MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 931679

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

TITLE: Rural Communities/Emergency Medical Services Innovation

PURPOSE: Background information for meeting between Minister de Jong and Dr. Granger Avery scheduled for June 11, 2012, 2:45 p.m. to 3:30 p.m., PVO, Boardroom #3, Vancouver, BC.

BACKGROUND:
Dr. Granger Avery is the Co-Chair of the Joint Standing Committee on Rural Issues (JSC), a joint British Columbia Medical Association (BCMA)/Government committee. He is also the Executive Director of the Rural Coordination Centre of BC (RCCbc), created under the auspices of JSC in 2008. Dr. Avery was the President of the BCMA in 1998. He has been a general practitioner in the community of Port McNeill, BC for over 30 years. He has a strong interest in rural medicine and in benefits/incentives for rural physicians.

DISCUSSION:
The Joint Standing Committee on Rural Issues (JSC) is established as part of the Rural Practice Subsidiary Agreement. The JSC is comprised of five members appointed by the BCMA and five members appointed by the Government, which includes Health Authority (HA) representatives. The JSC oversees the 10 rural recruitment and retention programs negotiated between the BCMA and the Government. In addition, the JSC the RCCbc and provides funding to it and receives reporting on its activities.

As part of the negotiated Agreement between the Government and the BCMA, the JSC is tasked with enhancing the delivery of rural health care in BC. Starting in April 2010, the Agreement included refers to expanding the programs that support the delivery of physician services to British Columbians who reside in rural communities including stabilizing payments resulting from the application of the isolation points, supporting the provision of physician services during periods of manpower transition and strengthening the emergency care system in rural communities.

In July 2011, the JSC allocated $10.7M to a new program called the Rural Emergency Enhancement Fund (REEF) which encourages the provision of reliable, continuous or regularly scheduled and posted, emergency department service hours as established by the HA, to improve public access to emergency services in HA designated emergency departments in rural British Columbia served by Fee-for-Service physicians.

The JSC approved $1.672M to support the RCCbc in 2011/12. The RCCbc supports the coordination of rural health care education, rural practitioners, and community health care service, professional partnerships and networks. One of the initiatives that the JSC tasked the RCCbc with is to analyze and make recommendations on the Communities in Transition. This included site visits by the RCCbc, at the request of the communities and the HA, to determine how to best assist these communities in transition. Three site visits have been conducted (Nakusp, Port Hardy and Williams Lake). S13

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Although the JSC has reviewed the rural Community Isolation Points as part of the annual point assessment process, no changes have been made over the past few years and therefore points have remained "stable". An ongoing strategy to deal with fluctuations in points and point stabilization continues to be discussed.

As negotiated between the Government and the BCMA the responsibility for the governance and oversight of the rural programs resides with the JSC. Day to day administration of rural programs is provided by the Ministry of Health. S13

S13

ADVICE:

S13

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File Name with Path:	Z:\PHRM ARCS\Admin 100-499\Executive 280\20 BN's\2012\931679 IBN - Meeting between Dr Avery Minister.doc

Appendix A

Response to RCCbc briefing note re: BC's Vulnerable Communities

- In 2011/12, JSC allocated $161,600 to the RCCbc for "vulnerable communities"
- A total of 3 site visits have been completed since 2009/10
- No funding has been requested for 12/13 under "vulnerable communities"
- As JSC is responsible for enhancing the delivery of rural healthcare it is imperative that there is JSC involvement

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Response to RCCbc briefing not re: Use of telehealth technology to support rural medicine

- The JSC has identified telehealth as an important initiative that should be explored
- Dr. Avery advised the JSC at their January 2012 meeting that there was a pilot telehealth project running, involving Dr. Pawlovich
- Telehealth had been identified on the list as one of many initiatives for the potential use of unspent JSC funding
- At the May 2012 JSC meeting there was discussion around telehealth and consensus that telehealth is a good opportunity on which to capitalize, particularly for GP to GP consult purposes. Members agreed that telehealth lends itself to huge potential time and cost savings, particularly if the JSC collaborates with other groups who are using and applying telehealth to rural sites. However, it was also agreed that in order to move forward, the Committee would need to consider ongoing operational costs and issues of privacy/security of patient information. As well, the Government Co-Chair committed to canvassing other stakeholders within the Ministry on the interest in telehealth prior to any commitment of funding being made

Response to RCCbc briefing note re: Recruiting International Medical Graduates and Canadians Studying Abroad to provide long term rural medical service

- In a 2010 Throne Speech, Government committed to increasing access to residencies for Canadians who have received their medical undergraduate training outside Canada.
- The Ministry of Health's response is to support the expansion and distribution of the International Medical Graduate-BC (IMG-BC) Program.
- Starting in 2011, 40 new entry-level residency positions in family medicine are being added and distributed across the health authorities over the next 5 years, for a total of 58 entry-level positions.

- The first 8 of the 40 new entry-level positions in family medicine were posted in the 2012 Canadian Resident Matching Service (CaRMS) match – 4 positions offered in the Fraser Valley and 4 on Vancouver Island.
- Another 8 new entry-level positions will be posted in the 2013 CaRMS.
- At full implementation of the expansion, there will be an expected 134 international medical graduates in training at any one time – a size similar to a distributed undergraduate medical program in BC.
- In CaRMS 2012, international medical graduates successfully competed for 13.3% of positions posted in CaRMS for all of Canada, while international medical graduates successfully competed for 13.5% of positions posted in CaRMS for BC (first and second iterations).
- Canadians studying abroad successfully competed for 70% of the positions posted for all of Canada in the *second* iteration of CaRMS.

MINISTRY OF HEALTH SERVICES
INFORMATION BRIEFING NOTE

Cliff #937500

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

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

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

BACKGROUND:

Dr. Ross received her medical degree from the University of Alberta S22 Her focus was on primary care with an emphasis in obstetrics when she set up practice in Burnaby. This remained an emphasis with Dr. Ross delivering about 300 babies each year. She recently closed her private practice to focus on medical administration.

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

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

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

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

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

DISCUSSION:

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ADVICE:

S13

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Date: July 14, 2012
File Name with Path: S:\PHRM ARCS\Admin 100-499\Executive 280\20 BN's\2012\937500 Minister Meeting with BCMA President Dr Ross.doc

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938746

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

TITLE: Admit and Discharge Privileges for Nurse Practitioners and the Oral and Maxillofacial Surgeons

PURPOSE: Update on progress for enabling Nurse Practitioners(NPs) and the Oral and Maxillofacial Surgeons to admit and discharge from health care facilities. For Minister's briefing August 3, 2012

BACKGROUND:

To enable NPs and Oral and Maxillofacial Surgeons to admit and discharge patients from hospital, both the *Hospital Act* and the *Hospital Insurance Act Regulations* must be amended, which requires an Order-In-Council (OIC). Additionally, implementation will require changes to Health Authority (HA) medical staff bylaws, as well as HA medical staff rules and hospital policies.

Each HA will determine the timing to implement changes to allow NPs and Oral and Maxillofacial Surgeons admit and discharge privileges within their region. With the requisite consultation, this could take three or more months.
Fraser Health Authority has indicated that they will be the first HA to move forward and have already started planning for implementation.

DISCUSSION:

The Ministry of Health (the Ministry) has been provided with two potential dates for the OIC review, August 29 or September 10, 2012. To support the August 29 date, the submission to Cabinet Operations is required by August 17, 2012, requiring Minister sign off by August 13, 2012.

- Amendments to the *Hospital Act* and *Hospital Insurance Act Regulations* are in progress, the draft for consultation was finalized July 27, 2012.
- Confidential discussions with the College of Registered Nurses of BC have occurred to determine if any standards, limits and conditions will need to be in place for NPs to be able to admit and discharge patients.
- Consultations with applicable HA staff (Chief Executive Officers, Vice Presidents of Medicine, and Chief Nursing Officers) have occurred.
- Consultation with the BC Medical Association (BCMA) occurred July 31, 2012. They want to ensure NPs are working in collaboration with physicians when admitting or discharging patients.
- Consultation with the BC Nurse Practitioner Association is being scheduled; however, they are aware that the Ministry was contemplating this change.

- The Ministry is developing a template for HAs to use to update their medical staff bylaws, to ensure a consistent approach is taken across the Province. HAs have supported this approach.

CONCLUSION:

By September 2012, the Ministry should be positioned to ensure that there is enabling language, and supports, that allows HAs to move forward with plans to allow NPs as well as Oral and Maxillofacial Surgeons to become the most responsible practitioner, with the ability to admit and discharge patients.

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Filename:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\MSHHRD\938746 - FOR MIN BFING AUG 3 - Admit and Discharge Privileges for NPs and the Oral and Maxillofacial Surgeons.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938602

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

TITLE: Health Care Worker Immunization Policy

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

BACKGROUND:

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

DISCUSSION:

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

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- July 2012 – Leadership Council was presented with the legal findings, including recommendations for implementation, and discussed the capacity for a fulsome roll-out this Fall. Leadership Council's decision was to continue with plans to fully implement the policy in all sectors.
- To ensure that the policy is successfully implemented, as well as to meet the *KVP* test of ensuring the policy must be brought to the attention of the employees affected before the employer can act on it, a strong communications/education strategy is required.
- Communications will begin by notifying the unions of the new policy (they were advised last year that the policy was being considered). Chief Executive Officers will be advising their staff of the new policy and a News Release will be issued to the general public.
- Communications will enforce the message that the policy is about patient safety and that HCWs have an ethical duty to provide safe care to their patients/clients.

CONCLUSION:

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

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Filename:	Z:\Clinical\Admin 100-499\Executive Services 280\20 Bns, Bullets & ADM Asgnmts\2012\Briefing Notes\938602 - INFO BN For The Minister - HCW Immunization - Jul 26 - ED APRVD.Docx

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Appendix B – *KVP* Test

The *KVP* test dictates that the unilateral implementation of an employer policy must satisfy the following requisites:

a) It must not be inconsistent with the collective agreement.
b) It must not be unreasonable.
c) It must be clear and unequivocal.
d) It must be brought to the attention of the employees affected before the employer can act on it.
e) The employee concerned must have been notified that a breach of such rule could result in discharge if the rule is used as a foundation for discharge.
f) Such rule should have been consistently enforced by the employer from the time it was introduced.

Appendix C – Implementation Recommendations

- Discussions with the unions to introduce the policy and answer questions.
- Policy to be rolled out consistently throughout health authorities (i.e., in same facilities at same time) to avoid it being undermined.
- Comprehensive communications plan for employees.
- A specific process should be developed and included for contractors, vendors, physicians and other individuals who will be attending or working in patient areas, to require compliance with the policy.
- Consider requesting visitors to wear surgical masks if not vaccinated against the flu.
- Develop framework this Summer/Fall for responding to issues of non-compliance.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 937226

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

TITLE: Nurse Practitioner-Anesthetists

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

BACKGROUND:

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DISCUSSION:

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

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

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

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

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

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

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

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

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

CONCLUSION:

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

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Filename:	Z:\Clinical\Admin 100-499\Executive Services 280\20 Bns, Bullets & ADM Asgnmts\2012\Briefing Notes\937226 - INFO BN For The Minister - Nurse Practitioner-Anaesthetist Role, Update - Jul 25 2012 - ED APRVD.Docx

Pages 17 through 28 redacted for the following reasons:
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MEETING ADVICE FOR MINISTER

CLIFF #: 934298

DATE OF REQUEST: June 19, 2012

REQUESTER: Minister's Office

MEETING REQUEST/ISSUE: Mental Health Review Board

BACKGROUND: Margaret Ostrowski (Chair) requested a meeting with the Minister

ADM RESPONSIBLE: Barbara Walman

RECOMMENDATION: To meet

SHOULD MINISTRY STAFF ATTEND (AND IF SO, WHO): Barbara Walman, ADM, Pharmaceutical Services Division

- The Mental Health Review Board is responsible (under the *Mental Health Act*) for conducting review panel hearings throughout BC. Detained psychiatric patients are entitled to periodic hearings within 14 and 28-day legal time limits.
- Review panels decide whether patients who exercise their right to a hearing should continue to be detained based on criteria in the *Mental Health Act*.
- Each panel has three board members: one legal (who usually chairs the hearing), one medical, and one member who must be neither a lawyer nor a physician.
- Before April 2005, the Minister appointed only the members authorized to chair the hearing while the detained patient appointed a patient representative and the mental health facility appointed a representative from the facility. The Minister now appoints the legal, medical and community members who are assigned by the Board Chair to sit on three person review panels throughout the province.

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- The legislative amendments creating this new board were brought into force on April 4, 2005. The Board has a Chair and approximately 68 members appointed by the Minister (19 legal, 27 medical and 22 community members).
  2012/13 Budget: $1,994,296 ($1,504,000, remuneration for members appointed by the Minister).

- Historically, volume levels before April 2005 ranged from approximately 1,100 to 1,200 applications per year with approximately 350 to 400 hearings held. (Hearings are not held if the patient decides not to proceed with their hearing or the mental health facility releases the patient from detention before the hearing). Volume levels since April 2005 have increased substantially with a current annual level of approximately 1,800 applications and 600 hearings.

- Margaret Ostrowski, QC, was appointed as Chair as of December 31, 2009, and her office is in New Westminster.

DATE: June 21, 2012

APPROVED BY: Barbara Walman, Assistant Deputy Minister
Pharmaceutical Services Division

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 930738

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
Honourable Patrick Bell, Minister of Jobs, Tourism & Innovation
- FOR INFORMATION

TITLE: BC's Position on the Comprehensive Economic and Trade Agreement Negotiations and Possible Changes to Canada's Pharmaceutical Intellectual Property Regime

PURPOSE: Background information for June 5, 2012, joint Minister's meeting with the Canadian Generic Pharmaceutical Association (CGPA) regarding changes to Canadian intellectual property rights in a Canadian and European Union Comprehensive Economic and Trade Agreement.

BACKGROUND:

As part of the Comprehensive Economic and Trade Agreement negotiations, the European Union (EU) has tabled proposals that would alter Canada's intellectual property regime for pharmaceuticals.

Each of the following three proposed changes by the EU would delay the launch of generic products in Canada which would have significant economic implications for public drugs plans and other payers:

1. The EU is requesting the establishment of a patent term restoration or extended patent term - IMPACT: up to five years of automatic additional protection after a patent expires (plus six months if paediatric studies have been carried out) for drug products requiring marketing approval.

2. The EU is proposing data exclusivity changes - IMPACT: Canada would be required to provide a minimum of 10 years data protection (currently eight years) against reference by generic drug manufacturers to clinical trial data that was used for the initial approval of a pharmaceutical product. The proposal also extends the timeframe for when Health Canada could receive an application for approval of a generic product from six to eight years after the brand receives initial marketing approval.

3. The EU is also seeking to change legislation to provide patent holders the right to appeal Federal Court rulings that rule infringement on a valid patent has not occurred - IMPACT: successful or not, would have the effect of delaying the launch to the market of the generic pharmaceutical product at issue. Patent holders' right to pursue separate patent infringement action would not be impacted.

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DISCUSSION:

S. 13, S. 16

FINANCIAL IMPLICATIONS:

S. 17, S. 13

ATTACHMENT:

Attachment A: Letter to Federal Minister Ed Fast, October 20, 2011
Attachment B: Letter to Federal Minister Ed Fast, March 29, 2012
Attachment C: Response letter from Federal Minister Fast, May 17, 2012

*NOTE - estimate of $21M is an average of annual savings for the years 1995 to 2012.

Program ADM/Division: Barbara Walman, Assistant Deputy Minister, PSD
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Drafters: Wendy Trotter & Kelly Uyeno
Date: June 1, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\930738 - BCs Position on Comprehensive Economic and Trade Agreement Negotiations .doc

Attachment A. Letter to Federal Minister Ed Fast, October 20, 2011

BRITISH
COLUMBIA

OCT 20 2011

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The Honourable Ed Fast
Minister of International Development, and
Minister for the Asia-Pacific Gateway
#205 - 2825 Clearbrook Rd.
Abbotsford, BC V2T 6S3

Dear Minister ~~Fast~~: Ed

It was a pleasure to meet with you in Ottawa in June 2011, and strengthen our long-standing collegiality and discuss our mutual priorities. I know that we both look forward to our jurisdictions continuing to work collaboratively on issues that affect international development and trade, such as the Canada-European Union Comprehensive Economic and Trade Agreement (CETA) negotiations.

As we discussed in June, Canada's acceptance of the changes being proposed by the EC to the intellectual property regime for pharmaceuticals in the CETA negotiations would likely have a significant financial impact on British Columbia (BC). The resulting delay in the introduction of generic products would lead to a requirement to purchase pharmaceuticals still under patent for an extended period. The increased costs would diminish anticipated Pharmacare program savings and would divert resources from the health system overall. The legitimate need to support research and manufacturing in Canada should not be done at the expense of the provincial and territorial public health care systems. If a trade accord were negotiated that added significantly to pharmaceutical drug costs, B.C. would feel compelled to seek financial compensation from the federal government to offset those costs and to maintain health care services to citizens. The challenge in any trade negotiation is to find the appropriate balance and I shall offer all possible assistance as you pursue that objective on this issue.

Thank you again for the meeting and the opportunity to discuss issues of importance to BC and Canada, and I look forward to meeting with you again soon. I hope your schedule has provided you with some personal time with your family in our mutual home of Abbotsford.

Yours truly,

Michael de Jong, QC
Minister

Attachment B: Letter to Federal Minister Ed Fast, March 29, 2012

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MAR 2 9 2012

The Honourable Ed Fast
Minister of International Development and
Minister for the Asia-Pacific Gateway
Room 105, East Block
House of Commons
Ottawa ON K1A 0A6

Dear Minister Fast:

I wish to follow-up on a letter I sent to you dated October 20, 2011 regarding the current Canada-European Union Comprehensive Economic and Trade Agreement (CETA) negotiations. In the letter, I raised concerns that Canada's acceptance of the proposed changes to the intellectual property regime for pharmaceuticals in the CETA negotiations would have a significant financial impact on British Columbia (BC), and that BC would feel compelled to seek financial compensation from the federal government if a trade accord added significantly to pharmaceutical drug costs in BC.

I trust that Canada is taking a balanced approach to the CETA negotiations, and is being mindful of the potential financial impacts for provinces and territories. As I expressed in my previous letter, I wish to offer all possible assistance as you pursue the objective of finding an appropriate balance on the intellectual property regime on pharmaceuticals.

I am aware that it is hoped that negotiations will conclude in the fall. Given the quickly approaching deadline, I look forward to a timely response and the opportunity to receive an update and discuss this further.

Yours truly,

ORIGINAL SIGNED BY

Michael de Jong, QC
Minister

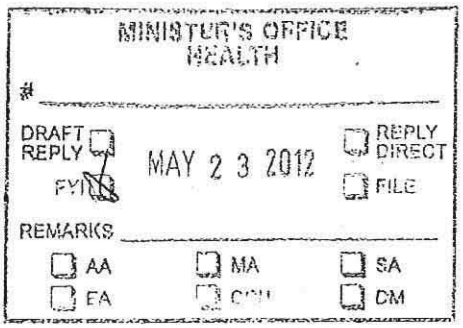
Attachment C: Response letter from Federal Minister Fast, May 17, 2012

Minister of International Trade and
Minister for the Asia-Pacific Gateway

Ministre du Commerce international et
ministre de la porte d'entrée de l'Asie-Pacifique

Ottawa, Canada K1A 0G2

MAY 17 2012



The Honourable Michael de Jong, M.L.A.
Minister of Health
Government of Columbia
P.O. Box 9050, Stn. Prov. Govt.
Victoria BC V8W 9E2

Dear Minister:

Thank you for your letter of March 4, 2012, regarding the Canada-European Union (EU) Comprehensive Economic and Trade Agreement (CETA) negotiations.

As you know, CETA represents a huge opportunity for Canadians in British Columbia and in the rest of the country. The EU is already Canada's second-most important partner for trade and investment, and the relationship holds great potential for growth. Through CETA, Canada would gain preferential access to the EU, the wealthiest single market in the world.

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As you know, the Government of Canada continues to closely engage British Columbia and other provinces and territories to ensure their perspectives are taken into consideration in the CETA negotiations, including through regular debriefs on the ongoing negotiations related to intellectual property issues.

British Columbia's continued support and commitment remains essential to the successful negotiation of a high-quality, ambitious agreement with the EU, and we remain committed to working with your government in this regard.

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Canada

Canada – European Union Free Trade Agreement (CETA)

In February 2011, it was announced that the free trade agreement negotiations between Canada and the European Union could add $2.8 billion a year to prescription drug costs in Canada, and potentially $250 million a year to British Columbia. Can the Minister elaborate on this?

- Canada and the European Union (EU) have completed the ninth round of negotiations towards a Comprehensive Economic and Trade Agreement (CETA), with the aim of concluding in 2012.
- S. 16
- The conduct of trade negotiations with the EU as well as the legislation which establishes Canada's pharmaceutical patent regime fall within the exclusive jurisdiction of the Federal Government.
- The Ministry of Jobs, Tourism and Innovation (JTI) is engaged with the federal government to represent British Columbia's interests in respect of the negotiations with the EU. PSD is providing advice to JTI on pharmaceutical patent issues.
- BC expects that, in considering any proposed change to the pharmaceutical patent regime, the Government of Canada will conduct a holistic analysis of the implications, including any economic impact on provincial governments and consumers.
- S. 17, S. 21
- S. 13, S. 17

Pages 38 through 41 redacted for the following reasons:
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s. 16, s. 17

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 931738

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

TITLE: Minister's Meeting with the British Columbia Pharmacy Association

PURPOSE: To provide background for the Minister's June 11, 2012, meeting with officials from the BC Pharmacy Association.

BACKGROUND:

The British Columbia Pharmacy Association (BCPhA) is a not-for-profit, voluntary, professional association of pharmacists and pharmacies. The BCPhA represents about 800 of BC's approximately 1,100 pharmacies and 2,600 of BC's 4,800 pharmacists. The BCPhA "aims to support and advance the professional role and economic viability of our members so that they may provide enhanced patient-centered care".[1]

The BCPhA participated in the negotiation of the Pharmacy Services Agreement (the Agreement). The Agreement was signed between the Ministry of Health (the Ministry), the BCPhA and the Canadian Association of Chain Drug Stores, and came into effect July 2010. The Agreement was to result in up to $380 million a year in total savings for BC taxpayers and the health care system, by reducing the price the province paid for generic drugs.

However, much of the savings did not materialize and the Agreement was terminated by the Ministry on April 1, 2012. While the Agreement has been terminated, many policies that resulted from the Agreement continue to be in effect, including limits on prices for generic drugs (currently 35 percent of brand name prices in BC), as well as policies which continue to invest in the sustainability, growth, and expanded role of pharmacy in BC (See Appendix A for BC PharmaCare Pharmacy Investments to Date).

On May 31, 2012, Bill 35, the *Pharmaceutical Services Act* (the Act), was given Royal Assent. The Act shifts the PharmaCare program from one which relies on government policy to a program protected by legislation, which also creates the framework to allow the Ministry to regulate and further lower drug prices.

S. 13

[1] http://www.bcpharmacy.ca/about-bcpha-pha

DISCUSSION:

S. 13

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File Name with Path: K:\3 POLICY OUTCOMES, EVALUATION & RESEARCH\Briefing Notes\2012\931738 - IBN Minister Meeting with BCPhA.docx

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S. 13

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #933448

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

TITLE: BIO Conference with Pharmaceutical Companies in Boston - June 18-20, 2012.

PURPOSE: Additional background information to be included as part of the Minister's Briefing binder prepared by the Ministry of Jobs, Tourism, and Innovation.

BACKGROUND:
The Ministry of Jobs, Tourism, and Innovation (JTI) has prepared an Information Briefing Note for the Minister of Health (Appendix 1). Details on the health and life sciences sector, including investments in BC, are covered as well as additional information for each pharmaceutical company (Appendices 2-10). CETA/IP is covered in Appendix 11 and Drug Shortages is Appendix 12.

The following provides additional information of issues facing large pharmaceutical companies identified by the Pharmaceutical Services Division, Ministry of Health.

DISCUSSION:
Threat of Generics - Large pharmaceutical companies are facing a reduced business climate brought on by the loss of patent exclusivity to their "blockbuster" drugs, and the resulting generic competition, on widely prescribed, high sales volume drugs. Examples include atorvastatin in 2011 (Lipitor® from Pfizer) and rosuvastatin (Crestor® from AstraZeneca), both cholesterol lowering agents, and most recently antiplatelet agent clopidogrel (Plavix® from Bristol-Myers Squibb and Sanofi).

In response to the loss of business due to generic competition, brand name pharmaceutical companies have shifted focus to new therapeutic areas and more specialized medicine in which fewer patients may benefit from treatment, but the price and resulting sales margin is much higher than traditional prescription drugs. Some of these products are acquired through licensing or acquisition of biotech companies.

Biologics and Increasing Product Prices - Newer, more complex agents made from biological processes ("biologics") have replaced traditional small molecule drugs.

S. 21, S. 17

S. 21, S. 17

The availability of these new classes of expensive pharmaceuticals presents a challenge to public and private drug plans which must balance limited budgets and the need to maintain access and equity for all plan members. For comparison, some drugs considered Expensive Drug for Rare Diseases (EDRD) may cost $200,000 to more than $500,000 per patient per year, as compared to typical biologic products (which may cost $15,000 to $25,000 per patient per year) or other typical drugs which costs BC PharmaCare $1,000 per patient per year.

[1] Policy, Outcomes Evaluation and Research Branch, PSD June 12, 2012.

Another challenge for drug plan payers with biologic drugs is they are not easily replicated by competing manufacturers. For these products, called biosimilars or Subsequent Entry Biologics, payers cannot expect to see the same reduction in expenditures that occur when traditional prescription drugs lose patent protection and multiple manufacturers are able to sell identical product at lower prices.

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BC Biotech Industry - Business activity in the BC biotech sector in the late 1990's and early 2000's were funded initially through private venture capital and many maturing to public markets. However, since then, while there have been a few success stories (e.g. ID Biomedical, Inex Pharmaceuticals), many have underperformed (eg. QLT, Angiotech,and Cardiome), due to market competition, product development setbacks, and/or inability to attract funding.

Investments in BC by Pharma - The total public and private drug sales in BC in FY 11/12 was about $2.5 billion. Of this amount, sales from brand name companies was about 65 percent or $1.6 billion. JTI has reported some examples of how much investment from Pharma occurs in BC, however, care should be taken to differentiate how such "investments" actually benefit BC versus benefiting corporate executives and investors.

Unlike eastern Canada, very few profitable pharmaceutical or biotech companies have decided to establish research or manufacturing facilities in BC. Amgen is one of the few examples. Instead, "investments" may include business deals with local private and publicly traded biotech companies in the form of upfront payments or milestone payments for exclusive sales and marketing rights of biotech products in development.

Research Spending in Canada - With the adoption of the 1987 amendments to the Patent Act, Rx&D made a public commitment to increase their annual R&D expenditures to 10 percent of sales revenues by 1996. According to the 2010 Annual Report of the Patented Medicines Prices Review Board (PMPRB), the Rx&D ratio has been less than 10 percent for previous eight consecutive years. In 2010, the R&D-to-sales ratio for patentees was 6.9 percent of the total $17 billion sales in Canada. The proportion of R&D spending in Western provinces was 12.6 percent, versus 41 in Ontario and 45 percent in Quebec.

ADVICE:
These meetings will provide an opportunity for industry to showcase new and innovative drugs in the product pipeline, as well as investment opportunities in BC. If the Minister is requested to comment on specific drugs that Health Canada has approved, kindly direct company representatives to contact PSD staff directly.

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Appendix 1

MINISTRY OF JOBS, TOURISM AND INNOVATION
INFORMATION NOTE

Cliff #: 67994

Date: June 13, 2012

PREPARED FOR: Honourable Michael de Jong, Minister of Health

ISSUE: B.C.'s Pharmaceutical Industry and Investments

BACKGROUND:

The health and life sciences sector includes medical devices, biopharmaceuticals, bio-products and process innovations. B.C. has the highest concentration of biotechnology companies in Canada, a strong industry association in LifeSciences BC, well-respected research and commercialization organizations, globally linked academic and research programs, and a supportive tax and regulatory environment.

Specific to the pharmaceutical industry, B.C.'s biopharmaceutical cluster is the seventh largest in North America, with more than 90 biopharmaceutical companies providing 2,200 jobs. Its commercial success has been impressive, with the highest growth in number of companies in Canada and revenue in the range of $800 million annually.

B.C.'s delegation to 2012 BIO International Convention in Boston will have the opportunity to meet with representatives of Canada's leading pharmaceutical companies. Meetings with Rx&D's Board of Directors and individual pharmaceutical companies, as well as networking events will all provide the opportunity to raise the profile of B.C.'s life sciences and pharmaceutical industries, and encourage investment and new partnerships with our research organizations and B.C. companies.

DISCUSSION:

The B.C. government has made significant investments in the life sciences sector, helping to create an attractive environment for private investment. Examples include:

- **Michael Smith Foundation for Health Research** – this world-class health research institution was established by the provincial government in 2001. Since then over $322 million has been invested to build research capacity and excellence, mobilizing the health research community to identify critically needed evidence and fast-track the development of solutions.
- **Centre for Drug Research and Development (CDRD)** – $33 million in provincial investment has leveraged a further $14.95 million from the federal government to create this national not-for-profit drug development and commercialization centre. CDRD provides expertise and infrastructure that allows global industry and research partners to "de risk" and advance promising early stage drug candidates and accelerate their commercialization. To date, CDRD has undertaken work on 80 novel health technologies (over 100 research projects), with 40 of those being successfully advanced toward commercialization.

- **Genome BC** – Genome BC is one of five Genome Centres established by Genome Canada, the primary federal funding and information agency for genomics and proteomics in Canada. The B.C. government has provided $177.5 million since 2001 to Genome BC, leveraging three times that amount in external funding and securing over 25 percent of Genome Canada's total funding. This non-profit research organization invests in and manages large-scale genomics and proteomics research projects and enabling technologies in areas of strategic importance such as human health, forestry, fisheries, bioenergy, mining, agriculture and the environment. Its research projects have attracted over 100 major international co-funders and partner organizations, including many multinational corporations, pharmaceutical and biotechnology companies, worldwide charitable foundations and top-tier research institutions. Genome BC research projects are carried out in partnership with key health provincial organizations including the BC Cancer Agency and Centre for Molecular Medicine and Therapeutics. Genome BC's objectives include developing a strategy for a strong genomics cluster in B.C. and helping to commercialize intellectual property from the projects and platforms they manage.
- **Wavefront** – an initial provincial investment of $5 million in 2007 launched this National Centre of Excellence dedicated to accelerating the growth and success of wireless companies. Wavefront is headquartered in BC and has a mandate to accelerate the commercialization of new technology in all sectors including health, mining, transportation, forestry, new media and clean technology. Wavefront is unique in North America as it provides physical testing environments for networked devices in global markets through its infrastructure partnerships. Wavefront also has relationships with the world's largest telecommunications companies. Wavefront is currently building its focus on machine to machine opportunities for wireless applications and is seeking new partnerships from medical device, pharmaceutical and natural resource industries to do so.

Notable investments by Rx&D member companies for pharmaceutical research in B.C. since January 2011 include:

- Lundbeck made a donation of $2.7 million to fund the establishment of the Canadian Depression Biomarker Network, a Canada-wide research study into the biomarkers of depression that will involve six academic centres across Canada, including the University of British Columbia.
- Merck provided a $1.4 million donation to Simon Fraser University, including equipment, to support research in a number of areas affecting human health.
- Merck is collaborating with Zymeworks, a privately held Vancouver biotechnology company, to develop potentially novel antibodies.
- Janssen provided $1 million in support for the *Treat to Prevent* initiative being spearheaded by Dr. Julio Montaner from the BC Centre for Excellence for HIV/AIDS. This initiative was recognized in the Globe and Mail as one of the top innovations in Canada in 2012 and is focused on an approach to HIV/AIDS treatment aimed at eradicating the illness.
- Johnson & Johnson provided $1.3 million to establish a business partnership with the provinces of Alberta and B.C. on early stage compounds in R&D.

- GlaxoSmithKline (GSK) is collaborating with CDRD and CDRD Ventures Inc. to advance the development and commercialization of Canadian health research.
- Pfizer Canada has provided several million to CDRD to establish a fund designed to accelerate the commercialization of some of Canada's most promising academic research projects into high-value medicines.
- The Western Canada Innovation Fund is a partnership with Johnson & Johnson (COSAT) which also includes investments from BC/CDRD and Alberta. The Western Canada Innovation Fund is co-managed by a joint steering committee that oversees a seed fund to enable early-stage innovative discoveries within the health sciences to advance toward commercialization.

CONCLUSION:

Bilateral meetings with representatives of leading pharmaceutical companies at BIO 2012 present an opportunity to encourage additional health research and commercialization investments in British Columbia and explain B.C.'s value proposition for future pharmaceutical investments.

Attachments 1 - 9 follow.

ATTACHMENTS:

Attachment 1 – Pharmaceutical Services Division (PSD) Information Briefing Note
Attachment 2 – Novartis Corporate Summary
Attachment 3 – Merck Corporate Summary
Attachment 4 – GlaxoSmithKline Corporate Summary
Attachment 5 – Pfizer Corporate Summary
Attachment 6 – Janssen Corporate Summary
Attachment 7 – Sanofi Corporate Summary
Attachment 8 – Versant Corporate Summary
Attachment 9 – Lumira Corporate Summary

Prepared by: Tim Ewanchuk, Director, Knowledge Transfer and Commercialization
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Appendix 2 - Novartis Pharmaceuticals Corporate Summary

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

DATE AND TIME OF MEETING: Tuesday, June 19, 2012 (Time TBD)

ATTENDEES: Dr. Riad Sherif B., President, Novartis Pharmaceuticals Canada Inc.

BACKGROUND:

- Novartis is a multinational pharmaceutical company based in Basel, Switzerland; it ranked number two in sales ($46.806 billion US) among the global pharaceutical industry in 2010.
- Novartis develops, manufactures and markets leading innovative prescription drugs used to treat a number of diseases and conditions, including those in the cardiovascular, central nervous system, cancer, ophthalmics, organ transplantation and respiratory areas.

CANADA PRESENCE:

- Novartis Pharmaceuticals Canada is headquartered in Dorval, Quebec; it employs 550 people and invested almost $100 million in R&D in Canada in 2011.
- Novartis Pharmaceuticals Canada conducts clinical trials at hundreds of sites across the country, involving thousands of patients, researchers, and investigators.
- Notable among these studies include: cardiovascular and metabolic diseases; respiratory diseases; Multiple Sclerosis; organ transplantation; bone and arthritic diseases; glaucoma and retinal disease; different types of cancer; and Alzheimer's Disease.
- The Novartis Group of companies in Canada consists of Novartis Pharmaceuticals Canada Inc., Novartis Animal Health Canada Inc., Novartis Consumer Health Canada Inc., Alcon Canada Inc. and Sandoz Canada Inc; together, they employ approximately 2,300 employees.
- Similar to other members of Canada's Research-Based Pharmaceutical Companies (Rx&D), Novartis Pharmaceuticals Canada Inc. has greatly increased its R&D activities in Canada following the modernization of the nation's pharmaceutical patent laws in 1987 and 1993.
- A major international study of 11,000 elderly persons with high blood pressure (hypertension) will be led and managed by the Population Health Research Institute (PHRI) of Hamilton Health Sciences and McMaster University, thanks to a $40-million investment in Ontario by Novartis.

BC PRESENCE:

- Novartis Ophthalmics partnered with Vancouver based QLT Inc. to develop Visudyne therapy, for the treatment of wet age-related macular degeneration (AMD), to treat approximately 150,000 patients worldwide. The use of Visudyne has now largely been replaced by more effective intravitreal treatments of bevacizumab (Avastin) and ranibizumab (Lucentis).

ISSUES IN BC:

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- Lucentis has a new approved use in diabetic macular edema, which is currently under review by the Ministry. Like AMD, Novartis will strongly discourage the off-label use of Avastin for this indication.

PHARMACARE EXPENDITURES:

S. 13, S. 17, S. 21

Appendix 3 - Merck Corporate Summary

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

DATE AND TIME OF MEETING: TBD

ATTENDEES: Cyril Schiever, President and CEO, Merck Canada Inc.

BACKGROUND:

- Merck is a leading global pharmaceutical and chemical company with a diversified portfolio of prescription medicines, vaccines, consumer and animal health products; it currently markets over 530 pharmaceutical products in areas such as cardiology, immunology, infectious diseases, respiratory, and women's health.
- Merck had total global revenues of €10.3 billion in 2011; it employs more than 40,000 people in 67 countries.
- The Merck family holds an approximately 70% interest in the company, and public shareholders own the remaining 30%.

CANADA PRESENCE:

- Based in Montreal, Quebec, Merck employs over 1,600 people across Canada; it is one of the top 25 R&D investors in Canada, investing $95.4 million in 2009.
- Merck has a large manufacturing facility in Quebec dedicated to the annual production of some 35 million units including the Claritin® and Aerius® brands; it is committed to maintaining a strong presence in the life sciences and innovation sector in Québec and Canada, and continues to invest in academic, biotechnology and clinical R&D collaborations to advance its internal research programs globally.
- Merck announced that, starting in 2010 and continuing over the next five years, it would invest an additional $100 million in biopharmaceutical R&D collaborations with Québec-based companies and academic institutions.

BC PRESENCE:

- In February 2010, Merck entered into a $1.5 million funding commitment and partnership over three years with the BC Centre for Excellence in HIV/AIDS in support of its research program entitled "Seek and Treat for Optimal Prevention of HIV/AIDS", focusing on HIV treatment and care for hard-to-reach residents in Prince George and Vancouver's Downtown Eastside.
- Merck recently provided a $1.4 million donation to Simon Fraser University, including equipment, to support research and teaching in a number of areas affecting human health.
- Merck is collaborating with Zymeworks, a privately held Vancouver biotechnology company, to develop potentially novel antibodies.

PHARMACARE EXPENDITURES:

S. 13, S. 17

Current Submissions with the Pharmaceutical Services Division for under review for inclusion in the PharmaCare formulary:

- Mometasone furoate (Asmanex) for asthma, mometasone-formoterol for asthma (Zenhale CR).

In March 2012, BC PharmaCare added coverage of boceprevir (Victrelis) for chronic hepatitis C. Expanding coverage to include boceprevir represents an investment of up to $50 million over the next three years.

Appendix 4 – GlaxoSmithKline Corporate Summary

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

DATE AND TIME OF MEETING: TBD

ATTENDEES: Peter Simpson, Senior Manager

BACKGROUND:

- Headquartered in the UK, GSK is a global organisation which employs over 97,000 people in over 100 countries, with approximately 12,500 people working in research teams in the UK, USA, Spain, Belgium and China.
- GSK invested nearly £600 million in vaccines R&D in 2011 and have more than 1,600 scientists working on the development of new vaccines. GSK is researching both medicines and vaccines for the World Health Organization's three priority diseases – HIV/AIDS, tuberculosis and malaria. They produce medicines that treat major disease areas such as asthma, anti-virals, infections, mental health, diabetes, cardiovascular and digestive conditions, as well as consumer products.
- Overall the company grew about 2% in 2011; sales to China were up 27% to £163 million.

CANADA PRESENCE:

GSK has made substantial investments in research and infrastructure in the Province of Quebec. Other Recent Canadian investments include:

- In 2005, GSK acquired BC-based ID Biomedical for $1.7 billion. ID Biomedical was a biotechnology company dedicated to the manufacturing and development of innovative vaccine products, including influenza vaccines.
- Launch of the new $50 Million GSK Canada Life Sciences Innovation Fund.
- $300,000 for collaboration with AngioChem in Montreal to discover, develop, and commercialize treatments for lysosomal storage diseases.
- $12 million in Canada for Influenza Research. Funding ensures key infrastructure will continue as surveillance research will be conducted in 40 hospitals across Canada
- $1.8 million Rotavirus surveillance investment in Quebec to enable implementation and sustainability of a "gold standard" in surveillance, demonstrated value of rotavirus vaccination, and apply learnings towards future disease targets.
- $300,000 Investment in the Quebec Consortium for Drug Discovery (CQDM) to strengthen innovative research in Quebec
- $750,000 to create the GSK-MaRS Innovation Fund that will support and fast-track the commercialization of some of the country's most promising translational research coming from 16 leading academic health sciences centres, hospitals and universities.

- GSK's Pathfinders Fund is providing $1.5 million toward the establishment of Manitoba's first-ever research chair in the immunobiology of infectious disease at the University of Manitoba.

BC PRESENCE:

- The GlaxoSmithKline Foundation, in partnership with ViiV, provided the Vancouver Native Health Society with $13,000 for the Dude's Club pilot project. The Society's mandate is to improve and promote the physical, mental, emotional and spiritual health of individuals, focusing on the Aboriginal community residing in Greater Vancouver. (2010).
- Each year, GlaxoSmithKline donates $100,000 to the HIV/AIDS Community Innovation Program that promotes innovative projects that use multi-dimensional approaches to optimize the health and well-being of people living long-term with HIV/AIDS and antiretroviral therapy. Recipients in 2009 included AIDS Vancouver.
- GlaxoSmithKline is collaborating with the Centre for Drug Research and Development (CDRD) and CDRD Ventures Inc. to help advance the development and commercialization of health research.

PHARMACARE EXPENDITURES:

S. 13, S. 17, S. 21

Current Submissions with the Pharmaceutical Services Division for under review for inclusion in the PharmaCare formulary:

- Belimumab (Benlysta) for the treatment of lupus.

Appendix 5 - Pfizer Canada Inc. Corporate Summary

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

DATE AND TIME OF MEETING: Wednesday June 20, 2012, morning [time TBD]

ATTENDEES: Bob Dawson, Director, Pfizer Canada Inc.
John Helou, President, Pfizer Canada Inc.
Dr. Bernard Prigent,Vice-President, Pfizer Canada Inc.

BACKGROUND:

- Pfizer Canada Inc. is the Canadian operation of New York-based Pfizer Inc. The company has a diversified health care portfolio that includes biologic and small molecule medicines, vaccines for humans and animals, and consumer products. Pfizer invests in a range of therapeutic areas including arthritis, cardiovascular disease, endocrinology, infectious disease, neurological disease, oncology and ophthalmology and smoking cessation.

CANADIAN PRESENCE:

- Pfizer Canada Inc. employs close to 3,000 people.
- The Canadian headquarters of Pfizer Bio-Pharmaceuticals and Animal Health are in Kirkland, Quebec; the Consumer Healthcare business is based in Mississauga, Ontario; and the Vaccines Research Unit is located in Ottawa, Ontario.
- Pfizer operates distribution facilities in Ontario and Alberta, Global Supply and Distribution Centres in Quebec and Manitoba, and an Animal Health Vaccines Research Unit in Victoria, British Columbia.
- Pfizer Canada has invested an average of $150 million per year in Canadian health care research and development activities, contributions and partnerships; the company has invested more than $1 billion in R&D since 2000.
- Recent investments by Pfizer Canada in pharmaceutical research in Canada include:
    - $5 million for the Pfizer-FRSQ-MSSS Chronic Disease Fund: this FRSQ-coordinated research grant program is aimed at evaluating chronic disease prevention and management initiatives.
    - $130,000 for the Nova Scotia Chronic Pain Collaborative Care Network (NSCPCCN).
    - $500,000 to the Alberta Pfizer Collaboration Fund, now a $2.5 million initiative, to identify and support promising health care innovations with market potential.

BC PRESENCE:

- Pfizer Canada has an Animal Health Vaccines Research Unit in Victoria, British Columbia.

PHARMACARE EXPENDITURES:

S. 13, S. 17, S. 21

Current Submissions with the Pharmaceutical Services Division for under review for inclusion in the PharmaCare formulary:

- Celecoxib (Celebrex) for pain control

Submission expected later in 2012, in partnership with Bristol-Myers Squibb:

- Apixaban (Eliquis) for prevention of clots after hip or knee surgery

Appendix 6 - Janssen Inc. Corporate Summary

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

DATE AND TIME OF MEETING: [time TBD]

ATTENDEES: Chris Halyk, President, Janssen Inc.

BACKGROUND:

- As a member of the Johnson & Johnson Companies, Janssen Inc. is a Toronto based pharmaceutical company that develops treatmenst for pain management, psychiatry, oncology, psoriasis, virology, anemia, attention deficit hyperactivity disorder, dementia, gastroenterology and women's health.

CANADIAN PRESENCE:

- Janssen recently invested $200,000 in COSAT – MaRS Co-Managed Fund. This partnership between the Corporate Office of Science and Technology of Johnson & Johnson and the MaRS Discovery District in Toronto establishes a working agreement to support the development of early stage medical innovations.
- Janssen Inc. employs approximately 700 across Canada.

BC PRESENCE:

- In November 2010, the Centre for Drug Research and Development (CDRD), based at UBC, announced the "Western Canada Innovation Agreement" (WCIA), which brings together CDRD, the Province of British Columbia, the Province of Alberta, and Johnson &Johnson Corporate Office of Science and Technology (COSAT) to jointly develop and manage a fund to support innovative health research programs in the life sciences sector.
- WCIA provides for a joint steering committee that will oversee a co-managed seed fund to enable early-stage, smart discoveries within the health sciences so that they may advance along a pathway to commercialization. Representatives from Alberta, British Columbia/CDRD and COSAT will jointly assess opportunities for the collaboration, funding, management, and commercialization of innovative health research projects.
- Janssen Inc. provided $1 million to the "Treat to Prevent" initiative at the BC Centre for Excellence for HIV/AIS. The initiative pioneers HIV/AIDS treatments aimed at eradicating the illness.

PHARMACARE EXPENDITURES:

S. 13, S. 17

Appendix 7 - Sanofi Canada Inc. Corporate Summary

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

DATE AND TIME OF MEETING: June 19, 2012 [time TBD]

ATTENDEES: Jon Fairest, CEO, Sanofi Canada

BACKGROUND:

- Sanofi Canada is a subsidiary of Paris based Sanofi, one of the world's largest health-care providers. Sanofi Canada is based in Laval, Quebec.
- Sanofi Canada specializes in developing treatments in several therapeutic areas, mainly diabetes, oncology and cardiovascular disease.
- Sister companies in Canada include, Sanofi Pasteur, based in Toronto, one of the world's largest vaccine producers; Sanofi Consumer Health (health and beauty products); Genzyme (treatments for rare diseases); and Meriel (animal health).
- Together, the Sanofi group of companies in Canada employ approximately 1,800, mainly in the greater Montreal and Toronto areas.
- In 2011, Sanofi companies invested $152 million in R&D in Canada.

CANADIAN PRESENCE:

- Opened a new $101 million vaccine research and development facility at Sanofi's Connaught Campus in North Toronto. Ontario contributed $13.9 million to the project through the Biopharmaceutical Investment Program.

BC PRESENCE:

- In April 2011, Sanofi Canada's funding for BC's Genetic Pathology Evaluation Centre (GPEC) surpassed $2 million.
- Sanofi Canada has a 10 year research collaboration agreement with GPEC, which was formed in 2001, as a collaborative research venture of the Pathology Department at Vancouver General Hospital, Vancouver Prostate Centre, and the BC Cancer Agency. GPEC research has developed protocols for cancer diagnosis and treatment.

PHARMACARE EXPENDITURES:

S. 13, S. 17, S. 21

In the Spring of 2012, generic competition was launched for Sanofi's clopidogrel

Attachment 8 - Versant Ventures Corporate Summary

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

DATE AND TIME OF MEETING: [time TBD]

ATTENDEES: Bradley Bolzon, Managing Director, Versant Ventures
Jerel Davis, Investment Professional, Versant Ventures

BACKGROUND:

- Versant Ventures was founded in 1999, and is a San Francisco based leading venture capital firm that specializes in investments in medical devices, biopharmaceuticals and other life science opportunities.
- One of its founders, Brad Bolzon, is Canadian and studied at the University of Toronto.
- Versant has $1.6 billion USD under management. They are currently investing their latest $500 million fund, raised in July 2008.
- Versant is composed of 13 Managing Directors and three Investment Professionals.
- Versant has over 75 companies in its portfolio.
- Initial Versant investments have been as small as $250,000, and as large as $30 million.
- Versant primarily invests in the United States; however, they hold investments in Australia, and in several European countries, including Finland, Italy and Switzerland.

BC PRESENCE:

- Versant Ventures currently has no investments in B.C.

OPPORTUNITIES FOR BC

- Versant backs a top-tier drug discovery team in San Diego known as Inception Technologies, headed by a Canadian from Montreal. Inception specializes in neurology and oncology research.
- This 12 person team has been responsible for licensing $37 billion worth of pharmaceutical platforms in the past 5 years. Their partners in this group include Merck Laboratories and GSK Pharmaceuticals. Both partners have now ceased funding the group and Versant is intending to relocate the team to Vancouver.
- Versant's rationale for relocating to Vancouver is that B.C. has significant research talent and institutions in neurology and oncology, as well as research entrepreneurs. JTI is helping Versant to find 12,000 square feet of lab space.
- Versant is also looking for the BC Renaissance Capital Fund to be part of its next Life Sciences Fund.
  Versant's interest in B.C. has been referred to PriceWaterhouseCoopers, which is investigating how Inception can attain tax efficiencies using federal SR&ED program tax incentives.

Attachment 9 - Lumira Capital Corporate Summary

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

DATE AND TIME OF MEETING: [time TBD]

ATTENDEES: Peter van der Velden, President and CEO, Lumira Capital Corporation
Daniel Hetu, Managing Director, Lumira Capital Corporation

BACKGROUND:

- Lumira Capital Corp. is a venture capital firm specializing in investments in emerging, mid and late stage companies. Lumira's investment focus is in life sciences, particularly pharmaceuticals, biotechnology, medical services, health information technology and health care products.
- Lumira Capital was founded in 1988 and is based in Toronto, with additional offices in Montreal, Quebec, Cambridge, Massachusetts, and Palo Alto, California. It has approximately 15 staff among the offices.
- Lumira Capital manages a number of funds, including Lumira Capital II, Lumira Life Sciences Capital Fund II, and in March 2012, Merck and Lumira jointly announced the creation of the Merck Lumira Biosciences Fund, a $50-million capital pool, that will invest primarily in Quebec companies.

BC PRESENCE:

Lumira Capital's investments in B.C. companies have included:

- In 2002 and 2003, $8.7 million and $32 million investments, respectively, in Neuromed Pharmaceuticals, developers of a next generation of chronic pain drugs.
- In 2001, a $14.5 million investment in Protiva Biotherapeutics Inc., a nucleic acid based pharmaceutical company developing products to treat human diseases such as cancer, influenza, Ebola, inflammatory diseases and chronic viral infections.
- In 2001, a $750,000 investment in Synapse Technologies Inc., a company developing techniques to deliver therapeutic drugs across the blood/brain barrier and new drugs targeting neurodegenerative disease.

OPPORTUNITIES FOR BC

- Lumira Capital is in the process of closing a $125 million fund in the next six months and is interested in the BC Renaissance Capital Fund's participation in this new fund. Given Lumira's previous presence in B.C. and the contribution B.C.'s key research centres have made to their portfolio companies, Lumira has indicated a renewed interest in B.C.'s life sciences centres and pipeline.

Attachment 10 - AstraZeneca Corporate Summary

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

DATE AND TIME OF MEETING: June 18, 2012, 1:45 – 2:15 p.m.

ATTENDEES: TBD

BACKGROUND:

- AstraZeneca is one of the world's largest pharmaceutical companies, employing more than 66,000 people in over 100 countries and spending approximately US$3.5 billion annually. Some 13,000 R&D personnel are employed at research centres located in Canada, the United States, the United Kingdom, Sweden, France, India and Japan.
- AstraZeneca's extensive product portfolio spans six main therapeutic areas: cardiovascular, gastrointestinal, oncology, respiratory, neuroscience and infection.

CANADIAN PRESENCE:

- Most of AstraZeneca's 1,050 Canadian employees work at its high-tech facility in Mississauga, Ontario, headquarters for clinical research, corporate affairs, sales and marketing, while over 120 scientists work at a pain research centre in Montreal, Quebec.
- The AstraZeneca Research Award program funds basic research by up-and-coming scientists at universities and medical institutions across Canada. The company also sponsors Chairs in organic synthesis, asthma, biotechnology, respirology, cardiovascular research and respiratory disease management at universities across Canada.
- AstraZeneca funds a disease management program in mental health called Prends Soin de Toi. In 2011 and 2012, the company invested $5.7 million in the program, which is aimed at funding locally initiated projects with the goal to improve knowledge, health care delivery, disease prevention and patient treatment in mental health.

BC PRESENCE:

- AstraZeneca has no significant corporate presence in BC.

PHARMACARE EXPENDITURES:

S. 13, S. 17, S. 21

Current submissions with the Pharmaceutical Services Division under review for inclusion as a benefit within the PharmaCare program:

- Ticagrelor (Brilinta) for Acute Coronary Syndrome

Attachment 11 – Comprehensive Economic and Trade Agreement (CETA) / Intellectual Property (IP)

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

DATE AND TIME OF MEETING: TBD

ATTENDEES: TBD

BACKGROUND:

- As part of the Comprehensive Economic and Trade Agreement negotiations, the European Union (EU) has tabled proposals that would alter Canada's intellectual property regime for pharmaceuticals.

- Each of the following three proposed changes by the EU would delay the launch of generic products in Canada which would have significant economic implications for public drugs plans and other payers:

    1. The EU is requesting the establishment of a patent term restoration or extended patent term (currently 20 years) - IMPACT: up to five years of automatic additional protection after a patent expires (plus six months if paediatric studies have been carried out) for drug products requiring marketing approval.

    2. The EU is proposing data exclusivity changes - IMPACT: Canada would be required to provide a minimum of 10 years data protection (currently eight years) against reference by generic drug manufacturers to clinical trial data that was used for the initial approval of a pharmaceutical product. The proposal also extends the timeframe for when Health Canada could receive an application for approval of a generic product from six to eight years after the brand receives initial marketing approval.

    3. The EU is also seeking to change legislation to provide patent holders the right to appeal Federal Court rulings that rule infringement on a valid patent has not occurred - IMPACT: successful or not, would have the effect of delaying the launch to the market of the generic pharmaceutical product at issue. Patent holders' existing right to pursue separate patent infringement action would not be impacted.

- S. 13, S. 17

CURRENT STATE – CANADA & BC:

- In Canada, international trade, and intellectual property legislation fall within the sole jurisdiction of the federal government.

- The patent regime for pharmaceuticals was amended in 1987 and extended significant monopoly protections to manufacturers of patented drugs in exchange for commitments regarding domestic research and development expenditures. At that time, Rx&D member companies pledged to spend at least 10 percent of domestic revenues on research and development. For 2010, the Patented Medicine Prices Review Board reported that Rx&D member companies spent only 8.2 percent of their Canadian revenues on research and development, marking the eighth consecutive year that Rx&D member companies have failed to meet their commitment in this respect. The corresponding investment-to-sales ratio for all brand companies (including Rx&D member companies) in 2010 was 6.9%.

- Minister de Jong has met with Federal International Trade Minister Ed Fast (in June of 2011) and written him two letters outlining BC's concern with changes to the intellectual property regime for Pharmaceuticals (see Attachments A and B) and Minister Fast has responded (see Attachment C).

- Although other provinces and territories have expressed concern over the potential financial implications, specific positions are not known, and no coordinated effort to inform the federal government has occurred.

FINANCIAL IMPLICATIONS:

- BC spent $1.1billion in 2010/11 for Pharmaceuticals.

- Every year of delayed entry of new generics due to patent regime changes would cost BC an estimated* $21M per delayed year (would be cumulative).

ATTACHMENT:

Attachment A: Letter to Federal Minister Ed Fast, October 20, 2011
Attachment B: Letter to Federal Minister Ed Fast, March 29, 2012
Attachment C: Response letter from Federal Minister Fast, May 17, 2012

*NOTE - estimate of $21M is an average of annual savings for the years 1995 to 2012.

Attachment A. Letter to Federal Minister Ed Fast, October 20, 2011

BRITISH
COLUMBIA

OCT 20 2011

888922

The Honourable Ed Fast
Minister of International Development, and
Minister for the Asia-Pacific Gateway
#205 - 2825 Clearbrook Rd.
Abbotsford, BC V2T 6S3

Dear Minister ~~Fast~~: Ed

It was a pleasure to meet with you in Ottawa in June 2011, and strengthen our long-standing collegiality and discuss our mutual priorities. I know that we both look forward to our jurisdictions continuing to work collaboratively on issues that affect international development and trade, such as the Canada-European Union Comprehensive Economic and Trade Agreement (CETA) negotiations.

As we discussed in June, Canada's acceptance of the changes being proposed by the EC to the intellectual property regime for pharmaceuticals in the CETA negotiations would likely have a significant financial impact on British Columbia (BC). The resulting delay in the introduction of generic products would lead to a requirement to purchase pharmaceuticals still under patent for an extended period. The increased costs would diminish anticipated Pharmacare program savings and would divert resources from the health system overall. The legitimate need to support research and manufacturing in Canada should not be done at the expense of the provincial and territorial public health care systems. If a trade accord were negotiated that added significantly to pharmaceutical drug costs, B.C. would feel compelled to seek financial compensation from the federal government to offset those costs and to maintain health care services to citizens. The challenge in any trade negotiation is to find the appropriate balance and I shall offer all possible assistance as you pursue that objective on this issue.

Thank you again for the meeting and the opportunity to discuss issues of importance to BC and Canada, and I look forward to meeting with you again soon. I hope your schedule has provided you with some personal time with your family in our mutual home of Abbotsford.

Yours truly,

Michael de Jong, QC
Minister

Attachment B: Letter to Federal Minister Ed Fast, March 29, 2012

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MAR 2 9 2012

The Honourable Ed Fast
Minister of International Development and
Minister for the Asia-Pacific Gateway
Room 105, East Block
House of Commons
Ottawa ON K1A 0A6

Dear Minister Fast:

I wish to follow-up on a letter I sent to you dated October 20, 2011 regarding the current Canada-European Union Comprehensive Economic and Trade Agreement (CETA) negotiations. In the letter, I raised concerns that Canada's acceptance of the proposed changes to the intellectual property regime for pharmaceuticals in the CETA negotiations would have a significant financial impact on British Columbia (BC), and that BC would feel compelled to seek financial compensation from the federal government if a trade accord added significantly to pharmaceutical drug costs in BC.

I trust that Canada is taking a balanced approach to the CETA negotiations, and is being mindful of the potential financial impacts for provinces and territories. As I expressed in my previous letter, I wish to offer all possible assistance as you pursue the objective of finding an appropriate balance on the intellectual property regime on pharmaceuticals.

I am aware that it is hoped that negotiations will conclude in the fall. Given the quickly approaching deadline, I look forward to a timely response and the opportunity to receive an update and discuss this further.

Yours truly,

ORIGINAL SIGNED BY

Michael de Jong, QC
Minister

Attachment C: Response letter from Federal Minister Fast, May 17, 2012

Minister of International Trade and
Minister for the Asia-Pacific Gateway

Ministre du Commerce international et
ministre de la porte d'entrée de l'Asie-Pacifique

Ottawa, Canada K1A 0G2

MAY 17 2012

The Honourable Michael de Jong, M.L.A.
Minister of Health
Government of Columbia
P.O. Box 9050, Stn. Prov. Govt.
Victoria BC V8W 9E2

Dear Minister:

Thank you for your letter of March 4, 2012, regarding the Canada-European Union (EU) Comprehensive Economic and Trade Agreement (CETA) negotiations.

As you know, CETA represents a huge opportunity for Canadians in British Columbia and in the rest of the country. The EU is already Canada's second-most important partner for trade and investment, and the relationship holds great potential for growth. Through CETA, Canada would gain preferential access to the EU, the wealthiest single market in the world.

S. 16

As you know, the Government of Canada continues to closely engage British Columbia and other provinces and territories to ensure their perspectives are taken into consideration in the CETA negotiations, including through regular debriefs on the ongoing negotiations related to intellectual property issues.

British Columbia's continued support and commitment remains essential to the successful negotiation of a high-quality, ambitious agreement with the EU, and we remain committed to working with your government in this regard.

.../2

Canada

Appendix 12 – Drug Shortages

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

DATE AND TIME OF MEETING: TBD

ATTENDEES: TBD

BACKGROUND:

- There have always been periodic shortages of both brand name and generic prescription drugs. However, there appears to be an increase in the frequency and duration of various drug shortages.
- Drug shortages are a national and international issue that have raised concerns about overall patient safety and continuity of patient care.
- A number of factors contribute to drug shortages, including shortages of raw materials; process problems at specific manufacturing plants; and quality control issues resulting in the recall of substantial lots or manufacturing plant shut downs.
- Changes to reimbursement of generic prescription drugs is not considered to be a contributing factor to drug shortages.
- In February 2012, an extensive national shortage of certain injectable drugs produced by Sandoz Canada emerged. For some of these drugs, Sandoz is the sole supplier.
- Sandoz Canada is part of the Novartis Group of companies in Canada (see Appendix 2).
- The shortage is due to reduced operation at the Sandoz manufacturing site in Boucherville, Quebec to remediate facility manufacturing quality-control issues identified by the U.S. FDA, as well as other related logistical supply chain issues.
- Production at the plant is ongoing but at reduced capacity for medically necessary drugs. This situation is expected to continue through December 2012.
- Clinical alternatives have been found for some Sandoz drugs, but there are few or no alternatives for other drugs, necessitating careful allocation of existing stock.

BC AND CANADA MITIGATION STRATEGIES:

- Major concerns with regard to drug shortages are continuity of care and patient safety. The Ministry of Health (the Ministry) will continue to monitor drug shortages closely to identify issues with continuity of care and patient safety issues.
- The Ministry is actively working with Sandoz, Health Canada, other provinces and BC's health authorities, Health Shared Services BC, health professional associations and the Colleges, to manage the situation.
- BC is also a participant in a Provincial/Territorial task group (P/T Drug Shortage Task Team) to identify and develop new strategies and reporting tools to better monitor and manage drug shortages in the future.
- In BC, a province-wide process has been developed for specific shortages and issues in order to minimize any patient impact, both in acute care facilities and in the community. Emergency Operations Committees were also activated to deal with the situation.

- A provincial working group with representatives from the Ministry, each health authority and health professional associations and Colleges has developed a framework for substitutions, alternate treatments, priority setting and rationalization. Clinical specialists have also been engaged.
- The Ministry is also providing communication updates to pharmacists, physicians, dentists, and other health professionals working in the community. The Ministry has established a webpage on the PharmaCare website to provide updated information sent through partner organizations. The Ministry has also established a network of specialty community pharmacies servicing hospices to help collaboration.
- Community pharmacies have been instructed to place orders through their usual supplier, and allocations are based on historical utilization over the last calendar year.
- BC hospital pharmacies are working through their group purchasing organization (HealthPRO Procurement Services) and Health Shared Services BC to place orders.
- Health Canada has also approved new drug products that have been affected by the reduced production by Sandoz and more new drug products are expected.
- The Ministry continues to collaborate with all stakeholders including drug manufacturers, wholesalers, the College of Pharmacists of BC, the BC Pharmacy Association and the College of Physicians and Surgeons of BC to ensure drug shortages are managed and communicated in a timely and efficient manner.
- FPT partners are working together to develop risk mitigation strategies to manage drug shortages, including developing a more comprehensive reporting system. To be successful, full cooperation with industry, distributors and pharmacies will be needed.

BC PATIENT IMPACT:

- Due to the significant efforts by health administrators and health professionals across the province, patient impact directly resulting from the shortage in BC has been minimized.
- There are no known significant adverse patient impacts attributable solely to drug shortages in BC.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936661

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

TITLE: Apotex Meeting on July 6, 2012

PURPOSE: To provide a briefing to the Minister on issues regarding coverage of single-source generics that may be raised in the meeting in Calgary.

BACKGROUND:
Apotex is one of the largest manufacturers of generic drugs in Canada and supplies much of the British Columbia market. Based in Toronto, Apotex has 5,800 employees with worldwide sales exceeding $1 billion.

Apotex is a member of the Canadian Generic Pharmaceutical Association (the Association), a key stakeholder group being consulted with in the development of Regulations stemming from the Pharmaceutical Services Act. On June 15, 2012, at the request of the Ministry, the Association provided a written submission detailing all elements they believe should be considered as Regulations are developed for the areas of price regulation and incentives. As background, this submission is included as Appendix A. On July 17, 2012 a full day consultation session has been scheduled with the Association. These initial consultations will be focused on the areas of price regulation and incentives.

DISCUSSION:

S. 13, S. 17, S. 21

S. 13, S. 17, S. 21

KEY MESSAGES:

- We do appreciate the significant costs incurred by manufacturers when they challenge patents. We also recognize the cost savings that payers realize through initiatives that bring generic alternatives to market sooner. However, we believe that the Province, private payers and those paying out of pocket should be getting pricing on generic drugs that is much lower than the levels that the generic manufacturer is maintaining for these products. The Province does not want to encourage this type of pricing practice for generic drugs.
- At a time when the Province is working hard to achieve the target pricing levels set, we believe it would be counterproductive to the Province's efforts to deviate so far from such pricing levels by listing Apo-esomeprazole on the PharmaCare formulary.
- Where generic drugs are priced at reasonable levels that meet our requirements, the Province is proud of its ability to list quickly. The Province has greatly supported the role of generic drugs by reducing the paperwork and complexity of generic drug submissions, resulting in what may be the simplest listing process and fastest timelines in the country for generic drugs. This has allowed many generic drugs into the public drug plan market much faster than in previous years.

Program ADM/Division:	Barbara Walman, Pharmaceutical Services Division
Telephone:	(250) 952-1705
Program Contact (for content):	Kelly Uyeno
Drafter:	Sophia Shin
Date:	July 5, 2012

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Pages 72 through 88 redacted for the following reasons:
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s. 21, 17

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 937567

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

TITLE: Minister's Meeting with Dominic Pilla, CEO of Shoppers Drug Mart

PURPOSE: To provide background information on generic drug pricing and the *Pharmaceutical Services Act* to be discussed on July 23, 2012.

BACKGROUND:

Shoppers Drug Mart Corporation (Shoppers) is the licensor of full-service retail drug stores operating under the name Shoppers Drug Mart® (Pharmaprix®in Québec) with annual sales of approximately $10.5 billion. The company's licensed Associate-owners operate 142 outlets in British Columbia.[1]

Shoppers is a member of the Canadian Association of Chain Drug Stores (CACDS) and currently has a representative on the CACDS Board of Directors. CACDS claims to advocate the impact of issues and legislation on the business of community pharmacy and its ability to deliver effective, frontline health care. Shoppers also has a representative on the Board of Directors of the BC Pharmacy Association (BCPhA). The BCPhA aims to support and advance the professional role and economic viability of pharmacists in BC.[2]

The BCPhA and the CACDS participated in the negotiation of, and were signatories to, the Pharmacy Services Agreement (the Agreement). The Agreement came into effect July 2010. The Agreement was to result in up to $380 million a year in total savings for BC taxpayers and the health care system, by reducing the price the Province paid for generic drugs. However, much of the savings did not materialize and the Agreement was terminated by the Ministry on April 1, 2012.

The Associations are key stakeholder groups being consulted with in the development of regulations respecting pricing regulation stemming from the *Pharmaceutical Services Act* (the Act). At the request of the Ministry of Health (the Ministry), the Associations' provided a joint written submission detailing all elements they believe should be considered as these regulations are developed. At the Associations' request, the Ministry extended the deadline of this submission by two weeks, up to June 18, 2012. This submission is included as Appendix A.

DISCUSSION:

S. 13

[1] http://www.shoppersdrugmart.ca/english/corporate_information/investor_relations/financial_information/annual_report/full_report/SDM_E_2011FULL.pdf
[2] http://www.bcpharmacy.ca/about-bcpha-pha
[3] Appendix A; pp.7-8

S. 13

Program ADM/Division: Barbara Walman, Pharmaceutical Services
Telephone: 250-952-1705
Program Contact (for content): Darlene Therrien, Executive Director
Drafter: James Kerr
Date: July 17, 2012
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[4] Appendix A; pp. 8-9,11
[5] Appendix A; pp. 23-24
[6] Appendix A; pp. 12, 17-18

Additional Information for Minister's Meeting with Shoppers Drug Mart on July 23, 2012

Agenda

- Introductions
- Discussion on Partnership Opportunities between Government and the broader pharmacy sector in BC.
- Next steps moving forward

Attendees

Generic Drug Manufacturers

- Paul Drake – President and General Manager, Ranbaxy
  - Paul Drake sits on the Canadian Generics Pharmaceutical Association (CGPA) Board of Directors, representing Ranbaxy.
  - Ranbaxy is also an associate member of the Canadian Association of Chain Drug Stores (CACDS) and a retail member of Canadian Association of Pharmaceutical Distribution Management (CAPDM).

- Ben Gray – Senior Vice President and General Counsel, Mylan
  - Mylan is represented on the CGPA, is an associate member of the CACDS and is a retail member of CAPDM.

- Peter Hardwick – Senior Vice President, Sales and Marketing for Canada, Apotex
  - Apotex is represented on the CGPA, is an associate member of the CACDS and is a retail member of CAPDM.

- Terry Creighton – Vice President Government Affairs, Teva
  - Teva is represented on the CGPA, is an associate member of the CACDS and is a retail member of CAPDM.

- Jacques Bergeron – Vice President, Trade and Government Relations, Sandoz
  - Sandoz is represented on the CGPA, is an associate member of the CACDS and is a retail member of CAPDM.

Drug Distributors

- Brent Teulon – Vice President & General Manager Western Canada, McKesson
  - Brent Teulon sits on the Board of Directors for CAPDM, representing McKesson.
  - McKesson is also an associate member of CACDS.

Chain Drug Stores

- Domenic Pilla – Chief Executive Officer, Shoppers Drug Mart
    - SEE IBN

- Frank Scorpiniti – Chief Executive Officer, Katz Group Canada Ltd (Rexall)
    - The Katz Group also comprises PharmaPlus, Guardian Medicine Shoppe, Meditrust and IDA pharmacies.
    - The Katz Group is a retail member in the CACDS.

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S. 17 and 21

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 928330

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

S. 12

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S. 12

S. 12

Approved/Not Approved
Michael de Jong, QC
Minister of Health

Date Signed

Approved/Not Approved
Don McRae
Minister of Agriculture

Date Signed

S. 12

Pages 121 through 123 redacted for the following reasons:
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MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 929259

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

S. 12

S. 12

Approved/Not Approved
Michael de Jong, QC
Minister of Health

Date Signed

Approved/Not Approved
Don McRae
Minister of Agriculture

Date Signed

S. 12

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 934232

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

TITLE: Hydro Supply to Woodley Range Water Works

PURPOSE: To provide background information on the Vancouver Island Health Authority decision to issue an order to BC Hydro under the *Drinking Water Protection Act*.

BACKGROUND:
The Vancouver Island Health Authority (VIHA) has been working with the operator of the Woodley Range Water Works (Woodley Range), to address operational concerns with the 22 home systems under the authority of the *Drinking Water Protection Act*. The Ministry of Health has received communications from VIHA, as well as from a user of the water system, regarding concerns with this utility.

Among other issues, Woodley Range, after failing to pay their electrical bills, received notice from BC Hydro that they were going to shut off power to the pumps that served the drinking water system. VIHA became concerned that if power is cut off, it may cause the potential for disease from system contamination due to pressure loss, and limit the water available for basic sanitation (i.e. food preparation, hand washing, toilet flushing, etc). As a result, VIHA has also engaged BC Hydro to discourage them from shutting off power to the systems.

S. 13, S. 14

DISCUSSION:
Section 32(1) of the *Hydro and Power Authority Act* exempts BC Hydro from the provisions of the *Drinking Water Protection Act* and the *Public Health Act*. Other pieces of legislation such as the *Employment Standards Act*, *Environmental Assessment Act*, the *Environmental Management Act*, and the *Forest Act* do apply to BC Hydro.
The *Drinking Water Protection Act* does include amendments (S83, S84), which have yet to be brought into force by Order In Council, that would provide for enforcement of the *Drinking Water Protection Act*, in part, or in whole, on BC Hydro.

Most health issues raised with BC Hydro have typically been brought to a close, with BC Hydro taking reasonable actions to resolve the situation.

S. 14

ADVICE:
This, and most other health issues raised with BC Hydro, have typically been resolved with BC Hydro taking reasonable actions. Ministry of Health's Health Protection Branch has discussed the issues relating to their exemption under the *Drinking Water Protection Act* with BC Hydro representatives. They have indicated that they are prepared to continue to deal with health-related matters on a collaborative, voluntary basis with the health authorities.

Program ADM/Division:	Arlene Paton, ADM, Population and Public Health Division
Telephone:	250-952-1731
Program Contact (for content):	Mike Zemanek, Director
Drafter:	David Fishwick, Manager Drinking Water
Date:	June 21, 2012

File Name with Path: P:\healthprotection\protecton\briefingnotes\2012\934232hydro supply to Woodley range water works

MINISTRY OF HEALTH
BRIEFING NOTE

Cliff: 936221

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

TITLE: Meeting with the Canadian Association of Petroleum Producers-Calgary Alberta

PURPOSE: To provide update on phase two of the Human Health Risk Assessment project associated with oil and gas development in northeastern British Columbia.

BACKGROUND:

The three phase Human Health Risk Assessment (the assessment) project is to identify, explore and assess concerns about human health risks relating to oil and gas development in northeastern BC.

Phase One: public engagement to inform the scope and terms of reference and identify concerns relating to oil and gas development.
Phase Two: a human health risk assessment based on findings from phase one and a comprehensive scientific review of evidence.
Phase Three: reporting of findings to the Province, stakeholders and the public.

The phase one report describes the targeted public engagement process conducted January – March 2012 and describes issues of public concern associated with possible human health risks, including those related to changes to land, air, drinking water, and food quality.

The Request For Proposal (RFP) for phase two of the assessment was posted on Thursday, June 28, 2012.

DISCUSSION:

Phase two is focused on assessing the human health risks specifically related to direct impacts of oil and gas activity. The assessment is an evaluation of how humans might be exposed to the hazards from the oil and gas industry (i.e., environmental pathways through which they are exposed), as well as the potential health impact from exposure to these hazards. The assessment will be combined with a jurisdictional scan of studies and reports related to human health risks with oil and gas activities. The regulatory review will provide, where appropriate, recommendations to address key human health risks associated with oil and gas activities in northeast BC. The successful proponent will need a team composed of industry, toxicology and public health experts.

The timeline for phase two is as follows:

- RFP posting closes Friday, August 10, 2012.
- It is anticipated that work on phase two will begin on October 1, 2012, and be completed by March 31, 2014.

A summary of the RFP requirements is attached as Appendix 1.

The scope of the RFP does not include all of the concerns outlined in the phase one report, which covered a broad range of issues such as changes to communities and socio-economic concerns; as opposed to direct health concerns related to the industry. This has been a key concern raised by the Canadian Association of Petroleum Producers as identified in their submission as part of phase one (attached – Appendix 2).

Ministry of Health staff will continue to work with the Canadian Association of Petroleum Producers and appreciated their involvement in phase one. Many of the items raised in their letter have been specifically addressed in the RFP. Staff are unaware of any specific issues that are of concern to the association related to this initiative.

Program ADM/Division	Arlene Paton, ADM, Population and Public Health
Telephone:	250 952-1731
Program Contact (for content):	Tim Lambert, Executive Director, Health Protection
Drafter:	Lidia Surman/Clyde Macdonald
Date:	June 29, 2012

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Phase 2 – Human Health Risk Assessment of Northeastern British Columbia Oil and Gas Activity

Ministry of Health Request for Proposals Number: RFP HL173
Issue date: June 28, 2012

The Ministry of Health (Ministry) is seeking proposals from qualified proponents for completion of Phase 2 (described below) of a human health risk assessment with respect to oil and gas activity in northeastern British Columbia (BC), with particular focus to environmental pathways of exposure (air quality, water quality and quantity, land and food quality). The study will consider the hazards posed through environmental issues and events such as incidents, fluid releases and increased traffic with regard to possible impacts on health via the identified pathways. In addition the Province's institutional framework (monitoring and compliance, regulation and enforcement, communication, emergency response planning and tracking and reporting) will be reviewed with respect to oil and gas operational issues (exploration and drilling, processing, wells and pipelines and transportation and traffic).

This three phase project is to identify, explore and assess concerns about human health risks relating to oil and gas activity in northeastern BC.

Phase 1: Included public engagement to inform the scope and terms of reference and identify concerns relating to oil and gas activity.
Phase 2: Includes a human health risk assessment based on in-scope (refer to section 3.3.1) findings from Phase 1 and the jurisdictional scan of past and current studies and reports related to human health risk with oil and gas activities (for complete details on deliverables refer to section 3.2.1).
Phase 3: The province reporting on findings to stakeholders and the public.

Phase 1 of the project has been completed and a report prepared that documents the concerns of stakeholders. This report describes the targeted public engagement process followed during phase 1 and sets out issues of concern associated with possible human health risks, including concerns that relate to changes to land, air, water, and food quality.

In phase 2, the focus of the project is to use certain findings from the Phase 1 report to investigate and research the potential for significant human health risks (further described in section 3.2.1), within the context of environmental health, stemming from oil and gas activity in northeastern BC. *In Phase 2 the successful proponent will be required to provide several deliverables (further detail provided in section 3.2.1) and meet milestone dates, based on their solution and approach, with final determination of the milestone and payment schedule by the Ministry.*

It is anticipated that the Contractor will begin work on Phase 2 on **October 1, 2012** and complete that work by **March 31, 2014**.

The budget for this project is from **$ 700,000 up to a maximum amount of $ 900,000 (nine hundred thousand dollars)** and proposal submissions must not exceed the maximum amount.

Proponents Please Note:

a) The successful Proponent of this Request for Proposals (RFP) is **NOT EXCLUDED** from participating in future RFPs that may be part of this three phase project – Human Health Risk Assessment of British Columbia Oil and Gas Activity. **This RFP is limited to PHASE 2 of this project.**

b) All working papers, meeting minutes, notes, and intellectual property related to this RFP and associated services provided under Contract, will become the property of the Province at the conclusion of Phase 2 of this project.

c) Proponents wishing to attend a bidders meeting on Friday July 13, 2012 must complete and submit the form in Appendix A of this RFP, **no later than Wednesday, July 9th, 2012**.

Appendix 2

CAPP

CANADIAN ASSOCIATION
OF PETROLEUM PRODUCERS

March 6, 2012

David Marshall
HHRA – Phase 1, c/o Fraser Basin Council
1st Floor, 470 Granville Street
Vancouver, BC V6C 1V5

via e-mail: info@hhra.ca

Dear Mr. Marshall:

Re: Human Health Risk Assessment Phase I

The Canadian Association of Petroleum Producers (CAPP) appreciates the opportunity to provide input into Phase I of the Human Health Risk Assessment by the British Columbia Ministry of Health. CAPP acknowledges the desire to have a human health risk assessment is a reflection that people want a greater understanding about how the natural gas industry operates and which processes we use. We support steps that increase the understanding of our industry. CAPP would like to underscore that protecting the health of the public and our employees, as well as the environment, is of paramount importance to industry. CAPP recognizes industry's responsibility to address public concerns, because it is vital the public has confidence that industry develops resources safely and responsibly. The industry is responsible, well regulated and provides many direct and indirect benefits to the people of British Columbia. Nevertheless, we always look for possible improvements.

CAPP represents companies, large and small, that explore for, develop and produce natural gas and crude oil throughout Canada. CAPP's member companies produce more than 90 per cent of Canada's natural gas and crude oil. CAPP's associate members provide a wide range of services that support the upstream crude oil and natural gas industry. Together CAPP's members and associate members are an important part of a national industry with revenues of about $100 billion-a-year.

CAPP and the industry has been investigating and studying, in collaboration with academics, regulators and governments in Canada, many of the topics and matters of concern the public may raise during Phase 1 of this assessment. The industry has taken a science based approach and CAPP would like to emphasize the importance of taking such an approach through all phases of this assessment.

Forty-plus years of these findings are evidenced in the large number of studies (some published and others prepared for regulatory approval processes) on human and wildlife health risk assessments. Notable references investigating health concerns associated with oil and gas developments in Western Canadian jurisdictions include comprehensive work completed by the Western

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Interprovincial Scientific Study Association (WISSA) and earlier investigations under the Acid Deposition Research Program (ADRP) and the Medical Diagnostic Research Program (MDRP). CAPP would be pleased to provide these and other references. This information is reflected in the many BC OGC and ERCB policies, initiatives, procedures, Directives and technical documents relating to the upstream oil and gas industry. The Ministry of Health should review this literature as it moves forward through Phase II of this assessment.

Within British Columbia, CAPP and its members have already taken additional investigations and actions to ensure the health and safety of its employees and public and the environment. For example the Science and Community Environmental Knowledge (SCEK) fund is an industry financed fund dedicated to improving the understanding and management of the impacts of oil and gas activities in British Columbia. In June 2010 the Debolt water treatment plant - a first of its kind in North America - treated non-potable water from deep in the earth for use in the industry, thus drastically reducing amount of fresh water needed for hydraulic fracturing operation. Additionally, CAPP has recently released five guiding principles and six associated practices for Hydraulic Fracturing to safeguard water quality for all. One practice, for example, requires every natural gas well to have an engineered steel casing system that is cemented to prevent any fluids from migrating to ground water aquifers. CAPP's practices also support the disclosure of fracturing fluid additives across Canada, which is now a regulatory requirement in British Columbia.

Additionally CAPP members have, through their community investment programs, contributed to many programs in British Columbia. A sample of these initiatives include anti-bullying, drug and alcohol awareness, Aboriginal Family Services, Women's' Health Initiatives and made significant contributions to health and recreation facilities in the communities of northeastern BC. One example of this is industry's contribution towards the re-construction of the Fort Nelson arena which collapsed under a heavy snow in 2008. Industry has also engaged with the public through participation in the local Stakeholder Advisory Committee, the Farmer Advocacy Office and other groups and forums.

The oil and gas industry has also provided many direct benefits to British Columbians in the form of royalties, which support government provided services, jobs and improvements to road and infrastructure. During the period of 2006 to 2010 industry paid $6 billion to the government of British Columbia for oil and gas rights. The Canadian Energy Research Institute forecast the natural gas industry will employ 40,000 directly by the year 2035, up from 12,000 employed in 2010. There is literature confirming the associations between personal wealth and healthier individuals and communities. CAPP believes the forecast development in the regions can continue to provide positive social supports and economic benefits which enhance the quality of life for which all Canadians strive.

The upstream oil and gas industry in British Columbia is well regulated by the Oil and Gas Commission as it applies the Oil and Gas Activities Act and associated regulations. Recognizing the need to ensure development is performed in a safe and responsible manner and the need for a contemporary regulatory framework that reflects technological advances, interest in unconventional gas, and increased social and environmental expectations, OGAA was implemented in 2010 after

extensive consultations with communities, local governments, First Nations, companies, landowners, environmental organizations and industry associations. All companies (operating and service companies) by law have safety programs that ensure safety and wellbeing of their employees. As well companies are mandated to have viable, tested site specific Emergency Response Plans to protect the wellbeing of the communities we operate in in the unlikely event of a safety issue.

CAPP understands the purpose of the study is to address human health concerning oil and gas development in BC's northeast. We recognize government must make the scope of Phase II appropriately broad and comprehensive in order to fully address the concerns of those living and working in BC's northeast. However, we suggest the study should have sensible boundaries on the investigation of social and social-economic impacts, as to ensure the crucial concerns of the public, as they correlate to the oil and gas industry, can be fully investigated in the time allowed.

CAPP would like to encourage and recommend that during the course of Phase II of the assessment that reviewers take an opportunity to conduct site tours of various oil and gas activities and facility in northeastern BC. CAPP recommends that the Ministry of Health should seek ongoing input from industry, academic and government experts during Phase II of the human health assessment as there is considerable experience and expertise with regulators, experts and ministries of health in other jurisdictions to draw upon. CAPP is pleased to provide useful information, expertise, contact and context where appropriate. We look forward to a continued dialogue throughout this important Human Health Risk Assessment.

In conclusion, sustainable and responsible development of natural resources has always been a hallmark of the oil and gas industry's commitment to our stakeholders. We aim for continuous improvement in the way we operate and how we relate to the public, and we recognize we can always improve as a result of our interactions with local communities and regulators. Canada's oil and gas industry is committed to delivering energy to Canada and the world in a responsible way.

Sincerely;

David Pryce
Vice President, Operations

Cc: Hon. Michael de Jong, Minister of Health
Hon. Rich Coleman, Minister of Energy and Mines & House Leader / Responsible for Housing

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936616

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

TITLE: City of Abbotsford Environmental Operator Certification and Training Issues

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

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

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

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

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

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

DISCUSSION:

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

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

ADVICE:

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

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

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

ABBOTSFORD

December 7, 2011

File:5600-01

Via email and post

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

and

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

Dear Minister de Jong and Minister Lake:

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

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

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

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

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

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

1. Operator Certification Requirements

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

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

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

2. Operator Training Requirements

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

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

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

3. Resolving the Concerns

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

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

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

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

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

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

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

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

Yours truly,

R. Bruce Banman
Mayor

encl.

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

For Consideration by the Minister of Health

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

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

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

Water System Classification and EOCP Operator Certification Levels:

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

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

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

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

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

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

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

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

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

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

Continuing Education Units Requirement for Level I and II Water Operators

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

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

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

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

ABBOTSFORD

Date: November 22, 2011

FACT SHEET

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

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

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

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

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

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

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

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

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

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

936671

His Worship Bruce Banman
Mayor of the City of Abbotsford
32315 South Fraser Way
Abbotsford BC V2T 1W7

Dear Mayor Banman:

The Ministry of Health (MoH) has recently received an email from Mr. Len Stein, Director of Utility Operations for Abbotsford, requesting a written response to your letter of December 7, 2011.

Your letter outlines a number of issues regarding water system operator certification requirements and water operator training requirements. First, I would like to give you some background on the overall program for the certification of water and wastewater treatment systems and facility operators. The program has existed in British Columbia since 1966. The model for training operators in BC is consistent with virtually all US states and most Canadian provinces. In 1977, BC and Manitoba signed the first reciprocity agreement between Canadian certification programs. This agreement has subsequently been modified a number of times and now includes most of the Canadian certification jurisdictions. Because of this agreement, an operator from BC can go to another province to work and be granted full certification at the level earned in BC. Alberta has exactly the same requirements as BC while Ontario has done it slightly differently by tying the training requirement to the class of facility in which the operator works.

The Health Protection Branch of MoH has been working closely with the Environmental Operators Certification Program and the Metro Vancouver Regional Engineers Advisory Council on approaches to address the challenges identified in your letter. Of note, your attachment from the Regional Engineers Advisory Council is out dated, and is not in agreement with their current views.

MoH has already taken action on the matter of continuing education units. MoH and the Environmental Operators Certification Program have developed a "Training Registry" that would allow improved access to training. The registry allows water operations staff with experience to become recognized instructors to offer training modules towards continuing education credits. This allows municipalities better access to internal programs developed and shared within and between local governments. Many local governments have taken advantage of this program and we would encourage the City of Abbotsford to take advantage of this improved approach. I understand that Len Stein of Abbotsford was briefed on this initiative along with the Regional Engineers Advisory Council in November 2010, and at that meeting the parties supported this initiative.

...2

With respect to the issue raised on water system classification and the Environmental Operators Certification Program operator certification levels, MoH has been consulting with the Environmental Operators Certification Program. Mr. Brian Crowe and Mr. Andrew Wood of the Regional Engineers Advisory Committee, and the Alberta Government are working to find an approach that meets the broad stakeholder needs and remains consistent with inter-provincial agreements. Our current proposal under discussion is examining the potential to expand the requirement specifying a single operator under the *Drinking Water Protection Act* to recognize the team of operators, including those at lower levels, required to operate a water system. We are also re-evaluating the concept of "direct responsible charge" that could make it easier for operators at lower levels to move up to higher levels of classification.

In terms of substituting a professional engineer for the duties of trained water operators, we have determined that conflicts with the New West Partnership Trade Agreement make this option infeasible. Along the same lines, the Ministry of Environment has recently removed a similar option in their more recent Municipal Wastewater Regulation.

I understand that the Fraser Health Authority has given the City of Abbotsford a five year extension to achieve the operator requirements in the *Drinking Water Protection Act* and in my opinion, this approach offers a degree of flexibility to ensure that the City has time to plan and incorporate some of the training programs noted above. Also, there have been complaints received by both the Environmental Operators Certification Program and MoH, with respect to the training of operators and career paths in Abbotsford, and I encourage you to address this issue.

I trust we will be able to continue our constructive and collaborative efforts towards common goals that work for all stakeholders involved.

Yours truly,

Michael de Jong, QC
Minister of Health

pc: Mr. Len Stein, Director of Utility Operations, City of Abbotsford
Honourable Terry Lake, Minister of Environment

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938113

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

TITLE: Smoke-Free Housing and the Real Estate Sector

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

BACKGROUND:

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

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

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

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

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

DISCUSSION:

S. 13

s. 13

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

MINISTRY OF HEALTH
DECISION BRIEFING DOCUMENT

Cliff # 926022

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

TITLE: Age-friendly British Columbia Recognition Program

PURPOSE: Approval of communities to receive Age-friendly BC Recognition

BACKGROUND:
In September 2011, Premier Christy Clark launched the renewed Age-friendly BC strategy which includes a recognition program for local governments who have taken key steps to become age-friendly. Appendix A provides an overview of the strategy. Age-friendly projects are one of the components communities can undertake as part of the Healthy Families BC - Healthy Communities program.

In November 2011, an Age-friendly Resource Kit was mailed to all local governments in the province, with an invitation to apply for recognition if the community had completed four milestone steps:

1. Establish an age-friendly advisory or steering committee;
2. Pass a local council or district board resolution;
3. Conduct an age-friendly assessment; and
4. Develop and publish an action plan.

To continue success, recognized communities will complete two additional steps: implement the action plan and monitor progress with regular reports to be evaluated tri-annually. The steps have been adapted from the Pan-Canadian Age-friendly Communities Milestones, developed jointly with the Public Health Agency of Canada.

The recognition program is being managed by the Seniors' Healthy Living Secretariat (the Secretariat) and administered by BC Healthy Communities. Recognized communities will receive an Age-friendly BC award poster and a $1,000 grant to create a legacy project or a celebration, and will be promoted on the SeniorsBC.ca website. BC Healthy Communities will help each community to identify suitable legacy projects.

DISCUSSION:
The first round of applications for Age-friendly BC recognition closed on February 29, 2012. Nine local governments applied: Duncan, Esquimalt, Metchosin, Revelstoke, Saanich, Sechelt, Surrey, West Vancouver, and White Rock. The applications are summarized in Appendix B.

The Seniors Healthy Living Advisory Network (the Network) reviewed the applications at its March 30, 2012 meeting. The Network noted that while all nine communities have made progress, some of the projects focused on accessibility or general healthy community themes, rather than an age-friendly theme. To address the Network's concerns, recognized communities will be offered feedback and encouraged to increase the visibility of the age-friendly concept by making "age-friendly" a specific mandate or title for their advisory committees and programs or by publishing reports specifically highlighting age-friendly achievements.

The award poster (Appendix C) and the congratulatory letter (Appendix D) are designed to be co-signed by the Minister of Health and the Parliamentary Secretary for Seniors to the Minister of Health, with the signature of the Director, BC Healthy Communities also included on the letter. The Secretariat is working with the Public Health Agency of Canada on acknowledgement from the federal government and the World Health Organization.

Government Communications and Public Engagement has recommended to the Minister's office that a press release be used to announce the first Age-friendly BC recognized communities during Seniors Week, June 3 to 9, 2012.

OPTIONS:

1. Approve the following:
   a) Age-friendly BC recognition for Duncan, Esquimalt, Metchosin, Revelstoke, Saanich, Sechelt, Surrey, West Vancouver, and White Rock based on the accomplishments described in Appendix B;
   b) Award poster signed by the Minister of Health and the Parliamentary Secretary for Seniors to the Minister of Health (sample in Appendix C); and
   c) Letter to be co-signed by the Minister of Health, the Parliamentary Secretary for Seniors to the Minister of Health and the Director of BC Healthy Communities (Appendix D).

In addition, direct the Secretariat to work with each community to ensure the age-friendly theme is more visible in community projects. This option acknowledges that, although the initiatives started before the age-friendly recognition steps were developed, the intent of the steps has been met.

2. Do not approve the communities or materials for age-friendly recognition.

FINANCIAL IMPLICATIONS:

Costs of $20,000 for the recognition award and cash grants were included in a $48,500 grant allocated in 2011 to BC Healthy Communities.

RECOMMENDATION:

Option 1

_____ _____

Approved/Not Approved
Michael de Jong, QC

Date Signed

Program ADM/Division:	Arlene Paton, Population and Public Health Division
Telephone:	250 952-1731
Program Contact (for content):	Donelda Eve, Manager Active Aging 250-356-8597
Drafter:	Rosemary Lawrence
Date:	May 24, 2012

File Name with Path: I:\Seniors Healthy Living Secretariat\Briefing_Material\InProgress\BRIEFING NOTES 2012\926022 Age-friendly Community Recognition 2012 DN.doc

MINISTRY OF HEALTH
DECISION BRIEFING DOCUMENT

Cliff # 926022

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

TITLE: Age-friendly British Columbia Recognition Program

PURPOSE: Approval of communities to receive Age-friendly BC Recognition

BACKGROUND:
In September 2011, Premier Christy Clark launched the renewed Age-friendly BC strategy which includes a recognition program for local governments who have taken key steps to become age-friendly. Appendix A provides an overview of the strategy. Age-friendly projects are one of the components communities can undertake as part of the Healthy Families BC - Healthy Communities program.

In November 2011, an Age-friendly Resource Kit was mailed to all local governments in the province, with an invitation to apply for recognition if the community had completed four milestone steps:

1. Establish an age-friendly advisory or steering committee;
2. Pass a local council or district board resolution;
3. Conduct an age-friendly assessment; and
4. Develop and publish an action plan.

To continue success, recognized communities will complete two additional steps: implement the action plan and monitor progress with regular reports to be evaluated tri-annually. The steps have been adapted from the Pan-Canadian Age-friendly Communities Milestones, developed jointly with the Public Health Agency of Canada.

The recognition program is being managed by the Seniors' Healthy Living Secretariat (the Secretariat) and administered by BC Healthy Communities. Recognized communities will receive an Age-friendly BC award poster and a $1,000 grant to create a legacy project or a celebration, and will be promoted on the SeniorsBC.ca website. BC Healthy Communities will help each community to identify suitable legacy projects.

DISCUSSION:
The first round of applications for Age-friendly BC recognition closed on February 29, 2012. Nine local governments applied: Duncan, Esquimalt, Metchosin, Revelstoke, Saanich, Sechelt, Surrey, West Vancouver, and White Rock. The applications are summarized in Appendix B.

The Seniors Healthy Living Advisory Network (the Network) reviewed the applications at its March 30, 2012 meeting. The Network noted that while all nine communities have made progress, some of the projects focused on accessibility or general healthy community themes, rather than an age-friendly theme. To address the Network's concerns, recognized communities will be offered feedback and encouraged to increase the visibility of the age-friendly concept by making "age-friendly" a specific mandate or title for their advisory committees and programs or by publishing reports specifically highlighting age-friendly achievements.

The award poster (Appendix C) and the congratulatory letter (Appendix D) are designed to be co-signed by the Minister of Health and the Parliamentary Secretary for Seniors to the Minister of Health, with the signature of the Director, BC Healthy Communities also included on the letter. The Secretariat is working with the Public Health Agency of Canada on acknowledgement from the federal government and the World Health Organization.

Government Communications and Public Engagement has recommended to the Minister's office that a press release be used to announce the first Age-friendly BC recognized communities during Seniors Week, June 3 to 9, 2012.

OPTIONS:

1. Approve the following:
   a) Age-friendly BC recognition for Duncan, Esquimalt, Metchosin, Revelstoke, Saanich, Sechelt, Surrey, West Vancouver, and White Rock based on the accomplishments described in Appendix B;
   b) Award poster signed by the Minister of Health and the Parliamentary Secretary for Seniors to the Minister of Health (sample in Appendix C); and
   c) Letter to be co-signed by the Minister of Health, the Parliamentary Secretary for Seniors to the Minister of Health and the Director of BC Healthy Communities (Appendix D).

In addition, direct the Secretariat to work with each community to ensure the age-friendly theme is more visible in community projects. This option acknowledges that, although the initiatives started before the age-friendly recognition steps were developed, the intent of the steps has been met.

2. Do not approve the communities or materials for age-friendly recognition.

FINANCIAL IMPLICATIONS:

Costs of $20,000 for the recognition award and cash grants were included in a $48,500 grant allocated in 2011 to BC Healthy Communities.

RECOMMENDATION:

Option 1

Approved/~~Not Approved~~
Michael de Jong, QC

4/6/12
Date Signed

Program ADM/Division:	Arlene Paton, Population and Public Health Division
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Drafter:	Rosemary Lawrence
Date:	May 24, 2012

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Age-friendly British Columbia Overview

BRITISH COLUMBIA AgeFriendly

In an age-friendly community seniors are able to enjoy good health and active social participation. Age-friendly communities provide welcoming public spaces, accessible transportation, affordable housing options, employment and volunteer opportunities as well as information and services that fit the needs of seniors. The age-friendly community initiative began with studies conducted by the World Health Organization and the Canadian Rural and Remote

Age-friendly Communities project. Building on these initiatives, the Province has supported the development of age-friendly communities since 2007 through direct assistance and the provincially-funded Seniors' Housing and Support Initiatives local government grant program managed by the Union of BC Municipalities (UBCM).

A renewed Age-friendly British Columbia strategy was launched on September 29, 2011, and includes:

- **Grant funding**: Through the partnership with the UBCM, funding from the Province has helped local governments with grants of up to $20,000 to support age-friendly planning and projects. On February 7, 2012, grants were awarded to 52 local governments, bringing the total number of communities that have received grants or direct support to 108 since 2007.
- **Age-friendly BC Recognition**: Local governments can apply to show that they have met criteria that focus on engagement, commitment, assessment, and action. (See details on page 2.)
- **Tools and Resources:** *Becoming an Age-friendly Community: Local Government Guide* and associated resources are available in print form and on www.seniorsbc.ca/agefriendly/communities to help communities get started. An Age-friendly coordinator is the primary contact to provide advice and support around age-friendly planning (email: Agefriendly@gov.bc.ca). A series of online videos released on April 25, 2012, highlight elements of age-friendly communities through examples of actions in several BC communities.
- ***Creating an Age-friendly Business in BC*:** The business guide was released in partnership with the BC Chamber of Commerce in June, 2011 and helps businesses address the needs of older customers and workers.

Age-friendly British Columbia Community Recognition

A community will be recognized as being age-friendly once it has completed basic steps which demonstrate its commitment to age-friendly principles.

To achieve Age-friendly BC status a local government must complete the following four steps:

1) Establish an age-friendly advisory or steering committee that includes the active participation of older adults. An existing committee can also take on this mandate.
2) Pass a council or district board resolution to actively support, promote and work towards becoming an age-friendly community. As an alternative, local governments may choose to commit to being age-friendly through specific goals, objectives or policies in an official community plan or strategic plan.
3) Conduct an age-friendly assessment in consultation with older adults.
4) Develop and publish an action plan.

The recognition program is being offered in partnership with BC Healthy Communities.

Age-friendly recognition will grant local governments:

- an Age-friendly BC recognition award;
- promotion on the Age-friendly BC section of the SeniorsBC website;
- promotion of the community in the SeniorsBC and BC Healthy Communities e-newsletters;
- recommendation by the Province to grant the local government age-friendly recognition at the national and international level through the Public Health Agency of Canada and the World Health Organization respectively;
- access to a cohesive network of age-friendly organizations (provincial, national and international); and
- a recognition reward to help the community provide an age-friendly legacy project or celebration.

To ensure continued age-friendly success and maintain recognition status, communities will also implement the action plan and monitor age-friendly progress by measuring and reviewing activities, and reporting publicly on action plan outcomes.

INFORMATION:

- email the Age-friendly coordinator at AgefriendlyBC@gov.bc.ca; or
- visit www.seniorsbc.ca/agefriendly/.

Appendix B - 2012 Age-friendly Recognition Review Summary

Community Name	Establish age-friendly advisory or steering committee	Pass a local council or board resolution	Conduct an age-friendly community assessment	Develop and publicize action plan	Comment
City of Duncan	Duncan Seniors Safety Advisory committee; Age-friendly Advisory Subcommittee	Included Age-friendly goals in Official Community Plan (OCP) (2008); Passed resolution to support age-friendly initiatives (2012)	Age-friendly Seniors Safety Project included a survey (2010)	Age-friendly Seniors Safety Project (2010)	Completed recognition steps
Township of Esquimalt	Access Awareness Committee; Parks and Recreation Advisory Committee	OCP included healthy community objectives and accessible community goal (2007, 2011)	Accessibility Audit for the Township of Esquimalt (2009)	Accessibility Audit for the Township of Esquimalt included an implementation strategy (2009)	Completed recognition steps but needs to expand focus from accessibility
District of Metchosin	Healthy Community Advisory Select Committee (HCASC); Active-aging Subcommittee	Passed a motion to develop a plan based on the Age-friendly Community Report to Council (2011)	Healthy Community Advisory Select Committee created the Age-friendly Community Report to Council (2011)	Currently developing an Action Plan based on priority actions identified by HCASC (2012)	Completed recognition steps, but anticipate revised / expanded action plan
City of Revelstoke	Seniors' Planning Steering Committee (part of the Social Development Committee)	Included in OCP (2009); Passed board resolution to reconfirm commitment to age-friendly work (2011)	Conducted a survey, public meetings, and presentations (2009)	An Age-friendly Plan for Revelstoke and Area (2009); Report on progress (2011)	Completed recognition steps
District of Saanich	Committees include seniors: Healthy Saanich; Parks, Trails and Recreation; Arts, Culture and Heritage	Participated in World Health Organization (WHO) Age-friendly Cities Project and created report (2007/08)	WHO Age-friendly Cities Project conducted focus groups and community consultation (2007)	WHO Age-Friendly Cities Project Report (2008)	Completed recognition steps
District of Sechelt	Accessibility Advisory Committee	Included 'balanced age-profile' and accessibility focus in OCP (2011)	Sechelt Accessibility Challenge (2009); Sechelt Seniors Survey (2010)	Annual: no single action plan, included in all projects	Completed recognition steps, but suggest summary of actions
City of Surrey	Seniors Advisory & Accessibility Committee of Council	Passed council resolution endorsing AFBC recognition application (2012)	Focus on Seniors Forums (2008-2012); Transportation and Accessibility Project surveys, forums, and events (2009)	Transportation and Accessibility Project (2009); Annual progress report to council on access and social wellbeing	Completed recognition steps but needs to expand focus from accessibility
District of West Vancouver	Seniors Activity Centre Advisory Board (SACAB) and subcommittees	Measuring Up Working Group Recommendations (2009); Access and Inclusion Policy (2009)	Lionsview Seniors Planning Society Seniors Today SACAB conducted survey (2011)	Paper on supporting age-friendly presented at workshop on age-friendly communities (2009)	Completed recognition steps, but anticipate revised / expanded action plan
City of White Rock	Semiahmoo Peninsula Seniors Planning Table	Age-friendly goals wording included in Leisure Services Master Plan (2009, 2010, 2011)	City of White Rock Age-friendly Assessment (2010)	Semiahmoo Peninsula Seniors Planning Table Action Plan (2012)	Completed recognition steps

Cliff

(Mayor)
(Community)
Address
City BC Postal Code

Dear Mayor (Name):

We are delighted to confirm that (Community) is one of the first communities to receive Age-friendly BC Recognition. This recognition acknowledges your leadership in making changes to ensure British Columbians can age actively, live in security, enjoy good health, and continue to participate fully in society. It confirms that your community has completed key milestones of commitment, engagement, assessment, and planning for an age-friendly community.

The recognition program is being offered as a partnership between the Ministry of Health and BC Healthy Communities. To support and celebrate your achievements, your community will be receiving a commemorative award and a $1,000 grant. The grant is intended to help with an age-friendly legacy project or a celebration to thank those who have worked on your age-friendly initiative. BC Healthy Communities is available to help you choose a suitable project.

Ministry of Health and BC Healthy Communities staff will be contacting your office in the next few weeks to make arrangements to deliver the awards, and to work on promotion of (Community)'s age-friendly experience on the SeniorsBC website and in the BC Healthy Communities newsletter.

Congratulations on your efforts and your commitment to create healthy communities to benefit all British Columbians.

Yours truly,

Michael de Jong, QC
Minister

Ron Cantelon
Parliamentary Secretary for Seniors to the Minister of Health

Jodi Mucha, Director
BC Healthy Communities

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 932424

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

TITLE: Background for meeting with the Applied Informatics for Health Society

PURPOSE: To prepare the Minister for a meeting with the Applied Informatics for Health Society on Thursday, June 7, 2012.

BACKGROUND:

The Applied Informatics for Health Society is a not-for-profit society in Prince George, which owns and operates an electronic medical record application called the Medical Office Information System. This application is more commonly known as "MOIS." The mission statement for the Applied Informatics for Health Society is to develop, implement and sustain quality software that in turn supports quality improvement, keeps pace with health initiatives and has the ability to respond quickly to the needs of health sector clients.

In February 2007, the Ministry of Health (the Ministry) issued a Request for Proposal (RFP) in collaboration with the British Columbia Medical Association (BCMA) to select six electronic medical record vendors for the Physician Information Technology Office initiative. The Applied Informatics for Health Society did not submit a proposal in response to the RFP process. As a result, their general practitioner customers are not eligible currently for funding through the Physician Information Technology Office initiative.

All physician reimbursement policies and programs under the Physician Information Technology Office are established by a steering committee which is jointly managed by the Ministry and BCMA. In July 2010, the steering committee approved a new funding program for specialists. The program reimburses specialists for achieving levels of meaningful use of an electronic medical record system, and is not restricted to the provincially qualified vendors. As such, specialists who use the Medical Office Information System application are eligible for funding from the Physician Information Technology Office.

DISCUSSION:

It is unclear if the Medical Office Information System could meet the technical and functional requirements established by the Physician Information Technology Office because it has not gone through the Ministry's conformance testing process. The current approved vendors were put through an extensive conformance testing process to validate that their applications were fully compliant with functional specifications listed in the contract. The conformance testing process involved several practicing physicians, medical office assistants and Ministry staff.

In late 2011, the Ministry had the option to renew the contracts with the existing qualified electronic medical records system vendors for an additional two years. The Ministry made the decision to renew the contracts, which effectively maintains the focus of the overall Physician Information Technology Office program on these vendors (e.g. Wolf Medical Systems, IntraHealth, Osler Systems, MedAccess).

S. 13

S. 13 Currently, the Ministry is working with one of the provincially qualified vendors as an early adopter of ePrescribing. Once this early adopter phase has been evaluated, the Ministry will update its eHealth integration specifications and make them available to the other qualified vendors.

S. 13

The Applied Informatics for Health Society has been invited to the Physicians Information Technology Office Steering Committee for June 20, 2012. They will be presenting an overview of their application to the Ministry, BCMA and health authority representatives on the committee.

ADVICE:

Suggested responses to stakeholders:

- The Ministry recognizes the advances in primary care that physicians in the Northern Health Authority have made in part with the Medical Office Information System application.
- The Ministry does not intend to limit which electronic medical record vendors can connect to the provincial eHealth systems.
- The Ministry will not make a decision about publishing the integration specifications to the entire vendor community until the early adopter phase has been evaluated.
- The Physician Information Technology Office Steering Committee has the accountability for adjusting its programs and policies as necessary to achieve its business goals.

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Drafter:	Jeff Aitken
Date:	June 5, 2012

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #: 934306

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

TITLE: Meeting with Grand Chief Doug Kelly – June 29, 2012

PURPOSE: Provide update on current status of implementation of the Framework Agreement on First Nation Health Governance (Framework Agreement).

BACKGROUND:

There is currently no proposed agenda for the meeting between Grand Chief Kelly and Minister de Jong, but it is likely that Grand Chief Kelly will want to discuss two outstanding issues: (1) the payment of Medical Services Plan (MSP) by the interim First Nations Health Authority (iFNHA) on behalf of First Nations, and (2) the Province of British Columbia's response to the transfer of Health Canada's Non-Insured Health Benefits program to the iFNHA, thus making it a private supplemental health insurance program instead of a federal one.

Progress has been made implementing the Framework Agreement and the Tripartite First Nations Health Plan. Almost all health authorities have signed Health Partnership Accords with First Nation regional caucuses and on-the-ground actions are beginning to result from these more formal structures for working together. The provincial-level health partnership accord is also under development.

DISCUSSION:

S. 16, S. 13

S. 13, S. 16

Program ADM/Division: Arlene Paton/Population and Public Health
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Date: June 22, 2012
File Name with Path: \\grayling\S15000\AHL-Staff\Admin\Exec Servs - Gen (280)\Exec briefing notes (280-20)\Briefing Notes\2012\934306_BN Grand Chief Doug Kelly

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 930996

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

TITLE: Minister of Health meeting with SUCCESS regarding Hepatitis B

PURPOSE: To provide information on the issues SUCCESS may raise regarding Hepatitis B

BACKGROUND:
Viral hepatitis remains a serious health issue in British Columbia. Over 60,000 British Columbians suffer from chronic hepatitis B and hepatitis C infections, respectively. Without intervention, approximately 15-30 percent of these individuals will require a liver transplant, or develop cirrhosis, liver cancer or end-stage liver disease in the next 40 years.[1] End-stage liver disease caused by chronic hepatitis B and hepatitis C is responsible for over 100 deaths and over $100 million dollars in associated costs per year.

In May 2007, the Ministry of Health released *Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC* to complement, guide and support community and health authorities in efforts to address viral hepatitis in BC. In 2011, the first progress report on *Healthy Pathways Forward* was released (attached).

Since 2007, hepatitis B rates in BC continue to decline, and three new drug therapies have been added to PharmaCare's formulary to prevent those with hepatitis B from progressing to serious liver disease. Culturally appropriate health resource materials have been developed and disseminated to improve communication between health care practitioners and individuals affected by viral hepatitis.

Despite these successes shown in the *Health Pathways Forward: Progress Report*, key challenges remain. Collaboration between the BC Centre for Disease Control and the Provincial Health Services Authority Centre for Chronic Disease Prevention has identified health inequalities for immigrants, refugees, individuals in corrections, and individuals requiring mental health and substance use support. To reduce over-reliance on acute care/specialist services, further increases in community-based prevention and care capacity are required, with particular focus on those who use injection drugs and new immigrants arriving from hepatitis B virus endemic countries.

DISCUSSION:
SUCCESS is one of the largest social service agencies in BC. On May 30, 2012, in collaboration with the BC Hepatitis program and the Division of Gastroenterology at the University of BC, they released the results of their Hepatitis B Awareness Study focused on Asian communities,

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[1] British Columbia Medical Association. (2005, May 1). *Viral Hepatitis Testing.* Retrieved July 11, 2011, from Clinical Practice Guidelines and Protocols in British Columbia: http://www.bcguidelines.ca/pdf/vihep.pdf

who carry a disproportionate burden of hepatitis B disease. It is expected that the results of this survey will be discussed at the June 11, 2012, meeting. This survey showed:

- general awareness of hepatitis B disease was relatively high in some communities, but lowest among south Asians (40 percent);
- 56 percent found that education about the disease was not adequate in the community (61 percent among Chinese);
- the majority of respondents (80 percent) felt that education about hepatitis would be more effective in their ethnic languages;
- of those diagnosed with hepatitis B disease, the majority are not being treated by a doctor for this condition (70 percent overall, 74 percent of Chinese and 73 percent of Filipinos); and
- 88 percent of those diagnosed with hepatitis B are not taking medication for the disease (90 percent of Chinese).

Ongoing initiatives highlighted in the *Healthy Pathways Forward: Progress Report* include improved communication between health care practitioners and those affected with viral hepatitis. One example is the development of culturally appropriate health resources aimed at improving communication and providing information to help individuals navigate the health system. Another future action is to streamline services among individuals leaving corrections, new immigrants and refugees, and Aboriginal people.

It is expected that SUCCESS will request hepatitis B be added to the Chronic Disease Management program, an initiative through the Medical Services Plan (MSP) to compensate physicians caring for people with certain chronic diseases; provide access to non-invasive Fibroscan® technology, currently paid as part of a specialist visit in Vancouver through MSP; and add additional flexibility for critical medicines already covered by PharmaCare. PharmaCare currently covers five drugs for the treatment of hepatitis B: lamivudine (Heptovir), interferon alfa (Intron A), adefovir (Hepsera®), entecavir (Baraclude®) and tenofovir (Viread®). As new information is available, government will also adjust PharmaCare coverage of hepatitis B drugs to improve coverage flexibility. In January 2012, the coverage criteria for tenofovir for hepatitis B was expanded.

SUMMARY:

Asian populations carry a disproportionate burden of hepatitis B disease. SUCCESS' recent Hepatitis B Awareness Study highlights opportunities for BC's health system to better reach and engage those affected by hepatitis B. The *Healthy Pathways Forward: Progress Report* released in December 2011 documents important population and health system outcomes since 2007, such as declining rates of viral hepatitis, as well as the development of culturally appropriate health resources aimed at improving communication and providing information to help individuals navigate the health system.

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Date:	May 31, 2012
File Name with Path:	Z:\A1 Admin\Executive 280\20 BNs\20 BBP\BBP 2012\930996 - Minister Mtg June 11 with SUCCESS re HBV.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

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Cliff # 938798

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

TITLE:

PURPOSE: S. 13, S. 16

BACKGROUND:

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

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On July 11, 2012, BCCSW sent a letter to the Canadian Council of Social Work Regulators and to BC's health professional regulatory colleges, asking regulators to speak to their counterparts and request they take issue with Alberta's position on the basis that it is contrary to the spirit and intent of TILMA, NWPTA and ultimately the Agreement on Internal Trade (AIT).

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

DISCUSSION:

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

S. 13, S. 16, S. 14

CONCLUSION:

S. 13, S. 16,

Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
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Date:	July 25, 2012
File Name with Path:	K:\TRADE AGREEMENTS\LABOUR MOBILITY\TILMA\938798 BN - TILMAbrief.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 934255

PREPARED FOR: Honourable Michael de Jong, Q.C. – **FOR INFORMATION**

TITLE: Fetal Sex Determination and Private Ultrasound Clinics

PURPOSE: To review potential for regulating fetal sex determination by "entertainment" ultrasound clinics under current legislation

BACKGROUND:

So-called "entertainment" ultrasounds, in which private, for-profit clinics offer 3D photos and videos of the fetus, are marketed to parents as a bonding experience. Such ultrasounds are not considered a medical procedure and are not paid for by the public health system. BC does not currently license or otherwise oversee the activities of entertainment ultrasound clinics or the staff employed by them. A recent CBC investigation found a number of such clinics willing to disclose the sex of a fetus earlier than 20 weeks, when abortion is more readily available. CBC also reports that Abbotsford, which has one of the largest Indo-Canadian communities in Canada, also has one of the country's most skewed gender ratios for children under fifteen, citing Statistics Canada figures showing 121 boys for every 100 girls.

An editorial in the January 16, 2012, edition of the *Canadian Medical Association Journal* advocated release of fetal gender information no earlier than 30 weeks gestation, while a study in the same publication in April of the male-female ratios in Ontario showed that multiparous women born in India but living in Canada were significantly more likely to have a male infant than women born in Canada.

On June 12, 2012, the Ministry of Health (MOH) distributed a new policy to Health Authorities' CEOs on "Fetal Sex Determination by Ultrasound". The policy states that the ultrasound technologist is not to release information about the sex of the fetus to the patient, but that the patient may obtain this information from her referring physician. The policy applies to all routine full fetal anatomical assessments by ultrasound provided by health authorities. It does not apply to entertainment ultrasound clinics.

On June 13, 2012, the Society of Obstetricians and Gynaecologists of Canada called for a complete ban on entertainment ultrasounds.

DISCUSSION:

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CONCLUSION:

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Program ADM/Division:	Elaine McKnight, CAO, 250- 952-1764
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Drafter:	Jennifer Webb
Date:	June 20, 2012
File Name with Path:	K:\GENERAL\2012\934058 BN - Fetal Sex Determination by Ultrasound.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 936244

PREPARED FOR: Honourable Michael de Jong, Q.C. – FOR INFORMATION

TITLE: Dental Profession Issues

PURPOSE: Prepared for the Minister's meeting with Dr. Chris Barlow, Abbotsford Representative for the BC Dental Association (BCDA), scheduled for July 3, 2012.

BACKGROUND:

This meeting is in follow-up to the BCDA's earlier meeting with the Minister on February 1, 2012. Dr. Barlow is expected to raise the same issues.

DISCUSSION:

A. Regulatory Issues

1. **Treating spouses** – interpreting the provisions of the *Health Professions Act* (HPA) and the bylaws of the College of Dental Surgeons of BC (CDSBC) in a manner that allows dentists to treat their spouses.

S. 13

2. **Health Professions Review Board (HPRB)** – addressing BCDA's concerns that HPRB's primary focus appears to be on mediated settlements instead of reviewing regulatory college processes.

   - BCDA appears to be asserting that HPRB's approach to its mandate, as seen in its procedural rules and individual case decisions, is inconsistent with the policy intent of the governing provisions of the HPA and the *Administrative Tribunals Act*. MOH understands that HPRB's approach to mediation is consistent with the applicable legislation and the overall policy direction for provincial administrative tribunals as set by Ministry of Attorney General (MAG).
   - HPRB is an independent tribunal and MOH has no role in how it applies its governing legislation.

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S. 13

B. Program Issues

3. *Limitation Act* – amending the *Limitation Act* to reduce the limitation period.

   - BCDA has sought to reduce the ultimate limitation period, which affects costs associated with retention of dental records.
   - The *Limitation Act* (Bill 34), which repeals and replaces the current *Limitation Act*, received Royal Assent on May 14, 2012. Once brought into force, Bill 34 will move from a 30-year ultimate limitation period to a 15-year ultimate limitation period.

4. ***Hospital Act*** - amending the *Hospital Act* to allow oral and maxillofacial dental surgeons hospital admitting privileges.

   - BCDA is seeking amendments to regulations under the *Hospital Act* to allow oral and maxillofacial dental surgeons to admit their own surgical and day patients. The regulations currently limit availability of admitting privileges to medical doctors and midwives.

S. 13

5. **Canadian Health Measures Survey (CHMS)** – BCDA is seeking funding to support a BC-specific version of the dental portion of CHMS.

   - In 2007-2009, Statistics Canada, with the support of Health Canada, collected key information relevant to the health of Canadians through CHMS. As part of CHMS, a clinical oral health examination was used to evaluate the association of oral health with major health concerns, such as diabetes and respiratory and cardiovascular diseases. BC residents were included in CHMS's sample population.
   - BCDA would like funding to help pay for a BC-specific version of the dental portion of CHMS in order to make comparisons with the national picture of oral health.
   - BC currently has a large pool of dental health information: BCDA has collected health information on adults aged 17-79 every five years since 1986 based on surveys in dental offices, kindergarten children are surveyed every three years and, in 2011, First Nation's kindergarten children were also surveyed.
   -

S. 13

6. **Funding for dental prosthetics** – increased funding for dental prosthetics.

   - Patients who have received treatment for oral cancer at a BC Cancer Agency (BCCA) clinic may require extensive dental restoration. BCCA arranges with community dentists to provide treatment, which often involves crowns, bridges and implants. Due to the cost of this treatment, there is a long wait list. BCDA would like funding to BCCA increased and additional funding to be made available to treat complex dental problems in other patients whose dental issues are the result of medical conditions.

S. 13

7. **Access to Care initiatives** – increased funding for low-income individuals.

   - The Ministry of Social Development (MSD) currently provides dental coverage to low income children and seniors who were disabled prior to age 65. Emergency dental care is also available to MSD clients. BCDA has advocated for expanding

government-supported dental coverage to low income seniors, but MSD has declined to institute such a program.

- Many low-income adults find it challenging to access dental care, particularly those whose employment package does not include a dental plan. BC currently has 18 not-for-profit dental clinics, ranging from small one-chair clinics located in church basements to larger four-chair clinics, such as Victoria's Cool-Aid Dental Clinic.
- BCDA would like annual subsidies to be made available to organizations that support not-for-profit clinics. However, the provision of such subsidies is at the discretion of Health Authorities, not MOH. MOH does not have the authority to direct Health Authorities to support not-for-profit clinics or, if Health Authorities choose to do so, to dictate what form that support should take.

CONCLUSION:

Negotiations with the BCDA began March 13, 2012. MOH and the BCDA have met a total of 4 times, most recently on June 28, 2012. S. 17, S. 13

S. 17, S. 13

S. 13

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Date:	June 29 2012
File Name with Path:	K:\HPRO\DENT\GENERAL\2012\BN 936244 BCDA meeting with the Minister.docx

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s. 13, s. 14

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 937559

PREPARED FOR: Honourable Michael de Jong, Q.C., Minister of Health –
FOR INFORMATION

TITLE: Amendments to the *Medicare Protection Act* audit provisions.

PURPOSE: To provide information regarding the changes to the *Medicare Protection Act* that were passed in 2003 and brought into force in 2006.

BACKGROUND:

Bill 92, the *Medicare Protection Amendment Act 2003,* was introduced to clarify and strengthen the provisions of the *Medicare Protection Act* related to the prevention of extra-billing by practitioners for medically necessary services. The amendments were required to ensure that British Columbia was in compliance with the *Canada Health Act,* which prohibits charging for medically necessary services.

DISCUSSION:

The following is a breakdown of the changes made to the *Medicare Protection Act* audit provisions in 2003. The amendments were brought into force in 2006, B.C. Reg. 306/2006. See the attached appendix for wording of provisions as they appeared before and after the amendments:

- Prior to Bill 92, section 36 (2) of the Act permitted appointed inspectors to audit only the practitioners enrolled in the Medical Services Plan. As amended, inspectors may now audit private clinics and unenrolled practitioners.
- Section 36 (4.1) added a new provision which permits audits to be completed retrospectively of private clinics and unenrolled practitioners records.
- Section 36 (5) (a) was expanded to include inspections of the records of private clinics and unenrolled practitioners.
- Section 45.1 added a new provision to allow the Medical Services Commission to seek an injunction to prevent a private clinic or practitioners from extra-billing.

FINANCIAL IMPLICATIONS: N/A

CONCLUSION:

The changes made to the audit provisions provided additional authority to access and audit the records of private clinics and of practitioners not enrolled under the Medical Services Plan. These provisions provide a mechanism for inspectors to verify whether extra-billing is occurring and allows the Medical Services Commission to remedy any contraventions.

Program ADM/Division:	Elaine McKnight, CAO, Office of the Chief Administrative Officer
Telephone:	250-952-2563
Program Contact (for content):	Robyn White, Director (250) 952-2246
Drafter:	Sabryna Tes **Date:** July 13, 2012
File Name with Path:	K:\MPRO\GENERAL\GENERAL 2012\937559 IBN - Audit Provisions.docx

APPENDIX A

Pre Bill 92 Provisions	Post Bill 92 Provisions
Section 36(2) The commission may appoint inspectors to audit claims for payment by practitioners and the patterns of practice or billing followed by practitioners under this Act.	The commission may appoint inspectors to audit (a) claims for payment by practitioners and the patterns of practice or billing followed by practitioners under this Act, (b) the billing or business practices of persons who own, manage, control or carry on a business for profit or gain and, in the course of the business, direct, authorize, cause, allow, assent to, assist in, acquiesce in or participate in the rendering of a benefit to beneficiaries by practitioners, and (c) the billing or business practices of persons who own, manage, control or carry on a business for profit or gain and who the commission on reasonable grounds believes (i) in the course of the business, direct, authorize, cause, allow, assent to, assist in, acquiesce in or participate in the rendering of a benefit to beneficiaries by practitioners, or (ii) have contravened section 17, 18, 18.1 or 19. ,
Section 36 (4.1) NEW	An audit under subsection (2) (b) or (c) may be made in respect of billing or business practices followed by persons before the coming into force of this subsection
Section 36 (5) (a) (5) An inspector may, at any reasonable time and for reasonable purposes of the audit, enter any premises and inspect (a) records of a practitioner, and (b) records maintained in hospitals, health facilities and diagnostic facilities.	(5) An inspector may, at any reasonable time and for reasonable purposes of the audit, enter any premises and inspect (a) records of a <u>person described in subsection (2) (b) or (c) or of a</u> practitioner, and (b) records maintained in hospitals, health facilities and diagnostic facilities.

Section 45.1 NEW	**Injunctions** **45.1** (1) The commission may apply to the Supreme Court for an injunction restraining a person from contravening section 17 (1), 18 (1) or (3), 18.1 (1) or (2) or 19 (1) or (2). (2) The court may grant an injunction sought under subsection (1) if the court is satisfied that there is reason to believe that there has been or will be a contravention of this Act or the regulations. (3) The court may grant an interim injunction until the outcome of an action commenced under subsection (1).

Subsequent Changes (since 2006) to the audit provisions

Provision in 2006	Current
Section 36 (1) 'prescribed agency' means a body that is prescribed for the purposes of this Part	2009 changes: 'prescribed agency' means a corporation or other body that is prescribed for the purposes of this Part
Section 36 (5) The power to enter a place under subsection (5) or (12) must not be used to enter a **dwelling house occupied as a residence** without the consent of the occupier except under the authority of a warrant under subsection (7).	2012 changes: The power to enter a place under subsection (5) or (12) must not be used to enter a private dwelling without the consent of the occupier except under the authority of a warrant under subsection (7).

MINISTRY OF HEALTH
OIC BACKGROUND NOTE

Cliff #: 931615

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

TITLE: Designation of a Medical Health Officer for the Interior Health Authority

PURPOSE: Dr. Perry Kendall, Provincial Health Officer, has requested that Dr. Trevor Corneil be designated as a Medical Health Officer for the Interior Health Authority.

BACKGROUND:

The Board of Directors of the Interior Health Authority approved a motion on May 29, 2012, that Dr. Trevor Corneil be designated as a Medical Health Officer for the geographic area for which the Interior Health Authority is responsible.

DISCUSSION:

Under the *Public Health Act*, a Medical Health officer may exercise powers granted to, and perform duties imposed on, medical health officers under this or any other enactment such as, but not limited to, monitoring the health of the population and advising authorities and local governments on public health issues, including health promotion and health protection, bylaws, policies and practices respecting those issues.

Dr. Corneil meets the requirements for appointment as a Medical Health Officer under the *Public Health Act* and his appointment has been recommended by the Board of the Interior Health Authority. Dr. Corneil's employment is dependent on the OIC appointment.

FINANCIAL IMPLICATIONS: None.

IMPACT ON REGULATORY COUNT: None.

CONCLUSION: Recommend approval of this OIC for the next available Cabinet Meeting.

Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
Telephone:	250-952-1764
Program Contact (for content):	Corrie Campbell: 250-952-2283
Drafter:	Debbie Barker
Date:	June 1, 2012
File Name with Path:	K:\APPOINTMENTS\Medical Health Officers\OIC 2012\931615 OIC Background Note.docx

MINISTRY OF HEALTH
OIC BACKGROUND NOTE

Cliff #: 921275

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

TITLE: Appointments to the Community Care and Assisted Living Appeal Board (CCALAB).

PURPOSE: Reappoint Paula Barnsley, Tung Chan and Richard Margetts, QC, as members of the CCALAB.

BACKGROUND:

The CCALAB is governed by both the *Community Care and Assisted Living Act* (CCALA) and the *Administrative Tribunals Act* (ATA).

Section 29 of the CCALA specifies that the CCALAB shall consist of individuals appointed by the Lieutenant Governor in Council. The Lieutenant Governor is to designate 1 member as chair and other members are appointed after consultation with the chair. The Lieutenant Governor in Council may designate one of the members as vice chair after consultation with the chair. Board Resourcing and Development Office confirmed that a merit based process was followed and the Chair was consulted on the appointments.

Section 2 of the ATA specifies that a member may be appointed to hold office for an initial term of 2 to 4 years, and may be reappointed for additional terms of up to 5 years.

DISCUSSION:

The CCALAB is an adjudicative tribunal that hears appeals under the CCALA. The CCALAB's purpose is to provide specialized, impartial, accessible and cost-effective forum for the hearing of appeals from licensing, regulation and certification decisions regarding community care and assisted living facilities and early childhood educators. Decisions made under the CCALA must balance the need to ensure minimum standards of health and safety for those cared for in facilities and the need to ensure fair process for operators and educators.

FINANCIAL IMPLICATIONS: None.

IMPACT ON REGULATORY COUNT: None.

CONCLUSION: Recommend approval of this OIC for the Cabinet Meeting scheduled for June 20, 2012.

Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
Telephone:	250-952-1764
Program Contact (for content):	Corrie Campbell: 250-952-2283
Drafter:	Debbie Barker
Date:	June 7, 2012
File Name with Path:	K:\APPOINTMENTS\Community Care and Assisted Living Appeal Board\OIC 2012\921275 OIC Background Note.docx

MINISTRY OF HEALTH
OIC BACKGROUND NOTE

Cliff #: 931615

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

TITLE: Designation of a Medical Health Officer for the Interior Health Authority

PURPOSE: Dr. Perry Kendall, Provincial Health Officer, has requested that Dr. Trevor Corneil be designated as a Medical Health Officer for the Interior Health Authority.

BACKGROUND:

The Board of Directors of the Interior Health Authority approved a motion on May 29, 2012, that Dr. Trevor Corneil be designated as a Medical Health Officer for the geographic area for which the Interior Health Authority is responsible.

DISCUSSION:

Under the *Public Health Act*, a Medical Health officer may exercise powers granted to, and perform duties imposed on, medical health officers under this or any other enactment such as, but not limited to, monitoring the health of the population and advising authorities and local governments on public health issues, including health promotion and health protection, bylaws, policies and practices respecting those issues.

Dr. Corneil meets the requirements for appointment as a Medical Health Officer under the *Public Health Act* and his appointment has been recommended by the Board of the Interior Health Authority. Dr. Corneil's employment is dependent on the OIC appointment.

FINANCIAL IMPLICATIONS: None.

IMPACT ON REGULATORY COUNT: None.

CONCLUSION: Recommend approval of this OIC for the next available Cabinet Meeting.

Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
Telephone:	250-952-1764
Program Contact (for content):	Corrie Campbell: 250-952-2283
Drafter:	Debbie Barker
Date:	June 1, 2012
File Name with Path:	K:\APPOINTMENTS\Medical Health Officers\OIC 2012\931615 OIC Background Note.docx

MINISTRY OF HEALTH
OIC BACKGROUND NOTE

Cliff #: 921275

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

TITLE: Appointments to the Community Care and Assisted Living Appeal Board (CCALAB).

PURPOSE: Reappoint Paula Barnsley, Tung Chan and Richard Margetts, QC, as members of the CCALAB.

BACKGROUND:

The CCALAB is governed by both the *Community Care and Assisted Living Act* (CCALA) and the *Administrative Tribunals Act* (ATA).

Section 29 of the CCALA specifies that the CCALAB shall consist of individuals appointed by the Lieutenant Governor in Council. The Lieutenant Governor is to designate 1 member as chair and other members are appointed after consultation with the chair. The Lieutenant Governor in Council may designate one of the members as vice chair after consultation with the chair. Board Resourcing and Development Office confirmed that a merit based process was followed and the Chair was consulted on the appointments.

Section 2 of the ATA specifies that a member may be appointed to hold office for an initial term of 2 to 4 years, and may be reappointed for additional terms of up to 5 years.

DISCUSSION:

The CCALAB is an adjudicative tribunal that hears appeals under the CCALA. The CCALAB's purpose is to provide specialized, impartial, accessible and cost-effective forum for the hearing of appeals from licensing, regulation and certification decisions regarding community care and assisted living facilities and early childhood educators. Decisions made under the CCALA must balance the need to ensure minimum standards of health and safety for those cared for in facilities and the need to ensure fair process for operators and educators.

FINANCIAL IMPLICATIONS: None.

IMPACT ON REGULATORY COUNT: None.

CONCLUSION: Recommend approval of this OIC for the Cabinet Meeting scheduled for June 20, 2012.

Program ADM/Division:	Elaine McKnight, Chief Administrative Officer
Telephone:	250-952-1764
Program Contact (for content):	Corrie Campbell: 250-952-2283
Drafter:	Debbie Barker
Date:	June 7, 2012
File Name with Path:	K:\APPOINTMENTS\Community Care and Assisted Living Appeal Board\OIC 2012\921275 OIC Background Note.docx

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #931649; Xref 926947

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

TITLE: Housing and Services Sustainability Strategy for the Mental Health Commission of Canada (MHCC) At Home/Chez Soi Vancouver Site Research Project.

PURPOSE: To provide an update on the strategy for sustainability planning for the At Home/Chez Soi project of the MHCC upon project completion in 2013 for the Minister's meeting with the MHCC June 11, 2012.

BACKGROUND:
The At Home/Chez Soi national research project was initiated on November 23, 2009, by the MHCC, a $110 million project involving 2210 participants across 5 sites in Canada, with the goal to provide evidence about what services and systems could best help people who are living with a mental illness and are homeless. The research project will end March 2013.

The Vancouver site includes three intervention approaches providing new services to 290 clients:

- Assertive Community Treatment (ACT) and access to subsidized housing; (90 clients)
- Brokerage Intensive Case Management (ICM) and subsidized housing; (100 clients)
- Congregate housing with onsite mental health and substance use service (the Bosman Hotel) (100 clients)

A fourth control group (200 individuals) are included in the study receiving 'Treatment as Usual'.

The total Vancouver site MHCC funding for health services and supported housing is $6.086 million annually (see Appendix A for budget[1]). Neither the Ministry of Health (MoH) nor the Vancouver Coastal Health Authority (VCHA) contributes resources to these services[2].

DISCUSSION:

S. 13, S. 16

S. 13, S. 16

Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
Telephone:	250-952-1049
Program Contact:	Ann Marr, Executive Director Mental Health &Substance Use
Drafters:	Monica Flexhaug
Date:	June 5, 2012

File Name with Path: Z:\HAD General\Briefing Notes\2012\DM Assignments\MHSU\931649 Xref 926947 At Home Chez Soi - Approved by Barbara Korabek June 7.docx

[4] Not including the meal program at the Bosman for $200,000/yr

Appendix A: Complete Vancouver Site At Home/Chez Soi Annual Budget[5]

Vancouver At Home/Chez-Soi
Intervention Description and Costing

Intervention	Intervention Description	Staff Composition	Number of Participants	Annual Cost	Notes
ACT	Assertive Community Treatment Team • 1:10 caseload • 24 hours/7 days a week • Outreach based model • Meets provincial ACT standards • Participants housed in scatter site market and social housing	1 team leader 1 administrative assistant 1 psychiatrist 1 nurse practitioner 2 registered nurses 1 peer specialist 1 aboriginal specialist 2 substance use counselors 1 supported employment specialist 1 occupational therapist 1 outreach worker	90	$1.5 million[6].	Higher need participants at baseline interview. Some attrition due to deaths in current number supported by ACT.
ICM	Intensive Case Management Team • 1:16 caseload • 12 hours/7 days a week • Outreach based model • Participants housed in scatter site market and social housing	1 team leader .2 administrative assistant 6 case managers	100	$650,000[7].	Less high need participants at baseline interview. Some attrition due to deaths and discharges in current number supported by ICM.

[5] Provided by the MHCC to the Vancouver Transition Team meeting Jan 25, 2012
[6] Includes administration and office costs
[7] Includes administration and office costs

Intervention	Intervention Description	Staff Composition	Number of Participants	Annual Cost	Notes
Bosman	Congregate Housing with Supports • Housing staff • Clinical service and support staff • Resident engagement • Meal program	Housing staff: • 1 daytime front desk staff; 2 nighttime front desk • Building maintenance Clinical service and support: • team leader • 1.2 licensed practical nurse • 1 registered nurse • 2.8 case managers • .4 family doctor • .2 psychiatrist • .4 peer support • 1.2 peer employment coordinator	100	Housing[8] and administration: $1.1 million. Meal Program (3 meals/day): $200,000. Clinical service and supports: $900,000.	Higher need participants at baseline interview.

[8] Costs include:
Front desk staff $390,805
Building maintenance staff $72,260
Lease costs total of $626,000 minus shelter component of income assistance with vacancy loss contingency of 10% (90 x $375 x 12 =$405,000) $221,000
Property tax costs of $103,000
Administration of $67,000
Building operation of $261,000

Intervention	Intervention Description	Staff Composition	Number of Participants	Annual Cost	Notes
Housing Subsidies	Housing portfolio development • Secure and maintain market and social housing • Ensure direct payment of rent • Landlord relations • Work with teams on re-housing • Provision of tenant insurance • Provision of one-time furniture	1.2 FTE Portfolio Development Officer	190	Rent supplements: $1.4 million[9]. Tenant Insurance: $36,000[10]. Landlord support and administration: $300,000.	One time furniture cost[11]: $285,000.

[9] Based on average rental subsidy of $600/month
[10] Annual insurance cost for each tenant of $189
[11] Based on one time cost

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 934317

PREPARED FOR: Honourable Michael de Jong, QC, Minister and
Honourable Mary McNeil, Minister of Children and Family Development - **FOR INFORMATION**

TITLE: **Cerebral Palsy Association of BC**

PURPOSE: To provide information to the Minister of Children and Family Development for a meeting with the Cerebral Palsy Association of BC.

BACKGROUND:
Cerebral palsy (CP) is a group of disorders that affect brain and nervous system functions such as movement, hearing, seeing, and thinking. CP is the result of an injury to the developing brain of an infant at anytime during pregnancy, birth, or until the age of three.

Approximately 8,800 British Columbians are affected by CP, with 400 new cases each year. [1] There are over 50,000 Canadians living with the condition.[2]

Spastic CP is the most common type and is caused by damage to the motor cortex making muscles tight and stiff which limits movement. Other types include ataxic (poor coordination and low muscle tone) athetoid (involuntary muscle movements) and mixed (combination of muscle tone and voluntary movement issues).

Infants diagnosed with CP are expected to have a normal life expectancy and the disease is considered non-progressive. The physical challenges of CP such as increased spasticity, fatigue, loss of strength and declining mobility may intensify with the age.
Treatment for those diagnosed with CP includes physical, occupational and speech therapies, orthotics and splints, medications, and orthopaedic and soft-tissue surgery.

Cerebral Palsy Association of BC
The Cerebral Palsy Association of BC (CPABC) is a non-profit association directed by a volunteer board of directors. Its membership includes those living with CP, parents of children and youth with CP, and interested community members.

CPABC provides programs, advocacy information and referral services for those affected by CP. Specific program initiatives include subsidies for children with CP to attend summer camp and post-secondary education bursaries for students with CP. It also raises public awareness about the condition through publications and by giving presentations across the province.

CPABC's 2012 priorities are to improve the association's connections with members and other organizations, and to improve its advocacy role.

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[1] CPABC-FAQ
http://www.bccerebralpalsy.com/index.php?option=com_content&view=category&layout=blog&id=40&Itemid=62
[2] CPABC- FAQ

Funding:
Funding for CPABC is provided through private and corporate donations, membership fees, fundraising efforts, the BC gaming commission and private grants.
The Ministry of Health does not provide funding to the CPABC.
The Public Accounts have not been released for 2011/12 yet so the information for most recent fiscal year is not yet available.
The Ministry of Social Development (also known as Housing and Social Development) has provided funding to CPABC including:

- $41,875 in 2010/11
- $42,000 in 2009/10
- $33,667 in 2008/09

The Ministry of Public Safety and Solicitor General also provided funding of $7,667 in 2008/09 and the Ministry of Children and Families provided $240 in 2008/09.

The Cerebral Palsy Sports Association of BC has also received government funding. The Ministry of Healthy Living and Sport provided funding of $7,625 to this organization in 2008/09. The Ministry of Public Safety and Solicitor General provided funding of $24,167 in 2008/09. The Ministry of Social Development provided funding of:

- $72,700 in 2010/11
- $74,473 in 2009/10
- $46,667 in 2008/09

DISCUSSION:
CPABC has stated that the funding it receives from the BC gaming commission has decreased in recent years.[3]

CPABC has publically lobbied for improvements to Community Living BC (CLBC). These improvements include an external review of CLBC, new funding and the establishment of an advocate for people with disabilities.[4]

BC Children's Orthopaedic Cerebral Palsy Clinic provides comprehensive care to children with CP, specializing in assessment, surgical management, and post operative care.

The BC Children's Hospital helps to administer the Canadian Cerebral Palsy Registry. The purpose of this registry is to help identify the risk factors associated with CP, improve statistical understanding of CP in Canada, and to better understand parents' perspectives on their child's care.

Sunny Hill Health Centre for Children, through the Neuromotor Program and Gait Lab supports children and youth with CP and their families through specialized clinical services and provincial initiatives, education events, research activities and partnerships with other provincial agencies. (See Appendix A for more information about services

Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
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Program Contact (for content):	Effie Henry, Executive Director – Hospital and Provincial Services Rebecca John, Director PHSA
Drafter:	Graham Young, Policy Analyst

[3] CPABC Spring 2012 Newsletter
[4] CPABC Spring 2012 Newsletter

Appendix A:
Sunny Hill Health Centre
Role and Services for children in BC with Cerebral Palsy (CP)

Sunny Hill Health Centre for Children, through the Neuromotor Program and Gait Lab supports children and youth with CP and their families through specialized clinical services and provincial initiatives, education events, research activities and partnerships with other provincial agencies.

Recent special initiatives include:

- **The Cerebral Palsy Registry - BC Division:** This project is a part of the Canadian Cerebral Palsy Registry, which is a confidential, nation-wide collection of information about people with cerebral palsy in Canada. The aims of the registry are to gain further understanding of the risk factors and causes of CP, to understand how often children are diagnosed with CP, and where they live in BC and in Canada and to better understand parents' perspectives on their child's care and how services are provided to them. Community agencies as well as family resources such as the CP Association of BC have been contacted to inform them of the project.

- **2013 hosts for CP Conference (through NeuroDevNet):** This national conference is open to children/youth with CP and their families as well as professionals who work with children/youth with CP. Currently in the planning stages, the conference theme will look at research, services and programs to support children/youth with CP and their families in daily living and future planning. We will be linking with groups such as the CP Association of BC to connect with families about the conference.

- **Creating provincial standards for hip surveillance for children with Cerebral Palsy:** Hip displacement is a common health issue in children with Cerebral Palsy and can result in pain, reduced function and the need for major surgical procedures. Hip surveillance is the process of identifying and monitoring the critical early indicators of progressive hip displacement by an active screening program. The premise of surveillance is that early detection (e.g. of hip subluxation) leads to early intervention, thus reducing the need for reconstructive surgery, and reducing or eliminating salvage surgery (and increased morbidity and health related costs). Sunny Hill together with BC Children's' Orthopedic department and Child Health BC have spearheaded a project to develop and implement provincial standards for hip surveillance for children with CP.

- **The Neuromotor Program and Gait Lab at Sunny Hill** offer specialized services to children with Cerebral Palsy and other neuromotor conditions. Services may be provided through our inpatient rehabilitation unit (i.e following orthopedic surgical procedures or gastrostomy tube placement), through outpatient services or offered in local communities through our outreach or telehealth services. Services include:
    - Feeding and nutrition
    - Tone management
    - Positioning and Mobility
    - Assistive Technology and Augmentative communication
    - Psycho-educational assessment

- Sleep disorders
- Vision and Hearing
- Therapeutic Recreation
- Transition planning
- Gait assessment and management

We work closely with clinics and departments at BC Children's hospital, such as the Orthopedic Department as well as the child's community services such as the Child Development Centres to best support but not duplicate services. Our role is also to share knowledge and evidence with our community partners through education events.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 934374

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

TITLE: Minister teleconference meeting with Fraser Health Authority (FHA) regarding future operations of Abbotsford hospice residence, under construction

PURPOSE: To provide background information for the Minister's teleconference meeting with Ms. Carolyn Tayler and Ms. Linda Foley of FHA at 1:00-1:30 pm on July 3, 2012

BACKGROUND:

The Minister's teleconference meeting on July 3, 2012 will be attended by FHA and Ministry of Health (the Ministry) executive. Representatives attending for FHA will be Ms. Lynda Foley, Executive Director, Home Health and End of Life and Ms. Carolyn Tayler, Director, End of Life Care. The Ministry executive attending the meeting will be Ms. Barbara Korabek, Assistant Deputy Minister, Health Authorities Division and Ms. Leigh Ann Seller, Executive Director, Home, Community and Integrated Care.

The July 3rd teleconference precedes a meeting by Ms. Foley and Ms. Tayler with Deborah Lehmann, Executive Director of Abbotsford Hospice Society on July 5, 2012 about operations of the planned Holmberg House adult hospice residence.

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

In May 2011, the Ministry provided $3.5 million to support hospice services through the Abbotsford Hospice Society. In February, 2012 the Minister was the guest speaker at the annual gala of the Abbotsford Hospice Society in which Mr. David Holmberg Jr. was honoured with a memorial slideshow posthumously.

DISCUSSION:

The Ministry developed the Provincial Framework for End-of-Life Care in 2006, which is used as a guide by health authorities and care providers in developing and delivering services to those in need. Under this framework, hospice palliative and end-of-life care is

provided by health authorities through the Home and Community Care Program to adults across community-based settings that may include the client's own home, supportive and assisted living residences, licensed residential care facilities that include hospice and flex beds for palliative care, and in adult day and respite care settings for caregiver relief.

FHA has four operational management models to provide residential hospice care: FHA owned and operated 'hospice residence' facilities, FHA leased and operated facilities, contracted service provider (CSP) operated facilities, and Hospice Society/FHA shared management operated facilities. Each model has different requirements in relation to the building, equipment and furnishings, management of staff and provision of additional services and comforts. Basic clinical services and standards of care are managed consistently across all settings. Appendix A is a comparison of the hospice care models provided in FHA.

FHA has an established Request for Proposal (RFP) process that must be followed by service providers interested in providing hospice care through a hospice residence model. The contract, capital equipment budget and operating budget are negotiated by the FHA Director for End of Life Care, and the service provider. FHA has an owned and operated hospice in the Mission Hospital that operates at less than 100% occupancy. Based on this utilization, FHA has not planned to expand hospice beds in the Abbotsford/Mission area.

ADVICE:

S. 13

Program ADM/Division:	Barbara Korabek, ADM Health Authorities Division
Telephone:	250 952-1049
Program Contact (for content):	Leigh Ann Seller, ED, Home, Community and Integrated Care
Drafter:	Anna Gardner, Policy Analyst, Home, Community and Integrated Care
Date:	June 26, 2012
File Name with Path:	M:\HAD General\Briefing Notes\2012\HCIC\934374 Minister de Jong teleconf July 3 re Abbotsford Hospice Soc - Approved by Barbara Korabek June 28 (2).doc

Appendix A. Operational Management Models for Hospice Care in FH

	FH owned and operated	FH leased and operated	Contracted Service Provider (CSP)	Hospice Society FH shared operations/management
Building	FH pays for all capital costs and maintenance of building	Building owner pays for capital costs and maintenance of building. FH pays lease, operating costs.	CSP pays for all capital costs and maintenance of building.	Hospice Society pays capital costs and maintenance of building
Equipment and furnishings	Hospice Society (and other donors) pay for a portion of costs of equipment and furnishings	Hospice Society (and other donors) pay for a portion of costs of equipment and furnishings	CSP pays costs of equipment and furnishings. Hospice Society may pay for a portion of costs of equipment and furnishings	Hospice Society (and other donors) pay for capital costs of equipment and furnishings
Clinical services & standards	FH pays operating costs for basic staff, basic services, pharmacy and medical supplies. FH determines care standards, admissions, clinical practice, and education. FH provides Meditech connections and computers for hospice clinical staff.			
Staff management	FH manages both nursing and non-nursing staff	FH manages both nursing and non-nursing staff	CSP manages both nursing and non-nursing staff	FH manages clinical staff. Hospice Society manages non-clinical staff.
Additional services and comforts	Hospice Society provides volunteers and complementary therapies. Hospice Society (or other donors) provides operating costs for television/internet cable, telephones for patients/families. CSP may provide added-value services and/or comforts.			

MINISTRY OF HEALTH
DECISION BRIEFING NOTE

Cliff # 934973

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

TITLE: Provincial Dementia Action Plan - Approval for Release

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

BACKGROUND:

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

DISCUSSION:

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

OPTIONS:

S. 13

Approved/Not Approved
Michael de Jong
Minister of Health

Date Signed

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

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #: 935750

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

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

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

BACKGROUND:

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

DISCUSSION:

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

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

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

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

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

Appendix 1: Recommendation #1

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

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

Improvements should include:

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

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

Appendix 2: Full Action Plan

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

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

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

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

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

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

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 935754

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

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

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

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

DISCUSSION:

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

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

CONCLUSION:

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

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

Attachment #1 – OCD Group Program Description

Vancouver General Hospital
Outpatient Psychiatry Team
715 West 12th Avenue, Ground Floor
Vancouver, BC V5Z 1M7
Telephone: (604) 875-4794
Facsimile: (604) 875-4285

OCD Workshop

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

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

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

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

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

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

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

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

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

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

OCD GROUP

Obsessive Compulsive Disorder

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

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

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

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

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

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

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

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

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

We accept clients from all health regions

Vancouver Coastal Health

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 935881

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

TITLE: Overall Update on Fraser Health Congestion

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

BRITISH COLUMBIA

927061

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

Dear Mr. Mitchell:

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

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

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

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

...2

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

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

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

Yours truly,

Michael de Jong, QC
Minister

Enclosures (2)

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

Appendix 2

BRITISH COLUMBIA

TO: Fraser Health Authority Board

SUBJECT: Directive to Fraser Health Authority

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

1. As soon as practical, but in no case more than 14 days from the date of this Directive:

    a) FHA shall ensure visible site leadership at Royal Columbian and Surrey Memorial Hospitals with full authority to improve access and flow.
    b) The Board shall submit for my review and approval, a congestion action plan which specifically describes how FHA will achieve the clinical targets described in Table 1, enclosed.

2. FHA shall achieve the clinical targets described in Table 1 within the specified timelines.

3. The Board shall report progress against these targets to the Deputy Minister of Health monthly beginning in June 2012 and provide any other information as requested by the Ministry of Health.

4. The Board shall instruct the FHA Chief Executive Officer and senior executive: to meet regularly with the Ministry of Health monitoring lead and senior Ministry of Health staff; to grant complete access to FHA facilities, staff and information as deemed required by the monitoring team; and to include them in FHA's weekly executive meetings and other meetings as deemed required to fulfill their monitoring role.

5. In the event that any dispute arises, it will be resolved by Mr. Graham Whitmarsh, Deputy Minister of Health.

Honourable Michael de Jong, QC
Minister of Health

Date

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

Appendix 3

Table 1: Quality Measures and Targets for Fraser Health Authority

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

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

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

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

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

Appendix 4

Table 2: Relevant Dates for FHA Congestion Monitoring Process

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

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938213 **XREF # 934374**

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

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

PURPOSE: To provide background information for the Minister.

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

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

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

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

ADVICE:

The Ministry will be confirm its direction to the CEO of FHA in writing, and will work with FHA to provide support and remain informed about FHA's planning for Abbotsford and Mission sites.

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

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

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 938016

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

TITLE: Posting of Substantiated Complaints and Inspection Results

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

BACKGROUND:

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

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

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

DISCUSSION:

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

Key areas where consensus has been reached include:

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

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

ADVICE:

Ministry and health authorities are very close to finalizing the details for posting substantiated complaints, and the focus is now shifting to establishing and implementing an inspection process for *Hospital Act* facilities, which will include the posting of summary results of inspection reports.

All health authorities report that they are on target to meet these timeframes, and that websites will be live in September 2012.

Program ADM/Division:	Barbara Korabek, ADM, Health Authorities Division
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Drafter:	Sue Bedford, Director, Community Care Licensing
Date:	July 18, 2012
File Name with Path:	M:\Z:\Briefing Notes\2012\HCIC\938016 Update on Posting of Confirmed Complaints July 2012 v.2.docx

Appendix A - Standardized Data Definitions and Principles

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

Definitions:

Service Type

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

Complaint

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

Complaint investigation

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

Substantiated complaint

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

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

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

Corrective Action

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

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

Substantiated findings

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

Other findings

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

Health and Safety Plan

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

Principles:

Governing standards

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

Complaint type

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

How complaints are counted

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

Complaint date

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

Website refresh

- Minimum of quarterly updates.

Posting date

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

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

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

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

Appendix B - Complaint Category Definitions

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

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

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

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

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

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

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

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

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

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

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

HEALTH AUTHORITY COMMUNITY CARE LICENSING WEBSITE

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

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

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

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

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

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

Appendix D - Frequently Asked Questions

What is a Long Term Care Facility?

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

Why is complaint information being posted?

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

What will the complaint information tell me?

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

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

What will the complaint information NOT tell me?

Summary complaint information will NOT:

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

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

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

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

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

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

Will personal information be posted in the complaint?

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

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

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

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

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

What happens when a complaint is substantiated?

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

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

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

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

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

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

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

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

Is the information on this website current?

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

MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 940557 xref 925390

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

TITLE: Provincial Colorectal Cancer Screening Program

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

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

The Plan was resource intensive and centralized most program elements within BCCA or BCCA's control, including: patient recruitment and follow-up, regional hubs, call centres, and nurse navigators to help patients through a pathway of registration, mailed laboratory test and results, colonoscopy procedures, surveillance, and patient call-back.

This model would have required moving significant funds to PHSA/BCCA that are currently embedded in the Medical Service Plan (MSP) and regional health authority (RHA) budgets. The Ministry did not support this approach, given challenges with baseline cost information and the various affected physician funding agreements.

Most importantly, the Plan had a diminished role for Primary Care providers. Given BC's recent investments on primary care initiatives, including cancer and other prevention strategies, it was decided that a primary care-centred approach was preferred for a provincial screening program.

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

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

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

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

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

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

FINANCIAL IMPLICATIONS:

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Next Steps:

S. 13

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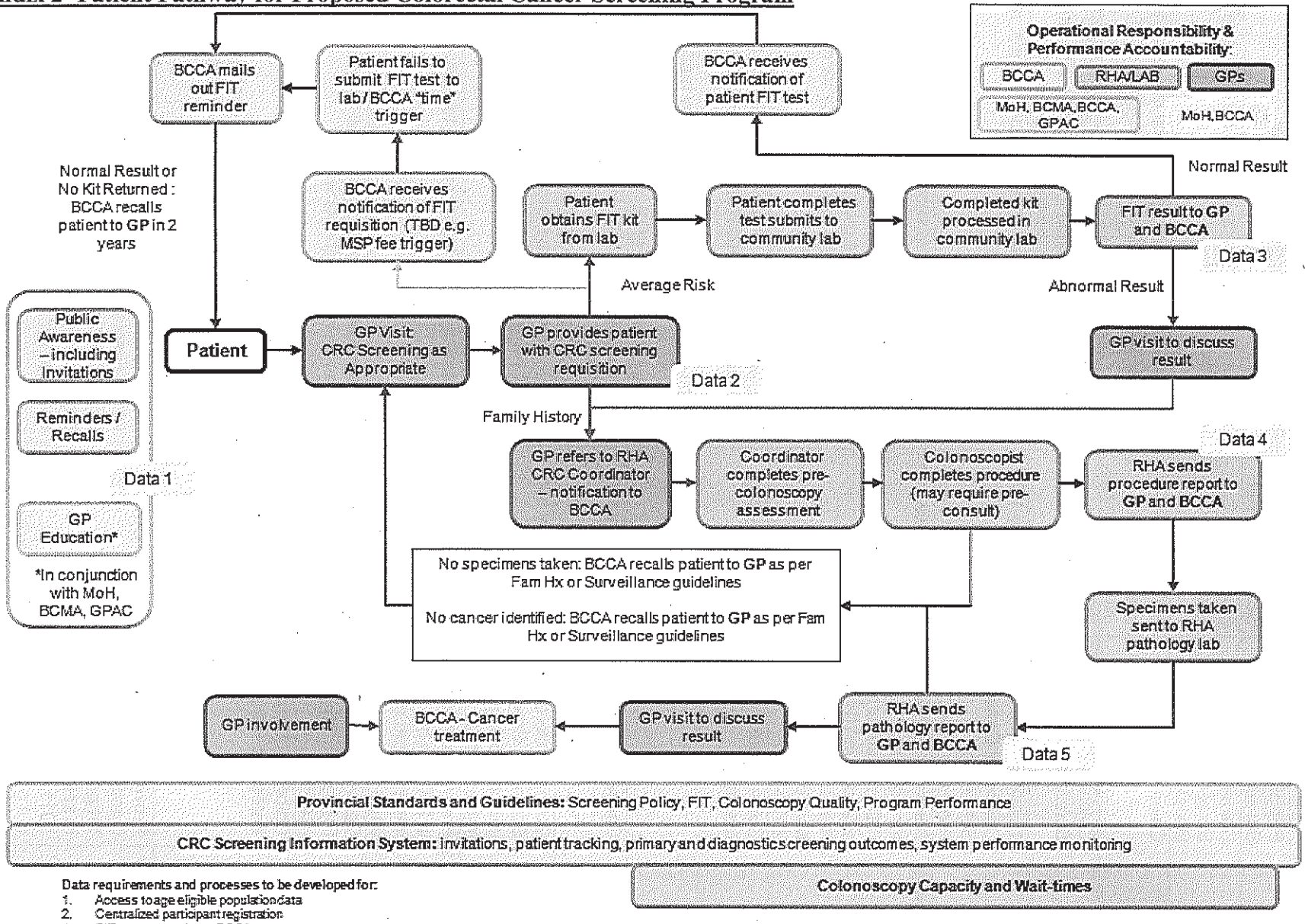
Program Contact (for content):	Effie Henry, Executive Director
Date:	August 14, 2012
File Name with Path:	S:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\MO BN's\940557 - xref 925390 Colon Check Update BN.docx

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

Appendix 1 – Colorectal Cancer Screening Programs in Canada

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

Appendix 2- Patient Pathway for Proposed Colorectal Cancer Screening Program



Data requirements and processes to be developed for:

1. Access to age eligible population data
2. Centralized participant registration
3. FIT result reporting to BCCA
4. Colonoscopy reporting to BCCA
5. Pathology reporting to BCCA

Preliminary Description – Clinical Pathway

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

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 936227

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

TITLE: Meeting with Alberta Government Regarding Health Authority Models

PURPOSE: To prepare for meeting with the Alberta Government to discuss both BC and Alberta's Health Authority structure.

BACKGROUND
Due to limited time constraints, only very general information has been provided.

BC Health Authority Model

- British Columbia moved to a regional model of health care delivery in the 1990s. The previous array of 52 regional authorities included 11 regional health boards, 34 community health councils and seven community health services societies.
- Each of these authorities had its own chief executive officer, corporate services and administrative infrastructure – making the structure one of the most complex and costly of its kind in Canada.
- On December 12, 2001, the province's 52 regional and community health authorities were streamlined to a new service delivery model consisting of one provincial and five geographic health authorities.
- The regional health authorities are primarily responsible for identifying population health needs; planning appropriate programs and services; ensuring programs and services are properly funded and managed; and meeting performance objectives.
- 15 Health Services Delivery Areas reside within the five health authorities to reflect provincial geography as well as patient and physician referral patterns.
- The sixth governing body is the Provincial Health Services Authority which is responsible for planning and coordinating the delivery of provincial programs and highly specialized services, such as transplants and cardiac care.
- Ambulance services and emergency health services in BC are coordinated by a provincial entity, the Emergency Health Services Commission, which is in the process of being moved out of core government and aligned with the Provincial Health Services Agency.
- Health Authorities are accountable to the Province, through the Ministry of Health for their performance. The key accountability mechanisms are the Government Letter of Expectations (GLE) and the Health Authority Service Plan, which are part of the annual accountability cycle.

Alberta Health Authority Model

- In May 2008, Alberta Health Services was created as a "superboard" with the abolition of nine regional health and three provincial agencies. Alberta Health Services is Canada's first province-wide, fully integrated health system.
- Alberta Health Services delivers medical care on behalf of the Alberta Department of Health and Wellness.

- Alberta Health Services took over responsibility for all Emergency Medical Services (EMS) from municipalities on April 1, 2009, making ground ambulances a responsibility of the provincial government. Provincial air ambulance transitioned to Alberta Health Services in April 2010.
- Alberta Health Services has been given a five-year funding and action plan that sets out clearly defined targets for health system performance and also outlines how Alberta Health Services and the Government of Alberta will meet those targets.

DISCUSSION

- Due to limited time constraints, we are unable to provide perspective on the Alberta Health model.

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