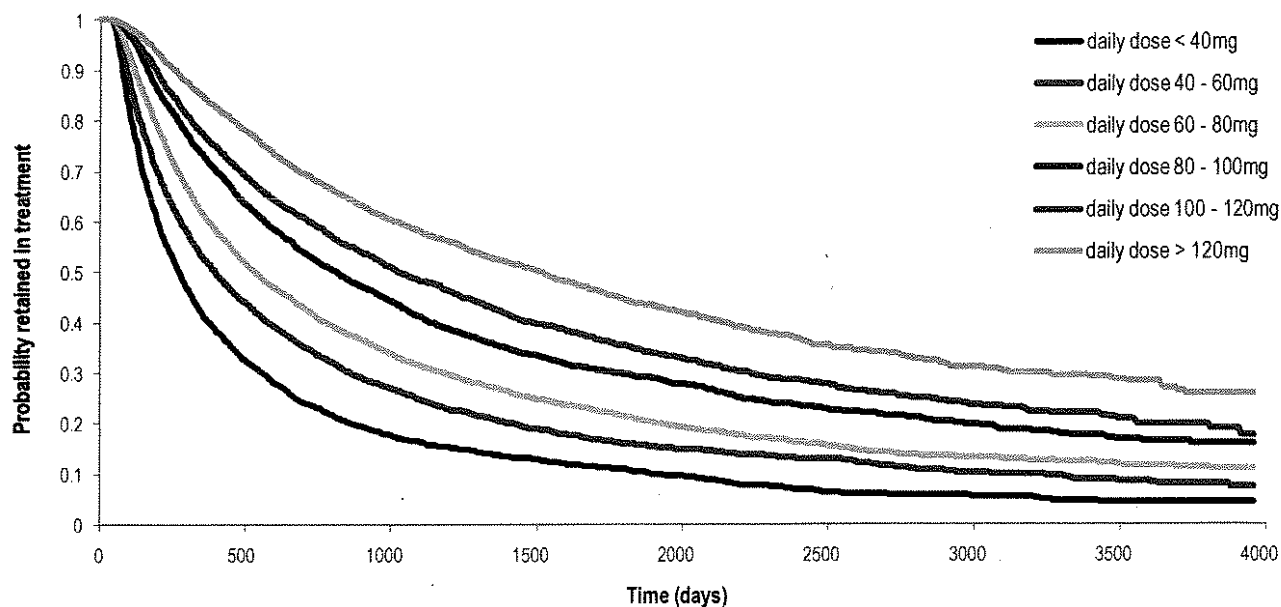
All outcome measures presented here are for episodes of methadone maintenance treatment, defined as continuous dispenses of methadone (plus additional days supplied for off-site use). A gap of more than 30 consecutive days determines the end of an episode of treatment.

An important caveat for this section is that the outcome measures were obtained without an attempt to isolate the effect of methadone maintenance (versus no treatment or other treatments). Therefore, the material presented here is intended to be hypothesis-generating and may initiate further analysis of more specific outcomes using observational study designs.

## 3.1 Methadone Maintenance Duration and Retention

Methadone maintenance duration is measured in days of maintenance per episode, and is an important indicator of treatment effectiveness. Studies referenced in Nosyk et al.<sup>1</sup> suggest that longer treatment duration is associated with improved post-treatment outcomes. Nosyk et al.<sup>1</sup> also found a significant correlation between dose and treatment retention, with probability of being retained in treatment lowest for patients receiving maintenance doses below 40mg per day and highest for patients receiving above 100mg per day (CPSBC, 2009, *Methadone Maintenance Handbook* recommends stabilization doses of between 60 to 120 mg per day as optimal for most patients).

Figure 9. Effect of Daily Dose on Methadone Maintenance Treatment Retention (Kaplan-Meier Curve)

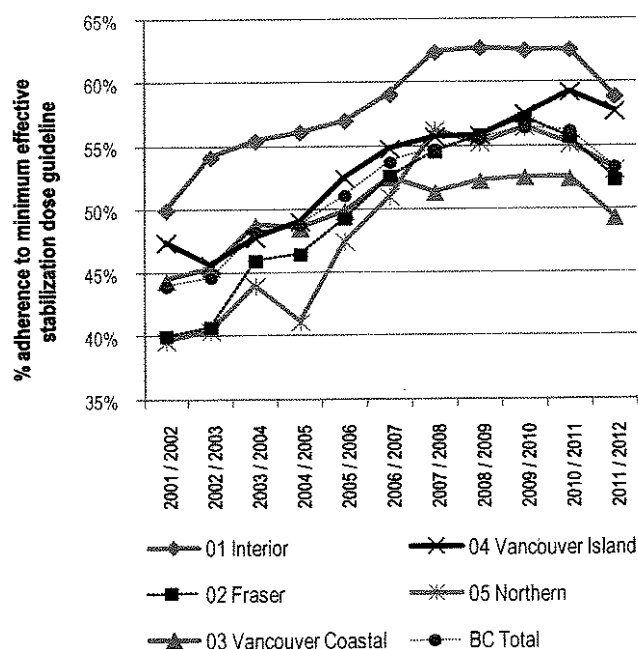


In Figure 9, daily dose is calculated as the average amount (in milligrams) of methadone prescribed during the maintenance period of each treatment episode. To examine the effect of the daily dose on the probability of remaining in treatment, episodes were categorized into the following six daily dose levels:

1. Episodes with a mean dose <40mg
2. Episodes with a mean dose 40-60mg
3. Episodes with a mean dose 60-80mg
4. Episodes with a mean dose 80-100mg
5. Episodes with a mean dose 100-120mg
6. Episodes with a mean dose >120mg

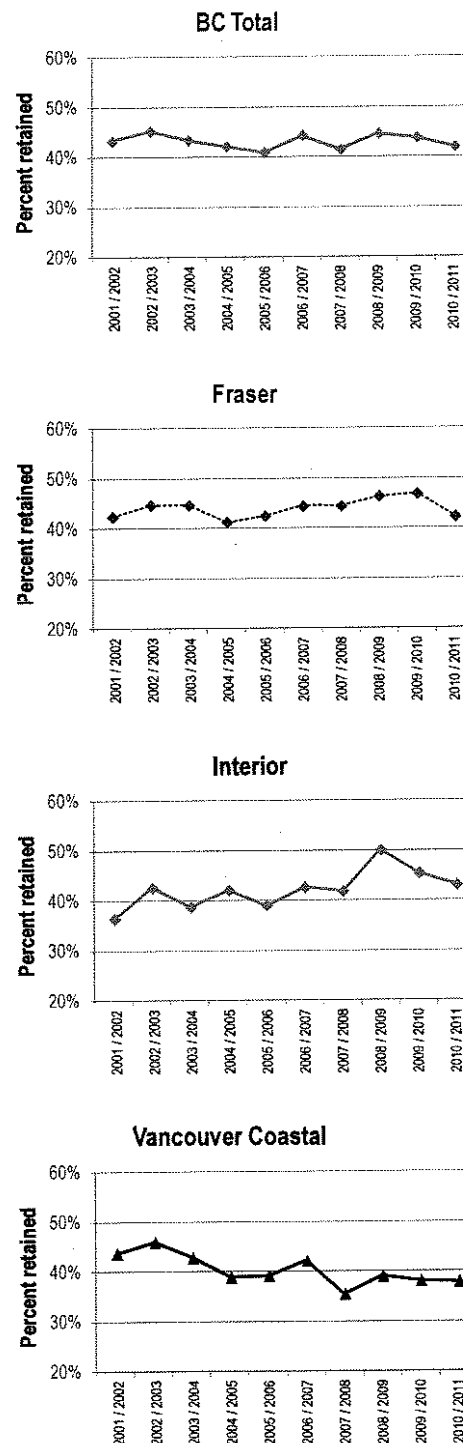
Figure 9 shows the probability of remaining in treatment over time by daily dose category as defined above. At the start of an episode, the patient has a high probability of remaining in treatment. As time passes, however, the probability of remaining in treatment declines for all daily dosage categories. Episodes with daily doses greater than or equal to 120mg had the highest probability of being retained in treatment at every time point. That is, these episodes had the longest duration. By contrast, episodes for which the mean dose was below 40mg per day discontinued the earliest. Figure 10 shows the percentage of physicians who adhere to CPSBC's minimum recommended stabilization dose of 60 mg/day.

**Figure 10. Adherence to Minimum Effective Dose Guideline, by Health Authority, BC, 2001/2002 to 2011/2012**

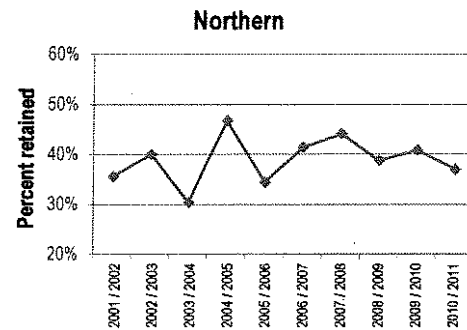
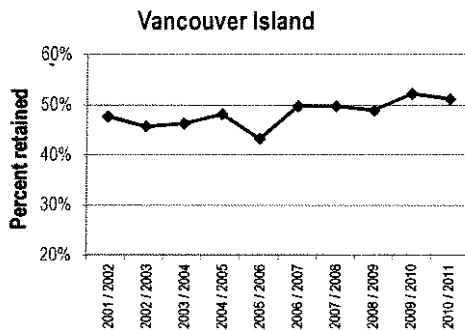


Methadone maintenance retention rates in Vancouver Island Health Authority are consistently higher than the BC average, while rates in Vancouver Coastal appear lower than the average in more recent years (see Figure 11).

**Figure 11. Percentage of People Started on Methadone Maintenance Treatment Retained at 12 Months, by Health Authority, BC, 2001/2002 to 2010/2011**







## 3.2 Hospitalizations and Costs

This section examines methadone patients' hospitalizations (for any cause) and the costs associated with hospitalizations. Table 1 summarizes the incidence and cost of hospitalizations while patients are engaged in methadone maintenance treatment.

The total cost of hospitalizations for patients engaged in methadone maintenance reached a high of \$14.5 million in 2008/2009. The average cost per patient was \$1,721. While

the corresponding total cost for total hospitalization in 2010/2011 increased again to \$14.2 million (up from \$12.6 million in 2009/2010), the average cost per patient was at its lowest level since 2002/2003 at \$1,299.

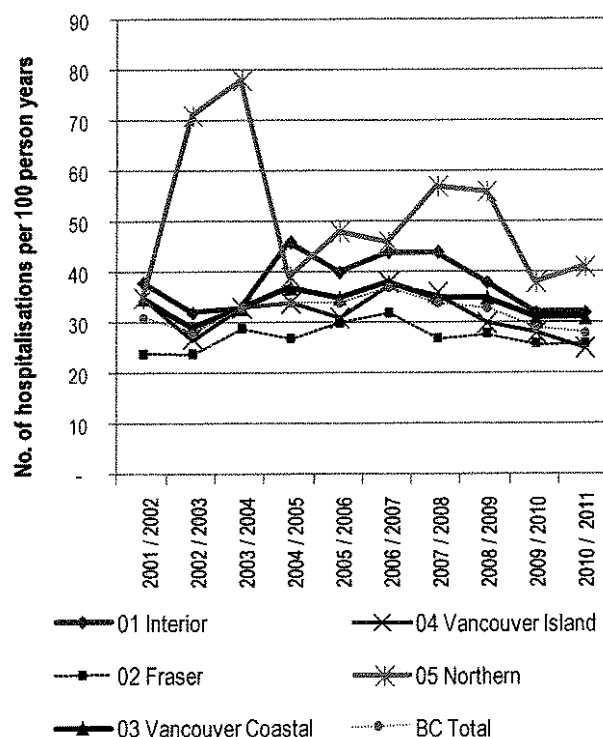
Figure 12 shows the number of hospitalizations per 100 person years for patients engaged in methadone maintenance.

**Table 1. Hospitalizations and Costs During Methadone Maintenance by Fiscal Year, 2001/2002 to 2010/2011**

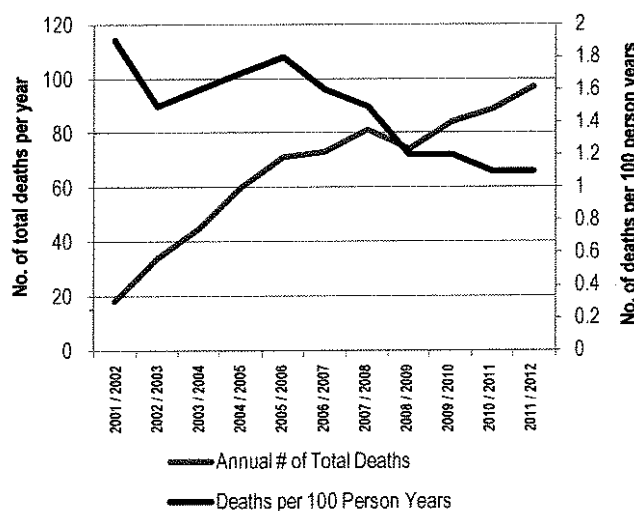
	No. of Admissions		Hospital Cost	
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\*Note: 2010/2011 figures may be incomplete because patients admitted to hospitals in 2009/2010 but not discharged until 2011/2012 will not appear in 2010/2011 data. Median costs were \$0 because fewer than 50 per cent of patients were hospitalized each fiscal year.

**Figure 12. Hospitalizations per 100 Person Years During Methadone Maintenance, by Health Authority, BC, 2001/2002 to 2010/2011**



**Figure 13. All-cause Mortality During Methadone Maintenance Treatment, by Fiscal Year, BC, 2001/2002 to 2011/2012**



Although the number of patient deaths has increased between 2001/2002 and 2011/2012 (reflecting overall growth of the patient population during this period), the rate per 100 person years on methadone has decreased (see Table 2 and Figure 14). These unadjusted rates cannot be used to draw conclusions about the effectiveness or risks of methadone maintenance therapy. However, Figure 13 shows that the number of patients engaged in methadone maintenance increased without a proportional increase in rates of death, providing some reassurance of the relative safety of methadone maintenance in BC.

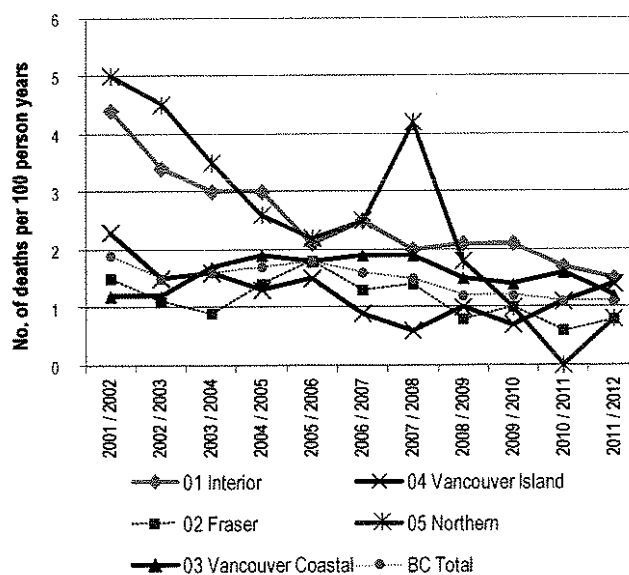
### 3.3 Mortality

This section provides measures of mortality during methadone maintenance. Mortality is measured in terms of deaths from any cause recorded within 30 days of an episode of methadone maintenance.

**Table 2. All-cause Mortality During Methadone Maintenance Treatment, by Fiscal Year, 2001/2002 to 2011/2012**

	No. of Deaths	
	Total	Rate per 100 person years
2001/2002	18	1.9
2002/2003	34	1.5
2003/2004	45	1.6
2004/2005	60	1.7
2005/2006	71	1.8
2006/2007	73	1.6
2007/2008	81	1.5
2008/2009	74	1.2
2009/2010	84	1.2
2010/2011	89	1.1
2011/2012	97	1.1

**Figure 14. Deaths by Any Cause per 100 Person Years During Methadone Maintenance by Health Authority, BC, 2001/2002 to 2011/2012**



## 4. CONCLUSION

Methadone maintenance treatment for opioid dependence in British Columbia has undergone significant growth over the past decade. Greater access to methadone maintenance, along with other harm reduction initiatives, has helped contribute to the lower incidence of HIV infection among people who inject drugs.<sup>5</sup> This report provides relevant data on key indicators of BC's

methadone maintenance system, although further work needs to be done on aspects of the system and indicators that are not covered here (such as psychosocial supports). The information it presents is important for improving health service delivery and health system planning—and, ultimately, achieving better health outcomes for opioid-dependent people—in the province.

# RESOURCES

## British Columbia Methadone Program Websites

BC Ministry of Health

[www.health.gov.bc.ca/cdms/methadone.html](http://www.health.gov.bc.ca/cdms/methadone.html)

College of Physicians & Surgeons of BC

[www.cpsbc.ca/node/94](http://www.cpsbc.ca/node/94)

College of Pharmacists of BC

[www.bcpharmacists.org/about\\_us/key\\_initiatives/index/articles144.php](http://www.bcpharmacists.org/about_us/key_initiatives/index/articles144.php)

## REFERENCES

<sup>1</sup> Nosyk B, Sun H, Sizto S, Marsh D, Anis A. *An evaluation of methadone maintenance treatment in British Columbia: 1996-2007*. Vancouver, BC: University of British Columbia; 2009.

<sup>2</sup> Ministry of Health Services, Ministry of Children and Family Development. *Healthy minds, healthy people: a 10-year plan to address mental health and substance use in British Columbia*. Victoria, BC: Ministry of Health Services, Ministry of Children and Family Development; 2010 Nov [cited 2013 Feb 19]. Available from: [http://www.health.gov.bc.ca/library/publications/year/2010/healthy\\_minds\\_healthy\\_people.pdf](http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf).

<sup>3</sup> College of Pharmacists of British Columbia. *Policy Guide: Methadone Maintenance Treatment – Professional Practice Policy #66*. Vancouver, BC: College of Pharmacists of British Columbia; 2010 [cited 2013 Feb 19]. Available at: [http://library.bcpharmacists.org/A-About\\_Us/A-8\\_Key\\_Initiatives/1029-PPP66\\_Policy\\_Guide\\_MMT.pdf](http://library.bcpharmacists.org/A-About_Us/A-8_Key_Initiatives/1029-PPP66_Policy_Guide_MMT.pdf).

<sup>4</sup> Centre for Addictions Research of BC. *Methadone maintenance treatment in British Columbia, 1996-2008*. Vancouver, BC: Centre for Addictions Research of BC; 2010 May [cited 2013 Feb 19]. Available from: [http://www.health.gov.bc.ca/library/publications/year/2010/Methadone\\_maintenance\\_treatment\\_review.pdf](http://www.health.gov.bc.ca/library/publications/year/2010/Methadone_maintenance_treatment_review.pdf).

<sup>5</sup> Gilbert M, Buxton JA, Tupper KW. *Decreasing HIV infections among people who use drugs by injection in British Columbia: Potential explanations and recommendations for further action*. Victoria, BC: Office of the Provincial Health Officer; 2011 [cited 2013 Feb 19]. Available at: <http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf>.

**Ministry of Health Data Platform for Methadone Maintenance System Monitoring**

The following list details the Ministry of Health indicators and data sources for methadone maintenance treatment system monitoring. Note that all PharmaNet and Medical Service Plan data can be disaggregated down to Local Health Area, Health Service Delivery Area or Health Authority

- Number of MMT patients currently in treatment – data source: PharmaNet
- Number of MMT patients newly enrolled in the program annually – data source: PharmaNet
- Number of physicians authorized to prescribe methadone for maintenance purposes – data source: BC College of Physicians and Surgeons
- Number of physicians authorized to prescribe methadone for maintenance purposes *and* actively prescribing for one or more patients – data source: PharmaNet
- Number of pharmacists (i.e., people) dispensing methadone for maintenance purposes – data source: PharmaNet
- Number of pharmacies (i.e., places) dispensing methadone for maintenance purposes – data source: PharmaNet
- Total costs paid by PharmaCare for methadone maintenance pharmacy services (ingredients, dispensing fee and interaction fee) – data source: PharmaNet
- Aggregate costs paid by others (i.e., patients, third-party insurers) for methadone maintenance pharmacy service costs *not* covered by PharmaCare – data source: PharmaNet
- Total costs paid by Ministry of Health for methadone maintenance prescribing (MSP fee item T00039) – data source: Medical Services Division, MSP billing records
- Adherence to minimum effective methadone maintenance dose guidelines – data source: PharmaNet
- Percentage of people started on methadone maintenance treatment retained at 12 months – data source: PharmaNet
- Number of hospitalizations of methadone maintenance patients during course of treatment, per year – data source: Ministry of Health's Hospital Discharge Abstract Database
- Cost of hospitalizations of methadone maintenance patients during course of treatment, per year – data source: Ministry of Health's Hospital Discharge Abstract Database
- Number of deaths (all-cause) of methadone maintenance patients during course of treatment, per year – data source: PharmaNet
- Rate of deaths (all-cause) of methadone maintenance patients during course of treatment, per year – data source: PharmaNet

This data platform provides a solid foundation for monitoring and improving the BC methadone maintenance program, with the exception of a few key indicators:

- 1) Data relating to psychosocial supports such as addiction treatment, counselling, psychotherapy; some of these data (e.g. Addiction Information Management System, or AIMS) may be collected

by the Ministry of Health, but are inconsistent and unreliable (see: [http://carbc.ca/Portals/0/AOD/AddictionTreatment/TreatmentReport09\\_10.pdf](http://carbc.ca/Portals/0/AOD/AddictionTreatment/TreatmentReport09_10.pdf)).

- 2) The Ministry of Health holds a unique data set that would allow for an analysis comparing morbidity and mortality outcomes for opioid-dependent individuals engaged and retained in methadone maintenance treatment versus those who are not. To date, such analysis has not been undertaken, although health economists at the BC Centre for Excellence in HIV/AIDS have funding and capacity to do so, if they are able to work out data access arrangements with the Ministry.
- 3) The estimated number of problem opioid users in British Columbia (i.e. the potential treatment population for methadone maintenance or other opioid dependence treatment services) is only an estimate. Improved drug use monitoring and surveillance would be required to come up with more accurate provincial statistics on opioid use and harms.

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 963050**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
- **FOR INFORMATION**

**TITLE:** Shearwater Resort and Marina Water Issue

**PURPOSE:** To provide an overview of the Vancouver Coastal Health Authority's (VCHA) order to disconnect a non-potable water source at Shearwater Resort and Marina.

**BACKGROUND:**

Shearwater Resort and Marina is a fishing and eco adventure resort and lodge located on Denny Island. Shearwater Resort and Marina is connected to the local community water supply, which VCHA put on boil water advisory ten years ago due to non-compliance with the *Drinking Water Protection Act*<sup>1</sup> (the Act). VCHA permitted Shearwater Resort and Marina to continue operation of a pre-existing restaurant so long as it installed a point of entry system to the building. The rest of the property continues to be on boil water advisory.

Shearwater Resort and Marina placed a new building on the property in 2011 and connected it to the community water system without seeking approval from VCHA. VCHA is committed to reducing boil water advisories as per the Ombudsman's Report<sup>2</sup> and, with respect to this commitment, does not allow new connections to be made to non-compliant systems until such time as they become compliant. As this new building is considered a new connection to the community water system, VCHA ordered the company to disconnect the new building.

Shearwater Resort and Marina contends that it has since submitted an application to VCHA to make improvements to the system. However, VCHA maintains that an adequate application must include engineering plans demonstrating that the proposal would be sufficient to supply the new building and the rest of the resort with potable water (water that meets the Drinking Water Protection Regulation and is safe to drink without further treatment). This was not in the application submitted by Shearwater Resort and Marina, and the company is reluctant to spend money on anything more than treating water to the new building, as there is speculation that the regional district may acquire and upgrade the community water system in the near future.

**DISCUSSION:**

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<sup>1</sup> British Columbia, *Drinking Water Protection Act* (2001).  
[http://www.bclaws.ca/EPLibraries/bclaws\\_new/document/ID/freeside/00\\_01009\\_01#section37](http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_01009_01#section37). (Accessed February 4, 2013).

<sup>2</sup> British Columbia. Office of the Ombudsman. (2008). Fit to drink: challenges in providing safe drinking water in British Columbia. Retrieved from  
[http://www.ombudsman.bc.ca/images/resources/reports/Special\\_Reports/Special%20Report%20No%20-%2032.pdf](http://www.ombudsman.bc.ca/images/resources/reports/Special_Reports/Special%20Report%20No%20-%2032.pdf). (Accessed February 4, 2013).



As per the Act, the legislative authority to make decisions pertaining to individual water systems, in this instance, rests solely with VCHA. The Ministry of Health does not have jurisdiction in this matter.

Representatives from VCHA have stated that they do not object to Shearwater Resort and Marina expanding, but to do so, the company must upgrade their infrastructure to ensure potable water access to already existing buildings in the vicinity. VCHA is concerned that if some fixtures in the resort have potable water and others do not, there is a high risk for cross connection of the two supplies, mix up of signage, or other human error. This could lead to the inadvertent ingestion of non-potable water by staff or patrons, which is a health risk for water-borne illness.

Given this position, the company has two options. Shearwater Resort and Marina can choose to propose to VCHA a solution that provides potable water to the entire resort, or it can disconnect the new building until such time as when the community water system upgrades are completed.

Shearwater Resort and Marina has the legislative right to request a review or reconsideration of decisions made by VCHA. Under section 39.1 of the Act, the company can request VCHA to reconsider decisions should there be new information respecting the matter. Also under section 39.1, Shearwater Resort and Marina can request an independent review of decisions made by VCHA and this request should be directed to the Office of the Provincial Health Officer.

**ADVICE.**

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**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 966385**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
**- FOR INFORMATION**

**TITLE:** Re-establishing a Drinking Water System in Johnsons Landing,  
British Columbia

**PURPOSE:** To provide an update on the Interior Health Authority's (IHA) activities on re-establishing a water system in the community of Johnsons Landing and on complaints raised by a Regional District Central Kootenay (RDCK) director

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**BACKGROUND:**

On July 12, 2012, a massive mudslide occurred within the small remote community of Johnsons Landing on the northeast shore of Kootenay Lake, resulting in loss of life and property. The mudslide also destroyed the community's drinking water source and water intake in Gar Creek. This small water system served approximately 15 homes and was operating without any of the regulatory permits under the *Drinking Water Protection Act* (the Act). The Act requires that any domestic supply that provides water to more than one single dwelling provide potable water and obtain a permit to operate.

To supply drinking water to the remaining homes in Johnsons Landing, provincial emergency funding was approved to provide this essential service. A temporary water intake was established as an emergency repair and a Boil Water Notice was issued until an alternate long-term solution for the water supply could be determined and constructed. The Gar Creek Water Users Association (the Association) - the community collective water group - is deciding whether to re-establish a new surface water intake and water license for withdrawal, or whether to drill a new community ground water well.

On behalf of the community of Johnsons Landing

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**DISCUSSION:**

- The community water system at Johnsons Landing meets the definition of a water supply system under the Act and therefore requires an operating permit issued by IHA.

- Generally, the primary role of the health authority is to work with the community to identify health risks and reduce those risks through regulatory requirements for water treatment and community education. It is the responsibility of the water supplier to deliver safe community drinking water.
- Shortly after the landslide event, IHA agreed to the proposed emergency repairs to establish a temporary intake until a long-term solution could be found. IHA requested that the community provide information on the work done for health risks to be assessed and recommendations to be made when time permits (see attached timeline).
- IHA has been working with the Association since the summer of 2012 to assist them through the approval process for the construction of a new water supply and an emergency repair.
- The correspondence between IHA, RDCK, and the Association shows that on several occasions, IHA has provided the community clear rationale for the approval processes, explained regulatory requirements, offered to meet with the community to assist them through the process, as well as offered to accept the necessary information and applications under reasonable timelines to assist the community. The approval process was further explained at an in person meeting with the Association and RDCK on January 14, 2013.
- IHA cannot guarantee the regulatory conditions necessary for a permanent drinking water system without first reviewing information on the source water quality, surrounding sources of contamination, or details on the construction and integrity of the community well. To date, this information has not been received.
- The concerns of the Area D Director appear related to the recommendations of a Union of BC Municipalities Small Water System working group that has suggested that water systems with less than 25 service connections should be re-defined as micro-systems and be exempted from certain provisions under the Act.
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## ADVICE:

Sect 13

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**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

Cliff # 968480

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health -  
**FOR INFORMATION**

**TITLE:** Chlorination of Chilliwack's Drinking Water

**PURPOSE:** To provide an overview of Fraser Health Authority's (FHA) intention to require the City of Chilliwack to apply chlorine to the municipal drinking water distribution system.

**BACKGROUND:**

The City of Chilliwack (the City) is a municipality with a population of approximately 80,000 people.<sup>1</sup> It is located within the jurisdiction of the FHA. The City's drinking water source is the Sardis-Vedder Aquifer for which the City has implemented an extensive ground water protection plan to mitigate potential vulnerabilities in the source.

*Escherichia coli*, which is only found in human and animal feces, was found in Chilliwack's distribution system on four separate occasions (2009, 2011, 2012 and 2013), with the most recent being a positive *Escherichia coli* test result from the main distribution system on February 25, 2013. This suggests that the distribution system is vulnerable to fecal contamination. Drinking water distribution systems (particularly if the system is aging) can be vulnerable to fecal contamination through leaks in pipes, from improper/illegal connections, as well as re-growth of inactive pathogens that may remain in the system. This vulnerability could put the residents of Chilliwack at risk for an outbreak of any of the pathogens (e.g., viruses, protozoa and bacteria) that can be present in feces.

FHA indicated to the City that chlorine will be required as a disinfectant within the City's drinking water distribution (pipeline) system and asked the City to present a timeline for implementation. This requirement will be made mandatory as a condition on the operating permit for the City's drinking water system. Under section 8(3) of the *Drinking Water Protection Act* (the Act), FHA has the legislative authority to impose this requirement.

The mayor, council and many residents of Chilliwack have expressed concerns over chlorination in the media (both traditional and social media) and during council meetings. There is also an online petition to keep Chilliwack's drinking water "chlorine free."<sup>2</sup> Some of the concerns expressed are related to the potential risk of cancer related to ingesting chlorine and they feel that FHA has taken away their ability to choose for themselves in this situation.

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<sup>1</sup> BCStats, 2012 Sub-Provincial Populations Estimates, Retrieved on March 19, 2013 from <http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx>

<sup>2</sup> Chilliwack Water. (2013). Chilliwack Water Petition. *Chilliwack Water: Help Keep Chilliwack Chlorine Free*. Retrieved from <http://www.chilliwackwater.com/>. (Accessed February 27, 2013).

## DISCUSSION:

Under the Act, the legislative authority to make decisions on individual water systems rests solely with the drinking water officer in FHA. The Ministry of Health does not have jurisdiction in this decision process.

FHA has made efforts to address the concerns of the mayor, council and residents of Chilliwack. Representatives from FHA sought consultation on the issue during a City council meeting on February 5, 2013, and a town meeting on February 26, 2013. Another purpose for this public outreach was to provide an explanation as to why FHA is requiring Chilliwack to chlorinate its distribution system and answer questions related to any health concerns. FHA posted a public document related to the matter on their website.<sup>3</sup>

The introduction of a minimal amount of chlorine to the distribution system may be the only practical solution if the system is at risk from fecal contamination. Other disinfection technologies, such as ultraviolet light or ozone, do not provide a "residual" protection needed for Chilliwack's 450 kilometres of pipes.<sup>4</sup> The Chilliwack water system already has the capacity to chlorinate the water.

Research suggests that chlorine by-products, which are created when chlorine reacts with organic content in water, increase the risk of certain cancers. FHA contends that the risk of fecal contamination in Chilliwack's drinking water outweighs the potential risk of cancer because Chilliwack's drinking water contains very little organic content. Drinking water chlorination is a scientifically accepted public health practice that is used by the majority of municipalities in British Columbia (including Vancouver, Victoria and Kelowna) and the rest of North America.

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## ADVICE:

This matter is under the jurisdiction of FHA and the Ministry of Health does not have the authority to override the decisions of FHA's drinking water officer. The City is legislatively required (as per section 8 of the Act) to comply with conditions on its operating permit.

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Date:	March 19, 2013
File Name with Path:	Y:\Protection\BRIEFING NOTES\2013\Minister

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<sup>3</sup> Fraser Health Authority. (2013). *The Truth about Water Chlorination: The Truth about Chilliwack Water Chlorination*. Retrieved from [http://www.fraserhealth.ca/your\\_environment/drinking\\_water/the-truth-about-water-chlorination](http://www.fraserhealth.ca/your_environment/drinking_water/the-truth-about-water-chlorination) .(Accessed February 27, 2012).

<sup>4</sup> *ibid.*

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

Cliff 968627

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister of Health  
– **FOR INFORMATION**

**TITLE:** Ministry of Environment's Sect 12 *Act* Request for Legislation  
(version dated March 2013)

**PURPOSE:** To provide information on of this Request for Legislation (RFL).

**BACKGROUND:**

The *Water Act* is the primary legislative tool in British Columbia for managing water resources. Under the *Water Act*, the government makes decisions on licences and water allocation planning. New pressures on water, including climate change and population growth, have resulted in a need to modernize the *Water Act*.

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Pages 196 through 198 redacted for the following reasons:

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**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 958124**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid, Minister  
– **FOR INFORMATION**

**TITLE:** College of Pharmacists of British Columbia proposed bylaw - Prohibition of Inducements

**PURPOSE:** To provide background information on the Ministry of Health's policy restricting pharmacy inducements and the College of Pharmacists of British Columbia's proposed bylaw that would prohibit all inducements.

**BACKGROUND:**

The purpose of the PharmaCare program is to assist British Columbians, particularly those with lower incomes, with the cost of eligible prescription drugs and designated medical supplies.

Incentive programs encourage people to shop at a particular pharmacy or pharmacy chain by enticing them with such things as loyalty points, coupons, discounts, goods, rewards and similar schemes rather than with lower prices. Incentive programs cost retailers money, which they build into the price they charge consumers. Rather than offering loyalty rewards, if a pharmacy sets its drug price or dispensing fee at a lower amount to attract customers, then customers, PharmaCare, and all taxpayers will save money.

In July 2011, the Ministry of Health (the Ministry) introduced a policy that prohibits pharmacies from providing loyalty points or other inducements to customers for the portion of their prescription covered by PharmaCare only. The prohibition was put in place based on the inappropriateness of using government money to subsidize customer rewards.

The policy was implemented after consultation with stakeholders such as the British Columbia Pharmacy Association and the Canadian Association of Chain Drug Stores, and respects the right of pharmacies to offer loyalty programs but believes that BC taxpayers should not have to subsidize such programs.

**DISCUSSION:**

This fall, the College of Pharmacists of British Columbia (the College) provided formal notice of its intention to introduce a bylaw to prohibit the use of loyalty points or inducements on the purchase of all pharmacy products in BC, regardless of the payer.

The College is the regulatory body for pharmacy in BC and is responsible for setting standards of practice. The College's mandate is to protect the public by ensuring pharmacists and pharmacy technicians provide safe and effective care to help people achieve better health.



In addition to supporting the rationale of the Ministry's policy, the College has cited issues of professionalism (physicians do not try to induce patients to their offices with customer rewards), and concerns over patient safety (such as patients filling prescriptions they may no longer need in order gain loyalty points), amongst its reasons for the proposed bylaw.

The College has the authority to make bylaws, consistent with the duties and objects of a College as set out under the *Health Professionals Act*. In making this bylaw, the College has undertaken a public consultation process ending December 28, 2012, to solicit input prior to requesting that it be brought into force.

Some pharmacies, particularly Canada Safeway, have voiced strong objections to the proposed bylaw stating that restricting customer rewards is unfair to customers. Safeway has instigated a letter writing campaign. Since the consultation period began in September 2012, the College and the Ministry have received over 10,000 responses in opposition to the prohibition.

Under the *Health Professions Act*, in order for a College bylaw to have effect, it must be filed with the Minister. If necessary and advisable, the Minister has the authority to disallow a College bylaw if it is not consistent with the College's specific duties and object, but instances of this occurring are rare as Colleges are recognized as being self-regulating entities.

#### **ADVICE:**

Sect 13

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**Date:** December 19, 2012

**File Name with Path:** K:\3 POLICY OUTCOMES, EVALUATION & RESEARCH\Briefing Notes\2012\958124 - IBN Inducements - CPBC bylaw change.docx

## **Bullets prepared for MO: Minister Meeting March 20 with BC Retired Teachers Association**

- Under the *Canada Health Care Act* (1984), prescription drugs are considered “additional benefits” that the provinces and territories may offer under their respective health insurance plans, funded and delivered on their own terms and conditions. As a result, prescription drug coverage varies across different provinces and territories.
- However, with the introduction of the national Common Drug Review (CDR) run by the Canadian Agency of Drugs and Technologies in Health (CADTH), there is less variability with drug coverage across Canada.
- A number of organizations have been advocating for a National and Universal Drug plan. These include: the Canadian Centre for Policy Alternatives, the Canadian Health Coalition, the Canadian Federation of Nurses Unions, and CARP (Canadian Association of Retired Persons).
- The Canadian Centre for Policy Alternatives report “The Economic Case for Universal PharmaCare” (2010) by Marc-André Gagnon, is often cited by these organizations or in media articles that advocate for universal Pharmacare. This report concludes that universal Pharmacare, with first-dollar coverage for all prescription drugs, would “not only make access to medicines more equitable in Canada and improve health outcomes, but also generate savings for all Canadians of up to \$10.7 billion in prescription drugs”.
- A 2010 study from the Canadian Centre for Policy Alternatives notes, “British Columbia is often held up as a model for the rest of Canada in terms of pharmaceutical policy and health outcomes,” and that these positive health outcomes are achieved at a lower cost than other provinces.
- In BC, BC PharmaCare helps residents with the cost of eligible prescription drugs and designated medical supplies. BC PharmaCare is one of the most comprehensive drug programs in Canada.
- Through Fair PharmaCare, every British Columbian is eligible for assistance with prescription costs. Deductible levels are set to reflect patients' ability to pay. The lowest income earners pay no deductible at all, and those born in or before 1939 receive enhanced assistance.
- PharmaCare is one of the fastest-growing areas of BC's health-care budget. Since 2001, the PharmaCare budget has increased by approximately 74 percent - from \$654 million to more than \$1.1 billion for 2011-12.
- BC has been, and continues to be involved in efforts to improve the health outcomes of Canadians while building a sustainable health care system. These efforts include:
  - Passing the *BC Pharmaceutical Services Act* (2012) which will allow the Province to control and further lower the prices of generic drugs.
  - Aligning Provincial and Health Authority Drug Formularies to improve continuity of patient care and drug therapy at transition points. In addition, alignment may result in increased policy effectiveness, and possibly reduced drug expenditures.
- On a national level, BC co-chaired the Ministerial Task Force (MTF) to develop and implement the National Pharmaceuticals Strategy (NPS) as part of the 2004 Ten Year Plan to Strengthen Health Care. The initial promise of the NPS failed to materialize following a change of government at the federal level.

- More recently (2013), provinces and territories (including BC) announced they are working together through a coordinated approach to price setting for six widely-used generic drugs:
  - These drugs represent approximately 20 percent of the publicly funded spending on generic drugs in Canada.
  - This joint approach will leverage combined purchasing power to obtain the lowest generic prices achieved to date in Canada.
  - 
  - It is expected that when fully implemented, this initiative could produce savings of up to \$100 million for provincial and territorial drug plans.

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## MINISTRY OF HEALTH INFORMATION BRIEFING NOTE

Cliff # 962577

**PREPARED FOR:** Honourable Margaret MacDiarmid - **FOR INFORMATION**

**TITLE:** Investigation 2012-0601 Costs

**PURPOSE:** To provide information of the year to date and estimated costs to the government for Investigation 2012-0601.

### BACKGROUND:

The Office of the Auditor General contacted the Assistant Deputy Minister of Financial and Corporate Services, Ministry of Health (MOH) on March 28, 2012, to advise that an allegation report was received by their office concerning inappropriate procurement, contracting irregularities, inappropriate data access arrangements, intellectual property infringement and code of conducts conflicts. MOH immediately launched an internal investigation and recommended a formal investigation be undertaken which began June 1, 2012.

### DISCUSSION:

An investigation team was established with members from the Office of the Chief Information Officer (OCIO), Public Service Agency (PSA) and the MOH. The first phase of the investigation focussed on MOH staff and resulted in the termination of

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The investigation team has determined that there has been inappropriate personally identifiable information released/lost resulting in notification being provided to at least 38,000 British Columbia residents. A contract has been established to handle phone inquiries for the notification for up to \$1.5M. In addition a contract has been established to review the ministry data practices making recommendations for improvement to reduce risk for \$.6M.

A summary of the costs include:

Cost Type	Year to Date	Future	Total
PSA	\$55,000	\$7,000	\$62,000
MOH	<u>1,014,000</u>	<u>1,688,000</u>	<u>\$2,702,000</u>

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\$2.542M of the total investigation costs are considered to be incremental costs.

Costs for the Ministry executive involved in this investigation are not included in the costs.

**ADVICE:**

- To date investigation 2012-061 has cos Sect 14

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- A more detailed breakdown of costs is attached as Appendix A

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**Program ADM/Division:** Manjit Sidhu, ADM, Financial and Corporate Services  
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**APPENDIX A**  
**Ministry of Health**  
**Investigation 2012-0601 Costs**  
**June 1, 2012 - April 30, 2013**

	YTD	Estimated Future	Total	Portion Incremental	Portion Reassigned	Comments
<b>PSA</b>						
<b>Salaries &amp; Benefits</b>						
	33,210	1,476	34,686		34,686	
	1,476	-	1,476		1,476	
Sect 19	5,000	500	5,500		5,500	All estimated
	5,000	500	5,500		5,500	All estimated
	5,000	500	5,500		5,500	All estimated
	<u>2,460</u>	<u>1,230</u>	<u>3,690</u>		<u>3,690</u>	
<b>Total Salaries</b>	52,146	4,206	56,352			
Transcription Costs	<u>3,375</u>	<u>2,500</u>	<u>5,875</u>	5,875		
<b>Total PSA Costs</b>	55,521	6,706	62,227			
<b>Ministry of Health</b>						
<b>Salaries &amp; Benefits</b>						
	60,470	1,693	62,163		62,163	100% June to Aug 31, 60% Sept 1 - Jan 15
	87,959	37,316	125,274		125,274	100% Since June 1
	52,060	11,661	63,721		63,721	100% June to Aug 31, 60% Sept 1 - Jan 15, 50% Jan 16-April 30
Sect 19	43,614	18,503	62,117		62,117	100% Since June 1
	45,233	25,331	70,564		70,564	100% Aug 1 - April 30
	7,970	-	7,970		7,970	2 months 50%
	39,129	21,912	61,042		61,042	100% Aug 1 - April 30
	<u>52,921</u>	<u>29,636</u>	<u>82,556</u>		<u>82,556</u>	100% Aug 1 - April 30
<b>Total Salaries</b>	389,356	146,052	535,408			
Deloitte Touche	611,000	-	611,000	611,000	-	Contract ends Jan 31, 2013
HSBC - 38000 letters ( <b>note1</b> )	-	1,500,000	1,500,000	1,500,000	-	Help support for 38K letters
Postage/print/fold/stuff	-	31,000	31,000	31,000	-	Mail out for data loss - BC Mail Plus
Data Extractions	11,400	11,000	22,400	22,400	-	Charged back fro
Blackberry     Sect 19	800	400	1,200	1,200	-	Charged back fro     Sect 19
Other office supplies	800	-	800	800	-	Charged back fro

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**Notes**

1) Assumes no further notifications required.

The amount for the contact centre of \$1.5M may be less - currently the number of calls is minor, but still will be at least \$1M

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## **MINISTRY OF HEALTH INFORMATION BRIEFING NOTE**

**Cliff # 970485**

**PREPARED FOR:** Honourable Dr. Margaret MacDiarmid - **FOR INFORMATION**

**TITLE:** Possible conflict of interest of Provincial Health Services Authority (PHSA) Board Member

**PURPOSE:** To provide an update on action taken to address the concerns expressed in the February 24<sup>th</sup> letter to the Minister of Health regarding the possible conflict of interest of PHSA Board member, Mary McDougall.

### **BACKGROUND:**

In the fall of 2012, Fraser Health Authority (FHA) approached Health Shared Services BC (HSSBC) to support them with a procurement process for residential complex care services and mental health and substance use licensed facility care. The goal of this procurement was to establish contracts with organizations that have a proven capability to design, construct, and operate complex care facilities to a high standard of service.

With this goal, it was decided that a two-step procurement process was the most appropriate: the capability of interested organizations would first be identified through a Request for Pre-Qualification (RFPQ); those companies identified as capable would then be asked to submit competitive proposals through a Request for Proposal (RFP). Recognizing the complex and sensitive nature of this procurement, a Fairness Monitor was engaged to provide independent oversight of the procurement process.

HSSBC posted HSSBC RFPQ 00770 on November 2, 2012, and completed the RFPQ process by issuing notice to qualified proponents in early February 2013. In late February 2013, the Minister of Health received a letter expressing concern that Buron Healthcare Ltd. (Buron) had qualified as a proponent to participate in the RFP phase. The letter identified the role of Mary McDougall as both a principal of Buron and a Board member of PHSA. PHSA is one of the six BC Health Authorities that funds and uses the services of HSSBC. Although the operations of HSSBC are directed by a separate Management Board, it operates as a Division of PHSA for administrative purposes (legal, fiduciary/financial reporting).

### **DISCUSSION:**

- Acquisition of the types of services being procured by Fraser Health in this procurement are outside of HSSBC's mandate. However, as part of HSSBC's service agreement with Fraser Health, HSSBC Supply Chain supports Fraser Health in these types of acquisitions through the provision of "professional procurement" services. As a result, HSSBC's involvement in this procurement was limited to the facilitation of the procurement process as well as the provision of RFPQ, RFP and contract templates. HSSBC Supply Chain was not involved in determining evaluation criteria or in the evaluation of the RFPQ responses. The



criteria were set by Fraser Health staff and the evaluation was conducted by Fraser Health staff alone. In addition, HSSBC will not be involved in negotiation of the resulting contract(s).

- HSSBC's RFPQ process and template do not require proponents to provide a statement of disclosure. HSSBC's standard process is to require qualified proponents to submit a statement of disclosure prior to their receipt of RFP documents during the second stage. If a submitted statement of disclosure identifies a conflict of interest or unfair advantage or potential for a perceived conflict of interest or unfair advantage, then, at the direction of the Evaluation Committee, a proponent would be disqualified if the conflict or advantage could not be adequately mitigated.
- Both Ms. McDougall and Buron were completely transparent about Ms. McDougall's relationship with Buron and PHSA. Buron disclosed Ms. McDougall's relationship with Buron and PHSA in their proposal, even though not required to do so by the terms of the RFPQ. Ms. McDougall also made a statement of disclosure to the PHSA Board Chair.
- Although a Division of PHSA for legal/administrative purposes, HSSBC affairs are managed by an independent Management Board comprised of the CEOs of all six Health Authorities, a representative of the Ministry of Health, and two outside directors. This structure is designed to ensure that no Health Authority Board (including PHSA) could have an undue influence on the affairs of HSSBC.
- In reviewing the concerns expressed in the letter, the Fairness Monitor noted that the language in HSSBC's RFPQ pre-ambles which describes the relationship between HSSBC and the Health Authorities, could lead a proponent to believe that the relationship between PHSA and HSSBC is more direct than the actual structure. The Fairness Monitor concluded that this could lead to a perception of bias and unfair advantage over other qualified proponents in HSSBC 00770.
- The Fairness Monitor further noted that because of the legal/administrative relationship between HSSBC and PHSA, there may have been an actual conflict of interest.
- HSSBC has identified that changes to the RFPQ language and HSSBC's standard processes could prevent this perception of a conflict of interest and could also highlight potential conflicts of interest earlier in the procurement process.
- The Fairness Monitor has recommended that to ensure the next stage of the procurement process is perceived to be fair; Buron Healthcare Ltd must be disqualified. This recommendation is based on the Fairness Monitor's belief that the language in the RFPQ preamble could be taken to indicate a direct relationship between PHSA and HSSBC and the public identification of a perceived relationship between HSSBC and Buron Healthcare Ltd. It is unlikely that a change in Ms McDougall's status on the PHSA Board (i.e. if she resigned) would change the perception of unfairness with other proponents.

- Although Fraser Health could cancel the RFPQ and start the whole process over again, this would impose a delay on the Fraser Health clinical program and could further aggravate the situation as successful proponents would see that they are being asked to incur further costs to accommodate an organization they may see as having an unfair advantage due to its current or past relationship.
- HSSBC RFPQ language provides Fraser Health with the right to disqualify any proponent at its sole discretion. Fraser Health has indicated to the Fairness Monitor that Buron will be disqualified.
- Given the fact that Buron has already been notified that it is a qualified proponent, it is possible that Buron will not accept disqualification from the next stage without some form of redress (e.g. judicial review).

## **SUMMARY:**

The Fairness Monitor engaged to provide independent oversight of HSSBC's RFPQ 00770 indicated that a perception of conflict of interest exists due to the apparent lack of clarity in the RFPQ preamble. He further indicated an actual conflict of interest may also exist. For this procurement process to proceed, it is essential that the integrity of the procurement process, specifically the perception of fairness, be maintained.

The Fairness Monitor has indicated that Fraser Health has provided him, through email, the assurance they will disqualify Buron. To further minimize the potential for a similar perception of conflict of interest, in future HSSBC Supply Chain will:

- Clarify the relationship of PHSA and HSSBC in the preamble of its RFPQ and RFP templates.
- Adopt the same Statements of Disclosure language and process in the RFPQ as utilized with the RFP, where disclosure is required prior to the submission of proposals by proponents.
- At the launch of a procurement process, educate the Evaluation Committee on the relationship between HSSBC and PHSA, as well as the other Health Authorities.
- Ensure that the tests for a conflict of interest are well-defined and that all Evaluation Committees are educated on these tests at the launch of a procurement process.
- When a Fairness Monitor is engaged to support a procurement process, ensure that the Fairness Monitor is oriented to the governance relationship between HSSBC and PHSA as well as the other Health Authorities.

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**Drafter:** Manjit Sidhu

**Date:** March 12, 2013

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## FACT SHEET



### KOOTENAY BOUNDARY REGIONAL HOSPITAL

#### ISSUE

Status of the planning for the replacement of Kootenay Boundary Regional Hospital (KBRH)

#### KEY FACTS

- In June 2011, Interior Health Authority (IHA)'s Chief Financial Officer (CFO) – Donna Lommer, attended the West Kootenay Boundary Regional Hospital District (WKBRHD) meeting to discuss IHA's plans for the replacement of the KBRH. The CFO advised the WKBRHD that work such as an environmental analysis, master programming and master site planning would need to be completed before a conceptual plan and timing of this work is critical so that the information does not become outdated.
- In Fall 2012, the Ministry of Health (the Ministry) started the phased (over 5 years) reassessment of the physical condition of health facilities in the province. The KBRH facility condition assessment is important for IHA in determining the priority of replacing this facility. The KBRH was reassessed in November 2012; however, the reassessment report has not been finalized.
- In January 2013, IHA advised the Ministry that IHA is developing its 10 year Capital Strategy which is expected to complete in April 2013.
- Planning steps for the Kootenay Boundary area will be considered and prioritized by IHA subsequent to IHA Board approval of the 10 year Capital Strategy. The planning will be required to determine the appropriate scope of acute care services to be provided in each community in the future, and whether these services would be delivered at their existing site or alternate location.
- IHA advised they will continue to consult with the WKBRHD on the capital program for the region, and the planning timelines for the replacement of KBRH.

#### FINANCIAL IMPLICATIONS

- Financial implications have not yet been determined.

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#### BACKGROUND

- Built in 1953, the KBRH is a 75-bed regional hospital located in Trail, between Grand Forks and Nelson. In 1968, a 4-storey Acute Care building addition was completed. Recent renovations and expansion to the Surgery and Emergency areas occurred in 2002, and final renovations and expansion to the Ambulatory area were completed in 2003.
- KBRH services include core physician specialties, 24 hour emergency and trauma services, diagnostic imaging, laboratory, acute and obstetrical care, psychiatry, and chemotherapy.

## FACT SHEET

- In January 2011, the WKBRHD passed a resolution and issued a letter to IHA regarding the RHD's proposal to fund up to 100% of the conceptual design for a new and/or upgraded health facility.
- In March 2012, the mayor of the City of Castlegar met with the Minister of Health. One of the topics they discussed was the issue of the postponement of IHA consultation on the capital program for West Kootenays, and specifically the replacement and location of the KBRH.

### APPROVALS

Approved by: Kevin Brewster, Executive Director,  
Capital Services Branch, January 24, 2013

Manjit Sidhu, Assistant Deputy Minister  
Financial and Corporate Services – [date approved]

**MINISTRY OF HEALTH  
INFORMATION BRIEFING NOTE**

**Cliff # 966530 x-ref: 957794**

**PREPARED FOR:** Honourable Dr Margaret MacDiarmid, Minister of Health  
- **FOR INFORMATION**

**TITLE:** K'ómoks First Nation and the North Island Hospitals Project

**PURPOSE:** Material for a meeting between the Minister of Health and representatives of the K'ómoks First Nation on February 28, 2012

**BACKGROUND:**

On April 26, 2012, the Province of British Columbia announced the approval of the business case to replace hospitals in the Comox Valley and in Campbell River for a total capital cost of \$600 million. This is known as the North Island Hospitals Project (NIHP).

While the new hospital in Campbell River will be developed on the existing hospital site, the hospital in the Comox Valley will be developed on a new site. After a comprehensive site selection process, the Comox Valley hospital will be built on property once part of the North Island College (NIC) in Courtenay. That property was recently transferred from the NIC to the Vancouver Island Health Authority (VIHA).

As part of the site transfer process, the K'ómoks First Nation (KFN) received written notification from NIC of the change of use of the property for the purposes of constructing the new hospital. The KFN responded advising they had no objection to the property disposition and reminded the NIC of the Province's duty to consult with First Nations.

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Beginning in late 2012, the KFN contacted the NIHP chief project officer inquiring about VIHA's intention to negotiate the KFN participating in the economic benefit of the NIHP development. Through subsequent communication between the KFN, VIHA and to the Ministry, the KFN are seeking either direct award contracts, or contracts through specific direction in requests for proposals, for construction of the NIHP facilities. Examples of the work for which KFN are seeking contracts include tree removal, excavation, gravel supply and site security.

On December 7, 2012, the KFN sent a letter to the Minister of Health (the Minister) seeking a meeting to discuss KFN involvement in the NIHP. Subsequent correspondence with the Ministry and VIHA staff clarified KFN's proposals for participating in the NIHP construction. This correspondence is included as Attachments One and Two and the Minister's response is Attachment Three.

It should be noted that the KFN recently completed negotiation with BC Hydro for similar economic involvement in the construction of the John Hart Dam project near Campbell River.

#### **DISCUSSION:**

The KFN's experience of government construction projects has primarily been with horizontal infrastructure (Vancouver Island Highway, John Hart Dam) which includes extensive environmental and First Nations consultation and development requirements. The KFN has expectations that the hospital project has similar consultation requirements. While the Ministry has a duty to consult with First Nations, it does not have the same level of policy and practice for involving First Nations in the construction phase as government agencies that develop horizontal infrastructure.

As outlined in Attachment Four, VIHA continues to have, extensive engagement with local First Nations regarding the development of the NIHP. VIHA is obligated to follow its Fair Business Policy in the competition and awarding of construction contracts and cannot direct the award of contracts to specific companies.

The Ministry of Health is researching the practices of other government agencies that involve First Nations in the construction phase of major infrastructure. BC Hydro's practices are extensive and are built on combination of First Nations procurement policy and direct negotiation with First Nations. The Ministry of Transportation and Infrastructure's practices are similar to BC Hydro but they require further research.

It is not the practice of health authorities or the Ministry of Health to permit direct, or directed, award of construction contracts. The recent Fort St John hospital project included language in the request for proposal making the project proponents aware of First Nations companies and/or labour but it did not require proponents to employ any specific group. The KFN want more specific language that guarantees awarding of contracts to KFN companies.

#### **ADVICE:**

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**Date:** February 25, 2013

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Pages 214 through 223 redacted for the following reasons:

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