MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 997534

PREPARED FOR: Honourable Terry Lake, Minister of Health -
FOR INFORMATION

TITLE: Sect 12 **Health Authority**
Cash

Sect 12

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 996906

PREPARED FOR: Honourable Terry Lake - **FOR INFORMATION**

TITLE: Seniors' Issues, Key Service Initiatives and Deliverables Update

PURPOSE: Update on seniors' issues, key service initiatives and key deliverable items.

BACKGROUND:
At the Minister's Health Service Roundtable held on October 23, 2013, the Minister asked for an update on seniors' issues, key service initiatives and key deliverable items.

DISCUSSION:
The following is an update on items identified as of interest.

Dementia Care

- Released in November 2012, the Provincial Dementia Action Plan has priorities with actions for implementation over two years, and includes support for prevention and early intervention. A key action in the Plan was to develop a new guideline on managing the behavioural and psychological symptoms of dementia (BPSD.) The BPSD guideline includes a decision support algorithm that has been completely revised with up-to-date clinical content. The updated algorithm will be available on desktops and as an app for handheld devices. Original target date for full completion was delayed and is now estimated for December 2013.
- The Ministry, health authorities (HA) and the BC Patient Safety and Quality Council (BCPSQC) are working together on implementation of the BPSD best practice approach, including P.I.E.C.E.S. dementia training across the province. Regional health authorities have been provided one-time funds to use for dementia care education and to support P.I.E.C.E.S and BPSD coordination and delivery.
- A high level provincial implementation plan has been drafted and health authorities are completing plans for submission in December 2013. HAs seconded a project lead for P.I.E.C.E.S. implementation for 2013/14 and are looking at ways to collaborate to maximize resources, such as electronic-based training.

Antipsychotic drug use initiative

- The BCPSQC launched their Call for Less Antipsychotics in Residential Care (CLeAR) initiative in June 2013. They held a kickoff event day for its facility and quality improvement teams, organizational members and alliance partnership members in October 2013 in Vancouver, BC.
- The BCPSQC will support CLeAR members and facilities to reduce inappropriate antipsychotic use through clinical advisory support, improvement coaching, alignment between partner organizations, and knowledge transfer opportunities.

End of Life Care

- In March 2013 the *Provincial End-of-Life Care Action Plan* (Action Plan) was released which is intended to guide HAs, physicians, health care providers, and community organizations in planning integrated primary and community end-of-life care services. Recent translation of advance care planning materials into Chinese and Punjabi completes the advance care planning deliverables. A number of physicians have been engaged and the focus is now on the development of a prioritized implementation strategy for outstanding items of the Action Plan.
- With the release of the Action Plan, a British Columbia Centre for Palliative Care (the Centre) was also established through grant funding. Work is currently underway to clarify the Centre's mission, vision, priorities and governance structure. Recruitment of an Executive Director is also in progress. Target for the Centre to be in operation is January 2014.
- In the summer of 2013, the government committed to doubling the number of hospice spaces in BC by 2020. Activity has begun on supporting this commitment and is currently focused on project planning, and identifying stakeholders and partners with whom to engage. A documentation of current state and forecasts of future need and distribution are expected in January 2014 with the development of a business case to identify the most cost-effective options following in March 2014.

48/6 Initiative

- In April 2011, the provincial Seniors Hospital Care Working Group (SCHWG) was convened. SHCWG identified the 48/6 initiative as their first priority to improve health outcomes for seniors during their hospital stay. 48/6 is an integrated care initiative that addresses six basic areas of care that must be addressed within 48 hours of admission to hospital. The care team screens for these areas and where concern(s) is identified, a further assessment is conducted, and a care plan is created. These steps must occur <u>within 48 hours</u> of the decision to admit the patient.
- 48/6 is expected to improve patient outcomes and patient flow through the hospital. This was adopted as a provincial Clinical Care Management Guideline and mandated for use in all hospitals in BC. All HAs are actively working towards the provincial target of full implementation of 48/6 by September 31, 2013, for patients 70+ years of age in acute care settings. Given the positive impact 48/6 is having on patient care in the implementation phase, all HAs have voluntarily decided to extend the 48/6 Model of Care to all adults patients (not just seniors).

Regulatory changes relating to reporting of adverse events

Government has approved changes to several regulations to strengthen reporting requirements for adverse events that come into force on December 1, 2013.

- <u>Residential Care Regulation</u>: the definition of "choking" has been amended to require facilities to report incidents of choking where first aid practices were administered. Additionally, a new reportable incident category entitled "aggression between persons in care" has been created and the existing definition of "aggressive or unusual behaviour" has been modified. This will result in any behaviour that results in an injury to another person in care being reportable.
- <u>Hospital Sector Regulation</u>: now mandated to report adverse events which result in severe harm or death of the patient/resident.

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Date: November 22, 2013

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #989771

PREPARED FOR: Honourable Terry Lake**,** Minister of Health -
FOR INFORMATION

TITLE: In-Patient Care Program

PURPOSE: Provide current status on the General Practice Services Committee In-Patient Care Program

BACKGROUND:

Effective April 1, 2013, the General Practice Services Committee (GPSC – a joint Ministry of Health/British Columbia Medical Association committee) implemented the In-Patient Care Program to better support hospital based patient care provided by family physicians (FPs) in BC's hospitals. This program replaced hospital care service agreements that 11 Divisions of Family Practice had with the Ministry and all Doctor of the Day arrangements provided through health authorities' Medical Oncall Availability Program budgets.

The management of patients in hospital, whether directly or indirectly by the FPs, helps ensure continuity and coordination of longitudinal care and strengthens patient attachment to a family practice.

Hospital in-patient care under this program extends to patients who:

a. are attached to an FP who has hospital privileges at the facility where the patient is admitted,
b. are hospitalized and did not have a FP,
c. have a FP who does not deliver in-hospital care, or,
d. have a FP who is outside the hospital catchment area.

GPSC funding totaling $31.9 million annually ($13 million from the current budget and $18.9 million from prior years' surplus) for fiscal years 2013/14 and 2014/15 is being used to make available the following suite of incentives for FPs who provide this care. In the majority of cases, care is coordinated through local Divisions of Family Practice where they exist. It is hoped these incentives will stop or reverse the trend that has seen approximately 3 percent of FPs give up hospital privileges annually over the last decade. The incentives include:

- Assigned In-patient Care Network Incentive
- Unassigned In-patient Care Network Incentive
- Unassigned In-patient Care Fee
- Enhanced clinical fees for select In-patient Most Responsible Physician services

DISCUSSION:

The In-Patient Care Program has been well received by the province's FP community for two primary reasons:

- The program has stimulated dialogue at a provincial, regional and local level around how in-patient care should be delivered. This dialogue has also helped identify many non-compensation issues that need to be addressed.
- Prior to the implementation of these incentives, it was widely believed by FPs that in-patient care was underfunded relative to other types of FP work. The theme of exploring comprehensive Full Service Family Practice at a community level will be further explored by GPSC working groups in September 2013.

Imparting information on the new incentives to FPs around the province and the administration of the implementation effort has been a significant effort that has continued non-stop since the announcement of the incentives on March 27, 2013.

As of August 19, 2013:

- The FPs around 68 hospitals are expected to be eligible for the GPSC In-patient Care incentives. 60 out of 68 communities have started some degree of implementation with 48 communities being complete.
- Based on the anticipated number of FPs who will register for the incentives, approximately three quarters of the In-Patient Care Program implementation has been completed. Several communities where the implementation is outstanding are in the process of establishing a Division of Family Practice who will have a role in administration of the incentives. In these communities they plan to complete the implementation in the early fall when the Division is fully in place.
- 778 FPs have billed the in patient care network fee.
- 289 FPs have billed the unassigned in-patient care fee.

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 989677

PREPARED FOR: Honourable Terry Lake, Minister of Health - **FOR INFORMATION**

TITLE: Overlander Extended Care

PURPOSE: To provide an update on progress made by Interior Health Authority following an incident of resident-to-resident aggression

BACKGROUND:

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- Interior Health Authority (IHA) carried out a quality review of this incident and, following the review, completed the "Overlander Residential Care Final Report" dated August 2013.

DISCUSSION:

The review identified a number of factors that contributed to this event. Some of the key findings, themed into five general areas (leadership, clinical oversight, quality improvement and risk management, corporate and organizational support and communication), include:

Leadership
- staff members perceive and feel a lack of manager support
- inconsistent management team members
- limited local capacity to review adverse events and plan to mitigate future incidents

Clinical Oversight
- care plans are not reviewed, updated or communicated consistently, specifically around behaviours
- lack of criteria and prioritization for referral to geriatric psychiatrist and behavioral consultant
- interRAI data not consistently reviewed or utilized by nursing and leadership teams

Quality Improvement and Risk Management
- no specific, validated, evidence-based admission criteria exists for the Blueberry Unit
- high level of staff turnover
- inconsistent staffing levels
- no multidisciplinary unit team meetings
- only one P.I.E.C.E.S trained staff on the unit
- locks were removed from doors as recommended by Fire Inspector

Corporate and Organizational Support
- inconsistent collaboration with licensing
- physical layout of the unit not designed for patients with behavioural issues

Communication
- staff and management not aware of incident management policy
- no regular management meetings to review status of residents

IHA is currently providing written weekly work plan updates to the Ministry of Health. They report that the following actions have been taken since the review of the Overlander incident:

Leadership

- Leader has been assigned to review Patient Safety Learning System (PSLS) reports and/or critical incidents, and to ensure training for event handlers
- Site manager position is to be posted and filled in late August

Clinical Oversight

- Care plans for all residents on the secure unit have been reviewed and revised
- Behaviour management care template has been developed and is being used on all units
- Behavioural consultant is on site to support staff and staffing has been increased
- Terms of reference are being established for interdisciplinary teams to review processes such as monitoring RAI and PSLS

Quality Improvement and Risk Management

- Appropriate locks that allow residents to exit but prevent others from entering have been installed. Staff have access to the room as required.
- Bed management meetings have been established to identify opportunities to shift/relocate residents to more appropriate environments in a proactive manner
- Quality Care Coordinator has been identified and will begin work in September
- Quality improvement plan has been developed and will be shared across the health authority in order to learn from this incident

Corporate and Organization Support

- Literature review is underway for best practices related to sundowning and aggression

Communication

- Team huddles have been established to discuss new behaviours and care
- Evaluation of relocating of charts and computers to a central location is in process

IHA has identified a number of actions to improve service delivery since the incident of resident to resident aggression at Overlander Extended Care, progress has been demonstrated and an implementation plan to move forward with the other recommendations is in place.

NEXT STEPS FOR MINISTRY OF HEALTH:

- The Ministry will continue to monitor the progress of this work on a weekly basis as IHA is in the early stages of moving forward with their action plan at this site only, and has not at this time transitioned the learning's to their other sites.

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 984541

PREPARED FOR: Honourable Terry Lake, Minister – **FOR INFORMATION**

TITLE: Overview of HealthLink BC Nursing Services and key metrics for HealthLink BC services.

PURPOSE: To provide an overview of Nursing Services and key metrics for HealthLink BC services in response to a request from the Minister's office.

BACKGROUND:
BC NurseLine was established in 2001 and was originally located in the E-Comm building in Vancouver. The contact centre moved in 2003 to the Still Creek site in Burnaby in order to accommodate ongoing growth in response to public demand. A second site was opened November 2006 in the Walnut Grove area of Langley, providing the service with a business continuity plan to respond to technical outages and disasters. In 2008, under the Emergency and Health Services Commission, BC NurseLine was rebranded as HealthLink BC Nursing Services. In 2010, HealthLink BC was transitioned into the Ministry of Health.

DISCUSSION:
Specially trained registered nurses provide 24/7 health information and advice, toll-free to the residents of British Columbia and the Yukon. Telenurses use credible sources of health information and access best-practice protocols within the Healthwise Knowledgebase. Encounters with callers are documented using the call tracking software, First Contact. Telenurses also refer callers to self-care resources available to the public on the HealthLinkBC website at www.healthlinkbc.ca.

Nursing Services is comprised of 150 telenurses including 10 shift leaders and 6 telenurses who work from home. Leadership is provided by five team managers reporting to the Director of Nursing Services. Clinical support is offered by two health information coordinators, four educators and three quality management coordinators.

Inbound calls to 8-1-1 are routed from Health Service Representatives to telenurses according to pre-determined rules or skill sets. Nursing Services has three main telephony queues – priority (BC Ambulance), urgent and general. The telenurse receives a call, establishes the nature of the inquiry then proceeds with providing relevant health information or conducting a nursing assessment to triage the caller's symptoms. On average, each call to Nursing Services lasts 12.5 minutes, and the service level target is to answer 80 percent of calls within 60 seconds.

Callers requiring language translation are assisted via interpreters through the Provincial Language Service, who can assist in more than 130 languages. Telenurses also provide province-wide after hours support to palliative care patients and their caregivers as well as to patients of designated primary health care organizations.

The pharmacist service was added in 2003 as a contracted service providing HealthLink BC and callers to 8-1-1 access to a licensed pharmacist between the hours of 5pm and 9am, 365 days per year. These pharmacists provide HealthLink BC callers with confidential information and advice on prescription and over-the-counter drugs.

Key metrics for Nursing Services in fiscal year 2012-13 were as follows:

- Calls answered: 262,214 (an average of 716 calls per day)
- Triage Disposition (Nursing Services advice to callers):
  - 9-1-1 (call 9-1-1 or be driven to emergency services) 8%
  - Red (call your doctor or visit physician/clinic in next hour) 26%
  - Yellow (call or visit your physician/clinic in next 24 hours) 22%
  - Green (home treatment; call back to 8-1-1 if symptoms worsen) 13%
  - Black (make appointment with physician/clinic in next 2 weeks) 3%
  - Null (general health information provided) 28%
- Top ten problem categories:
  - Gastroenterology 19%
  - Musculoskeletal 9%
  - Pediatrics 8%
  - Respiratory 7%
  - Dermatology 7%
  - Neurology 7%
  - Obstetrics and Postpartum 5%
  - First Aid 5%
  - Wellness 4%
  - Cardiovascular 4%
  - Gynecology 4%

Metrics for HealthLink BC's other core services for fiscal year 2012-13 were as follows:

- Navigation Services – 367,700 calls answered, an average of 1,007 calls per day. Of these calls, some 71 percent were transferred to a nurse, 8 percent transferred to a dietitian or pharmacist, and 2 percent transferred outside of HealthLink BC (e.g. Drug and Poison Information Centre, British Columbia Ambulance Service).
- Dietitian Services – 12,600 calls answered, averaging 51 calls per business day. In addition, Dietitian Services responded to 940 e-mail inquiries from professional dietitians and members of the public, and returned calls for close to 300 voice mails.
- Pharmacist Service – 23,550 calls answered, an average of 65 calls per day.
- Nicotine Replacement Therapy – 117,100 calls answered, an average of 321 per day. Of these calls, there were a total 95,084 Nicotine Replacement Therapy orders placed (53,016 original orders and 42,068 refill orders). From the start of the program on September 30, 2011 through May 31, 2013, HLBC has taken 215,005 Nictotine Replacement Therapy orders.
- HealthLinkBC.ca –website received 3,522,900 visits, averaging 9,625 visits per day.

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Health IT Strategy & Funding

June 2013
Health Sector IM/IT Division

Overview

- Health Sector Challenges
- Information Technology Supports the Change
- Current Focus: Highlights from the 2013/14 Health Sector IMIT Strategic Plan
- Funding Strategic IT Initiatives
- Next Steps

The Challenge We Face

Provincial government spending on the BC health system has been growing at a rate much higher than the growth rate of either government revenue or the economy.

This is largely due to:

- The aging population
- Overall increasing use of services
- Inflation

Addressing the Challenge

- In the long term, we can delay or prevent illness by supporting people to improve their health.
- Coordinated, proactive care focused on a patient's changing health needs can improve the experience and outcomes of care and reduce reliance on hospitals.
- Innovation can improve the performance and efficiency of the system and ensure its sustainability.

IM/IT is a key enabler of these health system changes

Information Technology Supports Change

Nearly ten years of effort supports the business challenges and change agenda

Electronic Health Record - Electronic Health Record Systems (EHR) enable patient health information (lab results, drug information, medical images) to be securely stored and shared electronically, to authorized users.

Electronic Medical Records - The 2006 Physician Master Agreement provides [redacted] to implement Electronic Medical Record (EMR) applications and supporting hardware in the physician practices.

Provincial Telehealth -Telehealth uses videoconferencing and other technologies to enable cost effective clinical consultation, health care management, general health promotion and continuing professional education when the participants are in separate locations.

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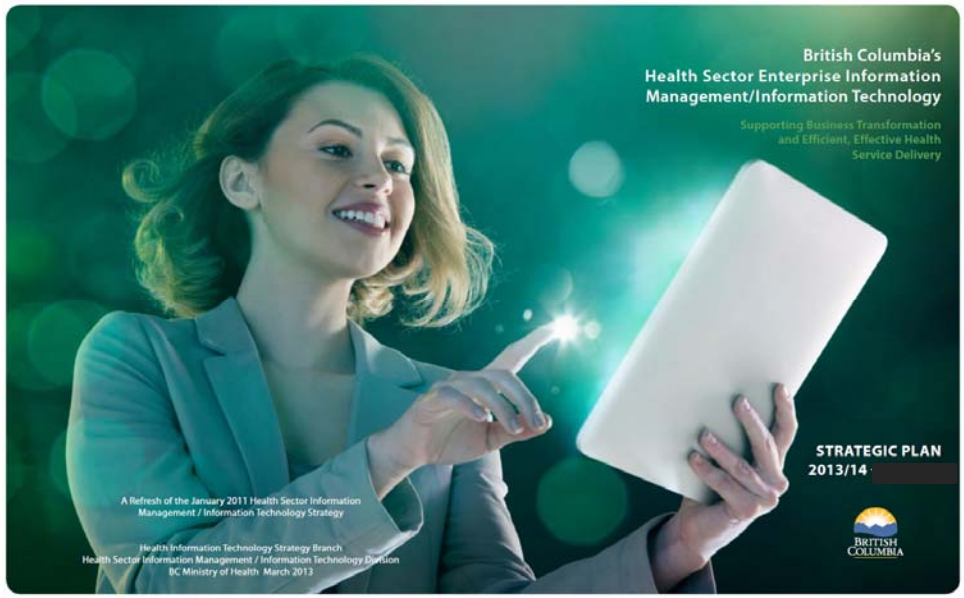
Key Information Technology Accomplishments To Date

- ✓ All major provincial Electronic Health Record components in place
- ✓ Over 90 million Hospital and Community lab test results available electronically
- ✓ Health authority medical images shared across all regions
- ✓ Approximately 75% Electronic Medical Record adoption across targeted physicians
- ✓ Early adopter deployment of electronic prescribing functionality
- ✓ Executed agreements to expand First Nations telehealth capacity and services in up to 30 First Nations communities
- ✓ BC Services Card launched province-wide

2013/14 Health Sector IMIT Strategic Plan

- Serves as an overarching guide for Health Sector IM/IT organizations
- Intended to facilitate alignment of effort and investment to strategic goals and priorities



IMIT Strategic Plan Addresses Key IM/IT Issues

Economic

- Funding mechanisms impede sector planning
- Difficult to demonstrate value for IM/IT investment
- Comparatively low investment in health IM/IT

Social

- Lack of single, integrated, reliable patient record
- Sector services wide range of clients, differing needs
- Increasing citizen expectation of access

Organizational

- Lack of shared vision
- Complex governance
- IM/IT not aligned for business transformation
- Lack of shared interoperability roadmap

Technology

- Technology outpacing development of standards
- Pace of change, mobile technologies
- Aging legacy environment
- Patchwork of health systems

Vision, Mission, Principles & Goals

Vision

Health care is accessible, when and where it is needed, to support personal health, health care decision making and health system sustainability

Mission

To support and enable achievement of health system priorities and goals through the effective management of information and related information technologies

Guiding Principles

IM & IT are care and service enablers · Engage Early in Planning Partnerships · Plan & Invest with Enterprise Focus
Provide Access from Anywhere · Adhere to Standards · Ensure Compliance· Maximize Business Value · Design for People
Exceptions are Allowed · Leverage Existing Strategic Investments First · Align Investments to BC Health Goals · Minimize Disruption

Smart Investments:

Demonstrated business value for collective IM/IT investments

Collaborative Leadership:

Courageous, engaged and inspired IM/IT leadership with a shared Sector-wide vision

Connected Solutions:

Connected systems with complete and integrated information at the point of care

Transformed Business:

IM/IT enabled transformation in partnership with business

Top Notch People:

Highly skilled, engaged and flexible resources aligned to strategic priorities

Funding Strategic IT Efforts

Through the implementation of eHealth, the Ministry identified the ongoing need to guide IM/IT investment and ensure technology and business alignment across the health sector

Creation of Health Sector Strategic Investment Fund (HSSIF) will incent and support strategic IT projects

- Sect 17
- Ministry will annually review and fund projects aligned to IMIT strategic agenda

Next Steps

June 30, 2013: Complete Enterprise Architecture Medical Imaging Pilot to enable electronic sharing of medical imaging information across the BC health sector

July 31, 2013: Execute agreements with First Nations Health Authority for Telehealth expansion

Sept 30, 2013: Develop shared vision for Health Sector IM/IT

Sept 30, 2013:

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Dec 30, 2013: 2014/15 Strategic Plan for Health Sector IM/IT

Mar 31, 2014: Develop comprehensive IT Strategic Planning Program

Mar 31, 2014: Citizen Access Strategy

Questions?

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #: 985219

PREPARED FOR: Honourable Terry Lake, Minister- **FOR INFORMATION**

TITLE: Tobacco Sales in Pharmacies

PURPOSE: To review issues regarding tobacco sales in pharmacies and stores that contain pharmacies.

BACKGROUND:

Most pharmacies are comprised of a dispensary area in the front of the store, where a variety of products are sold. Examples are:

- A small retail pharmacy that has a dispensary and sells products like toothpaste and bandages (e.g. Medicine Shoppe);
- A larger retail pharmacy that has a dispensary and sells products like toothpaste, and bandages, as well as computers and appliances (e.g. London Drugs); and
- A supermarket or warehouse that sells groceries, furniture, garden supplies, and contains a dispensary (e.g. Costco, Safeway).

British Columbia bans the display and promotion of tobacco where youth have access, so customers entering stores that allow youth to enter (like drug stores and supermarkets) will not see any tobacco. BC is the only province that does not ban the sale of tobacco in stores that contain a pharmacy; the majority of pharmacies (55 percent[1]) report they no longer sell tobacco.

Health organizations[2] support a ban on tobacco sales in all parts of stores that have a dispensary on site, stating tobacco is contrary to a pharmacy's mission to promote health and that pharmacists, as health care providers, should not profit from the sale of tobacco. The College of Pharmacists (the College) has stated that tobacco sales are inconsistent with a pharmacist's professional standards. On the other side, the BC Pharmacy Association, the Canadian Association of Chain Drug Stores, and the Canadian Council for Grocery Distributors strongly oppose bans, with the BC Pharmacy Association stating:

> "…the choice to sell tobacco products, or not, is a business decision made in the context of the business operations that do not involve the health care setting (i.e. the dispensary), and do not involve the pharmacy professional staff. The trend towards inclusion of pharmacies within very large retail operations means that the sale of tobacco products and the dispensary may be physically well-removed from each other within the store…[3]"

There is no evidence that a ban in pharmacies has had a negative retail impact in any province where a ban is in force.[4] There is also no literature on whether a ban on sales in

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1 BC Lung Association Backgrounder, http://www.cleanaircoalitionbc.com/uploads/2012/01/120116-Backgrounder-Tobacco-Free-Pharmacies-FINAL.pdf -

2 Heart and Stroke Foundation, BC Lung Association, BC Medical Association, College of Pharmacists of BC

3 BC Pharmacy Association, Tobacco Position Statement, July 28, 2006

4 The Case for Creating Tobacco-Free Pharmacies in British Columbia, The College of Pharmacists of British Columbia, June 2011, page 21

pharmacies would impact smoking rates, given the current restrictions already in place. In provinces with a ban, stores with dispensaries simply moved tobacco sales to a side location (such as a kiosk in the mall) and customers walked a bit further to buy tobacco.

Government's approach has been to let pharmacies decide whether they sell tobacco, noting that customers in a pharmacy no longer see tobacco promoted (see Appendix A for quotes from previous Ministers). Pharmacies are the only retail site with professionals knowledgeable about cessation medication and who can encourage customers to quit.

DISCUSSION:

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[5] Canadian Community Health Survey (2012), Table 105-0501, Current daily or occasional smokers. Statistics Canada

Appendix A

March 7, 2007 – Hansard – Hon. George Abbott during debate on legislation establishing the *Tobacco Control Act*

> "Some issues have been raised by members. On some I think we'll have an honest difference of opinion. I did think about the issue of banning the sale in pharmacies, and I took a considered position in respect of that. As long as tobacco remains a legal product in this province and pharmacies are a business in this province, unless we decide at some point that we're going to control the sale of it through liquor stores only, or a source like that.... I had some difficulty coming to the considered position that pharmacies should be excluded from being a place of sale.
>
> Some would argue, in fact, that pharmacists, because they can offer up a range of products and advice around tobacco cessation, are perhaps a better place to be selling tobacco than some others. I don't know about that. As I say, I think we may have an honest difference of opinion around that point."

CKNW, CKNW World Today Weekend - May 30, 2010

Sean Leslie: Well, then let me ask you this, Minister Kevin Falcon. Yeah, you're right: B.C. has the lowest smoking rate in the country, 15 per cent. The Cancer Society, though, says, "You know what? Do more to crack down on smoking. Let's stop letting pharmacies sell cigarettes." Your government has never acted on that. Why not? Why not get smokes out of pharmacies?

Kevin Falcon: Well, I think a lot of the pharmacies are coming in that direction. One of the things we're trying to do here is recognize that a lot of the pharmacies, good or bad, have built a bit of their business model around cigarettes. I think that's increasingly shrinking, and I do think there's a real debate within the pharmacy system, but I would certainly be willing to engage in that discussion with pharmacies, for sure.

I do think we all have to do our bit, but you know it's not just.... That would just deprive one other place for them to be sold. I do think it's inconsistent to have cigarettes being sold in a place that's supposed to be all about health and wellness, and I do think that increasingly pharmacists are starting to feel the same way. I think you'll see that change coming probably sooner than most people think.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 994455

PREPARED FOR: Honourable Terry Lake, Minister - **FOR INFORMATION**

TITLE: Guiding Framework for Public Health and Priority Areas for 2014/15

PURPOSE: Provide information on the Guiding Framework for Public Health and the priority areas of focus for 2013/14 – 2014/15.

BACKGROUND:
British Columbia has built a solid foundation for public health, particularly through the development and implementation of Core Public Health Functions (Key Result Area 2). BC has also developed several targeted public health strategies that address a range of health issues; however, at times these have been perceived to be part of stand-alone, targeted, temporary or fragmented strategies and programs. As such, there was an opportunity to improve integration and arrive at a more coordinated set of provincial prevention strategies built on past and current efforts.

In spring 2013, Leadership Council and the former Minister of Health approved *Promote, Protect, Prevent: Our Health Begins Here. BC's Guiding Framework for Public Health* (the Guiding Framework). The Guiding Framework aims to improve the health and well-being of British Columbians by:

- Creating a long-term vision for the public health system that incorporates all pre-existing public health strategies.
- Formalizing a collaborative process to identify future public health priorities.
- Reinforcing core public health functions as the foundation for public health services.
- Supporting a population health approach and the public health role in health equity.
- Connecting to and supporting self care, primary care and clinical prevention.

The Guiding Framework was released by the Ministry of Health in March 2013; however, no formal launch took place given the then-impending Writ period.

DISCUSSION:
The Guiding Framework is a high-level guidance document for the public health system. The first of its kind in BC, the Guiding Framework establishes long-term direction for the public health system and sets the stage for more strategic resource allocation, infrastructure development and service delivery over the next 10 years. It aligns and explains existing public health priorities and formalizes a process for identifying future priorities to be approved by the Minister of Health. It does not commit government to new programs or spending.

The Guiding Framework was developed with the strategic oversight and advice of the Provincial Public Health Committee, and with broad consultative feedback from key public health partners and stakeholders including health authority staff, the Union of BC Municipalities, non-governmental organizations, Health Officers' Council, the Assistant Deputy Ministers' Committee on Population Health Improvement, the Public Health Association of BC, the Public Health Association of Canada and public health academia.

The Guiding Framework identifies seven visionary goals for the public health system, which support the vision of "Vibrant communities in which all people achieve their best health and well-being where they live, work, learn and play." The goals are largely influenced by and aligned with core public health functions, and they are intended to organize existing provincial strategies and inspire action to address the burden of disease/injury. They will inform the development of new public health priorities, identify opportunities for key partners to influence population health through inter-sectoral action and form the basis of future strategic investment.

Objective statements describe key areas under each goal and a set of performance measures are included to help measure progress over the next 10 years. These measures were drawn largely from existing strategies to further align efforts and ensure adequate data are available. A set of overarching bellwether measures is also included to help measure overall system performance.

One of the key components of the Guiding Framework is a priority-identification model that aims to provide a more consistent, transparent and inclusive process to determine what new/enhanced initiatives to recommend to the Minister as future public health priorities. This priority-identification process would ideally happen on a cycle that is consistent with broader strategic planning in the health system, and is supportive of other key planning processes such as budget development.

Given the then-impending Writ period, the budget cycle and the recent consultations around the Guiding Framework, a scaled-back version of the initial priority-identification process was initiated in March 2013. A number of stakeholders, including Health Officer's Council, the Public Health Vice Presidents Steering Committee, the Provincial Public Health Committee, the BC Healthy Living Alliance and the Union of BC Municipalities, were engaged to help generate potential priorities for 2014/15.

While a wide range of suggestions were received for new/expanded programs, a few key areas were recognized as needing refreshing or strategic direction, and given budgetary conditions this fiscal it was decided to move forward with strategic planning in the following areas for 2013/14 and moving forward into 2014/15: Physical Activity; Sexually Transmitted Infections; Tobacco Use; Healthy Eating; and Food Safety. Following this strategy development phase, specific actions/initiatives under each may be proposed as part of the next priority-identification phase and recommended to the Minister for direction and decision.

The Guiding Framework also commits to developing a Public Health Surveillance Plan by 2014, as a road map to address key gaps, particularly in environmental health, population health and regional capacity.

Another area of substantial consensus raised in the consultation was the need for an injury prevention strategy. Work is underway to improve the committee structures related to injury prevention and to align surveillance capacity as first steps towards improving support in this area.

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 989029

PREPARED FOR: Honourable Terry Lake, Minister of Health
- FOR INFORMATION

TITLE: Minister Response to Question on Notice by Mr. Andrew Weaver, MLA, Oak Bay-Gordon Head

PURPOSE: To provide information on the Ministry of Health's response to MLA Weaver's Question on Notice.

BACKGROUND:

The Ministry of Health (the Ministry) is providing responses to the following two questions posed by MLA Weaver during the July Estimates session.

DISCUSSION:

Question 1:
The Revised Service Plan highlights the fact that many chronic diseases that cost our province billions in health care spending are associated with preventable risk factors. What percentage of the Ministry's overall budget is allocated to preventative medicine?

Answer:
The Ministry is operating with a primary goal of improving the health and wellness of British Columbians while meeting the changing demand and projected supply capacity of the system, continuing to improve quality care and bending the cost curve of the health system budget. This strategic agenda focuses on system level change while continuing to support health authority-specific strategies that are responsive to regional population health needs and priorities.

The Ministry's Population and Public Health Division anticipates spending approximately $29.4 million in 2013/14 on public health related expenditures (including staff wages and benefits, travel, centralized services and other direct public health related expenditures). Health authorities indicate they anticipate spending just over $500 million in 2013/14 for public health services, including chronic disease prevention. Each health authority's expenditures vary based on population needs and demand for services.

Question 2:
With risk factors such as obesity on the rise, has the Minister considered incentive schemes to promote healthy eating and reduce the consumption of unhealthy foods, including taxation of foods that are high in sodium or sugar with the purpose of using the subsequent income to reduce the relative costs of healthier food options or offset growing health care costs?

Answer:
The effectiveness of tobacco taxes in reducing tobacco use has stimulated interest in taxes as a policy tool to support sugary drink reduction. Proponents believe that charging a tax on sugary drinks could help prevent the health problems associated with these beverages, both by providing a source of funding for health improvement programs and by potentially reducing consumption.

The effect of a tax is largely dependent on the amount of tax imposed and how the tax is passed on to the consumer. If the objective of the tax is to fund public education and intervention programs, a lesser tax could be considered. However, if the objective is to reduce consumption, a larger tax is necessary.

Researchers estimate that a 10 percent increase in the price of sugary drinks would reduce consumption by 8 to 11 percent. In a Norwegian study, increasing the price of soft drinks by about 11 percent was estimated to decrease consumption by nearly 7 percent in the lowest consumption group, by 17 percent in the highest consumption group and by an average 9.5 percent overall. Increasing the price by 27 percent was associated with a drop in consumption of 17 percent in the lowest use group, 44 percent in the highest use group, and an overall 24 percent reduction in consumption across the population.

Public concerns have been raised that a sugary drink tax is unfair and discriminatory because it impacts low-income individuals the most. Some suggest that the elderly and low-income families would have even less income to spend on other groceries if a sugary drink tax were in place.

In light of the current economic climate, the introduction of a new taxation strategy does not appear to be favourable, but could be given future consideration.

Rather than taxation, the Ministry has focused on incentive initiatives like the Farmers' Market Nutrition Coupon Program (the Program). The Program provides subsidies in the form of coupons to low-income pregnant women, families with children and seniors to buy select BC-produced foods at local farmers' markets. Families receive $15 worth of coupons each week; seniors receive $12 worth. Coupons are treated like cash and can be used to purchase a variety of BC food products including fruit, vegetables, meat, fish, nuts, dairy and fresh cut herbs.

Coupon participants must complete nutrition and skill-building classes to be eligible to receive coupons. These programs teach participants how to cook healthy, nutritious meals including locally produced farm products. By increasing access to healthy foods linked to cooking and skill building activities, the government can foster immediate behavioral changes that will improve health and decrease the burden of chronic disease.

On July 20, 2013, Minister Terry Lake announced $2 million was provided to the BC Association of Farmers' Markets through the Provincial Health Services Authority to sustain and expand the Program.

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #: 989852

PREPARED FOR: Honourable Terry Lake, Minister of Health -
FOR INFORMATION

TITLE: Regulating Flavoured Tobacco Products in British Columbia

PURPOSE: To review provincial and federal regulatory issues regarding flavoured tobacco, particularly those flavours appealing to youth.

BACKGROUND:
Flavoured tobacco products include cigarettes, little cigars/cigarillos, cigars, bidis, smokeless tobacco and water pipe tobacco. Flavours include adult-oriented ones (rum, port, menthol) as well as those that would be seen as more-youth-oriented (bubble gum, root beer and fruit flavours). Flavoured tobacco products can act as a starter product as the addition of flavours masks the harshness of tobacco, which makes the product more palatable for younger users (Alberta Health Services, 2009).

The Youth Smoking Survey (YSS) is a biennial school-based survey of Canadian youth in grades 6-12. The 2010-2011 results (released in May 2012) measured flavoured tobacco use in the past 30 days for the first time. In Canada 9 percent of youth (representing 247,000 students) used at least one flavoured tobacco product in the past 30 days[1].

Under the federal *Tobacco Act*, cigarillos, little cigars and blunt wraps must be sold in packages of at least 20 units. If a tobacco product contains a cigarette filter and/or is 1.4 grams or less, it cannot contain youth-oriented flavours like bubblegum and cherry. Menthol is an exception to the flavouring ban. The tobacco industry has exploited the requirements; they have increased the product weight to more than 1.4 grams with no filter and as a result the product is considered a cigar and not subject to the flavouring ban. The pricing and flavours varies widely for these products.

Some jurisdictions are moving to restrict more flavourings. Bill 206, the *Tobacco Reduction (Flavoured Tobacco Products) Amendment Act* in Alberta would provide the Alberta government with the authority to prohibit all flavoured tobacco products. The bill has received second reading as of May 2013. Germany has banned menthol flavoured cigarettes and Brazil has adopted a law to ban all flavours in all tobacco products, including menthol, effective September 2013. Articles 9 and 10 of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) call for regulation of the contents of tobacco products and of tobacco product disclosures. The partial guidelines state that: “Tobacco products are commonly made to be attractive in order to encourage their use. From the perspective of public health, there is no justification for permitting the use of ingredients, such as flavouring agents, which help make tobacco products attractive”.

[1] Youth Smoking Survey 2010-2011, Health Canada and Propel Centre of the University of Waterloo

DISCUSSION:
By masking the harsh taste of tobacco, flavoured tobacco may be a gateway product for youth. s.13

s.13

The issue of flavoured tobacco and its appeal to youth is a concern across Canada. As Health Canada has already initiated regulation of flavoured tobacco, creating a consistent product and retail standard across Canada, it is recommended that Health Canada be encouraged to amend their regulation to reduce or eliminate flavourings used in tobacco.

In 2008, the Honourable Mary Polak wrote to the federal Minister of Health to express her support for national regulation of package size and flavouring restrictions. BC may be interested in requesting a strengthening of the federal regulation to further protect Canadian youth from flavoured tobacco products.

ADVICE:
Advocate for the federal government to implement a ban on all youth-flavoured tobacco.

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